KPMG

Independent review of cancer prostheses equity in Australia

Final Review Report

Department of Health, Disability and Ageing

—

29 August 2025

Acknowledgement of Country

KPMG acknowledges Aboriginal and Torres Strait Islander peoples as the First Peoples of Australia. We pay our respects to Elders past, present, and future as the Traditional Custodians of the land, water and skies of where we work.

At KPMG, our future is one where all Australians are united by a shared, honest, and complete understanding of our past, present, and future. We are committed to making this future a reality. Our story celebrates and acknowledges that the cultures, histories, rights, and voices of Aboriginal and Torres Strait Islander People are heard, understood, respected, and celebrated.

Australia's First Peoples continue to hold distinctive cultural, spiritual, physical and economical relationships with their land, water and skies. We take our obligations to the land and environments in which we operate seriously.

We look forward to making our contribution towards a new future for Aboriginal and Torres Strait Islander peoples so that they can chart a strong future for themselves, their families and communities. We believe we can achieve much more together than we can apart.

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Acknowledgement of participation

KPMG and the Department of Health, Disability and Ageing would like to sincerely thank all participants who generously contributed their time to the consultation process for this review.

Gaining the perspectives of a diverse range of stakeholders, including people with lived or living experience of cancer and their carers, was invaluable in shaping this report and ensuring the review reflected a broad and balanced range of views.

Inherent limitations

This report has been prepared as outlined with the Australian Government Department of Health, Disability and Ageing in the scope section of the engagement letter / contract executed on 3 March 2025. The services provided in connection with this engagement comprise an advisory engagement, which is not subject to assurance or other standards issued by the Australian Auditing and Assurance Standards Board and, consequently no opinions or conclusions intended to convey assurance have been expressed.

No warranty of completeness, accuracy or reliability is given in relation to the statements and representations made by, and the information and documentation provided by Australian Government Department of Health, Disability and Ageing stakeholders consulted as part of the process.

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Acronyms

Acronym	Description
ACT	Australian Capital Territory
ACALS	ACT Artificial Limb Scheme
AIHW	Australian Institute of Health and Welfare
BCNA	Breast Cancer Network Australia
CALD	Culturally and Linguistically Diverse
CAPS	Cancer and Population Screening
CPCD	Canadian Dental Care Plan
CHS	Canberra Health Service
CPI	Consumer Price Index
DVA	Department of Veterans' Affairs
EBPRP	External Breast Prosthesis Reimbursement Program
ENT	Ear, Nose and Throat
FECCA	Federation of Ethnic Communities Councils of Australia
GP	General Practitioner
HBCF	Hunter Breast Cancer Foundation
HME	Heat Moisture Exchanger
HTA	Health Technology Assessment
ICT	Information and Communications Technology
KRQ	Key Research Question
LGBTIQA+	Lesbian, Gay, Bisexual, Transgender, Intersex, Queer and Asexual people
LHD	Local Health District
MASS	Medical Aids Subsidy Scheme
MMM	Modified Monash Model
MSAC	Medical Services Advisory Committee
NACCHO	National Aboriginal Community Controlled Health Organisation
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NHS	National Health Service
NHMRC	National Health and Medical Research Council
NGO	Non-Government Organisation
NSW	New South Wales
NT	Northern Territory
OAPL	Orthopaedic Appliances Pty Ltd
OPST	Orthotic Prosthetic Services Tasmania
OPS	Orthotic Prosthetic Solutions
PAHO	Pan American Health Organization
PLS	Prosthetic Limb Service

Acronym	Description
PMO	Project Management Office
PSP	Prosthetic Service Provider
QLD	Queensland
RAP	Rehabilitation Appliances Program
RFT	Request for Tender
SA	South Australia
SAALS	South Australian Amputee Limb Service
SACH	Solid Ankle Cushion Heel
SWEP	State-Wide Equipment Program
TAS	Tasmania
TGA	Therapeutic Goods Administration
UK	United Kingdom
VED	Vacuum Erection Device
VIC	Victoria
VHL	Virtual Health Library
WA	Western Australia
WALSA	WA Limb Service for Amputees

Executive summary

Executive summary

In March 2025, the Department of Health, Disability and Ageing (the Department) engaged KPMG to undertake an independent review of cancer prostheses equity in Australia. The purpose of the review was to understand current access to external prostheses across Australia for people with lived or living experience of cancer. This provided the evidence to consider the options for, and the costs associated with, a potential future national program designed to address service gaps and barriers to equitable access.

Background

Cancer remains the leading cause of death and the most significant contributor to disease burden in Australia, with approximately 165,000 new cases diagnosed each year. While recent medical advancements have improved survival rates, many people experience lasting impacts to their physical health and emotional wellbeing. These impacts can be particularly significant for individuals who have undergone an amputation or resection of a part of their body to treat or manage their cancer. For these individuals, prostheses can play a crucial role in helping to maintain their quality of life, restore functionality, foster independence, and support psychological wellbeing. However, access to publicly funded prostheses services in Australia is inconsistent and depends on the type of prosthesis required.

The inconsistencies in current funding schemes and barriers to accessing prostheses for people with living or lived experience of cancer have been highlighted by several recent federal reviews and strategies, including:

- Recommendation 14 from the Senate Community Affairs References Committee enquiry into *Equitable access to diagnosis and treatment for individuals with rare and less common cancers, including neuroendocrine cancer*. The committee recommended that the Australian Government work with State and Territory Governments to identify the barriers faced by cancer patients requiring rehabilitation, prosthetics and implants as a result of their treatment, with a view to ensuring they have financial support for those services.
- The evaluation of the External Breast Prosthesis Reimbursement Program, which highlighted notable barriers that limit equitable access to external breast prostheses, including the need for an up-front payment. It was also noted that these barriers are significant for priority population groups, including First Nations and CALD communities.
- The Australian Cancer Plan, which includes the aim of reducing disparities in cancer care, particularly for priority populations.

Review purpose and scope

The Department commissioned KPMG to review equity in access to cancer prostheses in Australia. The review focused on understanding current prostheses services available across the country to identify gaps and barriers to access. Additionally, the review sought to understand the potential cost implications if a new national program were to be established to support equitable access to prostheses for people living with or who have lived experience of cancer.

The scope of this review was provided by the Department and was validated with key stakeholders as part of a review design workshop (see Appendix B for a list of workshop attendees). For the purposes of this review, the term ‘prosthesis’ referred to an external device that replaces a part of a person’s body that was removed due to cancer and / or cancer treatment. This included:

- Facial prostheses, including prosthetic ears, noses, eyeballs, orbital prostheses and hemi-facial prostheses
- External breast prostheses
- Limb prostheses, including arm prostheses fitted at, above or below the elbow and leg prostheses fitted at, above or below the knee.

Throughout the review, several other types of prostheses were discussed by stakeholders that were considered to be outside the agreed review scope. This included oral prostheses, which are typically considered implants, and

prostheses that require further evaluation to determine if they meet the definition of an external prosthesis. This included non-indwelling voice prostheses and male reproductive prostheses. While not in scope, these prostheses have been included in some sections of this report for completeness; however, they were not considered in the development of options for a potential national cancer prostheses program.

Review methodology

A mixed-methods approach was adopted for this review, guided by a set of seven Key Review Questions (KRQs), which each included several sub-questions. These included:

- **KRQ 1:** What prostheses services / schemes are current available to people living with or who have lived experience of cancer?
- **KRQ 2:** What role do state, territory and commonwealth governments currently play in providing access to cancer prostheses?
- **KRQ 3:** In what health setting/s are people living with or have lived experience of cancer accessing cancer prostheses?
- **KRQ 4:** What are the current barriers faced by people living with or who have lived experience of cancer in accessing prostheses?
- **KRQ 5:** Are there particular prostheses types that are more difficult to access than others? Are there particular prostheses types not covered by any existing support schemes>
- **KRQ 6:** Is there a gap in equity and access to prosthetics for individuals living with or post a cancer diagnosis?
- **KRQ 7:** what would be the cost and an appropriate delivery model for a national cancer prostheses program?

Both primary and secondary data was collected and analysed to inform the review, with a range of data collection activities undertaken, including:

- **Stakeholder consultation** with 70 individuals, including representatives from Australian Government agencies, peak bodies and advocacy groups, state and territory health departments, clinicians involved in the delivery of prostheses services, prostheses retailers and individuals who are living with or who have lived experience of cancer
- **A survey** of 61 people living with or who have lived experience of cancer and their carers
- **A survey** of 57 clinicians involved in the delivery of prostheses services
- **A review of publicly available documents**, including peer-reviewed and grey literature sources, relating to the current provision of prostheses services, programs and schemes in Australia and internationally
- **A review of publicly available quantitative data** relating to the incidence of cancer in Australia, the need for prostheses as a result of cancer and the cost of prostheses.

Review findings

This report outlines the key findings from the review. When considering the findings outlined within this report, it is important to note the following:

- The ability to report on cancer prostheses services, schemes and programs currently in place across Australia was limited by the availability and quality of publicly available information. Where publicly available information was unavailable or incomplete, qualitative insights from stakeholder consultations were relied upon to supplement the documentation.
- Stakeholder perceptions used to inform this report were limited to the stakeholders who were willing and able to attend consultations with KPMG during the consultation period and may not necessarily represent the diverse views or experiences of all who have an interest in, or interaction with, cancer prosthesis programs or services. The method used to develop this report did not include verification of whether stakeholders' perceptions aligned with actual events or practice.
- Limited public quantitative data was available to support the development of cost estimates, with input from stakeholders relied upon to inform cost modelling. Therefore, the cost estimates included in this report may not accurately reflect the actual costs associated with a potential national program.

Current prostheses services, programs and schemes in Australia

People requiring external breast prostheses and limb prostheses due to cancer or cancer treatment can access prostheses through national programs funded by the Australian Government. The primary national program for breast prostheses is the External Breast Prostheses Reimbursement Program (EBPRP), while limb prostheses can be accessed through the National Disability Insurance Scheme (NDIS) or jurisdictional limb schemes. In contrast, there is no national program or scheme in place for individuals requiring a facial prosthesis due to cancer or cancer treatment.

Most types of prostheses are covered under the Department of Veterans' Affairs (DVA) for eligible individuals. Some private health insurance policies provide limited coverage for prostheses; however, as external prostheses are not included on the Prescribed List, private health insurers are not required to pay benefits for these items. Further details regarding the prostheses services, programs, and schemes available in Australia by prosthesis type are provided below.

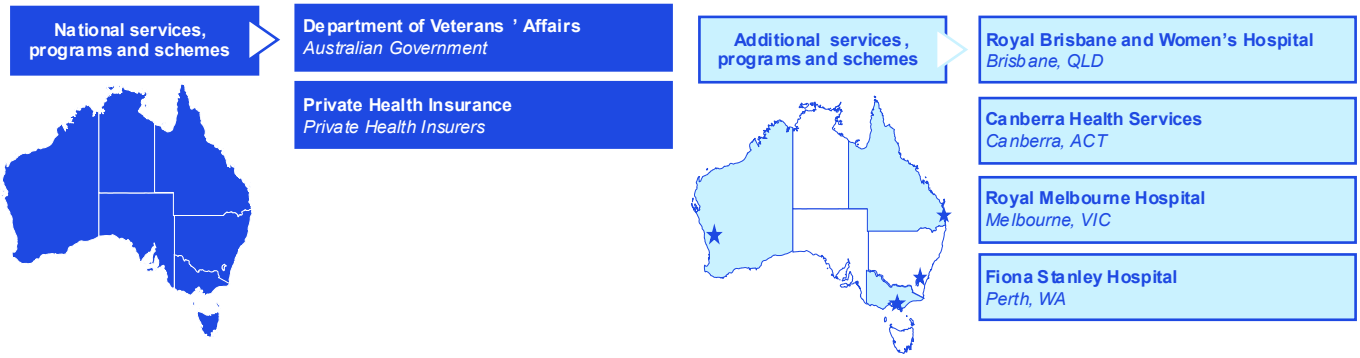
Facial prostheses

There is no national program or scheme currently in place that provides broad coverage for facial prostheses to people across Australia. A small proportion of people may be eligible to receive funding through the DVA or their private health insurance. The NDIS typically does not fund facial prostheses, as they fall outside the scheme's eligibility criteria.

There is significant variation across jurisdictions in the availability of publicly funded facial prostheses services, schemes and programs. As shown by Figure 1, in Victoria, Queensland, and Western Australia, some major public hospitals provide access to and funding for facial prostheses, including orbital, ear, nasal, and hemifacial prostheses. In the ACT, only ocular prostheses are publicly funded, whereas in New South Wales, South Australia, Tasmania, and the Northern Territory, there are no publicly funded facial prostheses services available.

Access to facial prostheses generally requires a prescription or referral from a maxillofacial surgeon, ophthalmologist or specialist. The design and fabrication of facial prostheses are undertaken by anaplastologists, maxillofacial prosthetists, and ocularists.

Figure 1: Overview of facial prostheses services, programs and schemes in Australia



Source: KPMG (2025)

Breast prostheses

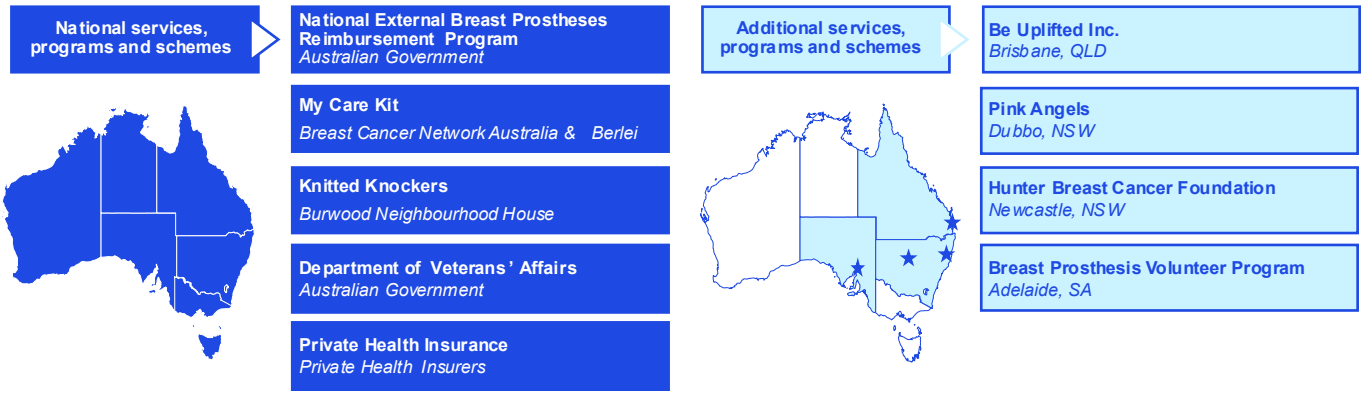
People requiring external breast prosthesis due to cancer or cancer treatment can access interim and definitive prostheses through national programs and schemes[1] including the EBPRP, funded by the Australian Government, and the My Care Kit program, delivered by Breast Cancer Network Australia and Berlei. As shown in Figure 2 on the next page, in some states and territories, additional supports are available through non-government organisations, including financial assistance for the upfront payment required under the EBPRP.

External breast prostheses are typically purchased through specialist retailers. These retailers are widely available in metropolitan and some regional areas; however, people living in rural and remote areas are generally reliant on online retailers.

[1] For the purposes of this report, the term *National services, programs and schemes* refers to those services, programs and schemes that are available across all jurisdictions in Australia. This may include services, programs and schemes that are funded by the Australian Government, private health insurers or Non-Government Organisations. *Additional services, programs and schemes* refers to services, programs and schemes that are available in some locations in Australia only and may include services, programs and schemes that are funded by State/Territory Governments or Non-Government Organisations.

A prescription or referral from a medical practitioner is not required to receive an external breast prosthesis. Trained external breast prostheses fitters, who may include breast care nurses, will typically assist with measuring and fitting the prosthesis.

Figure 2: Overview of breast prostheses services, programs and schemes in Australia



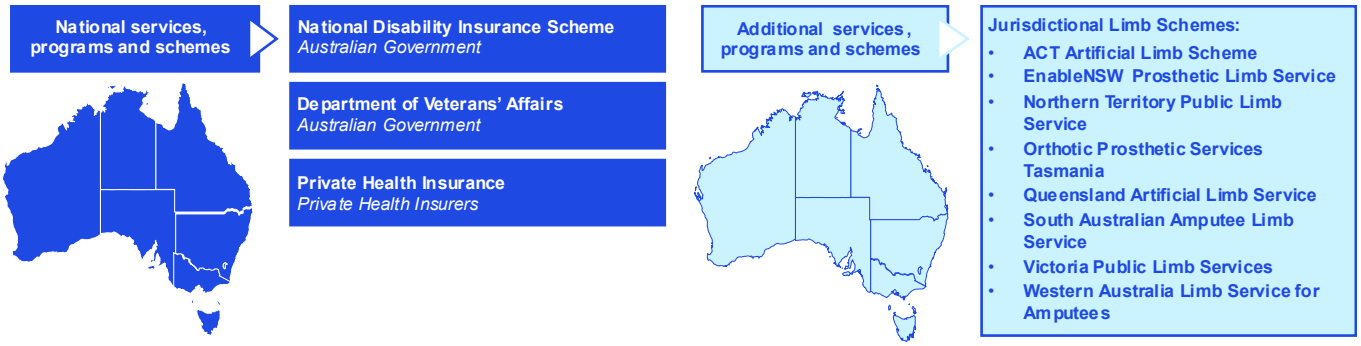
Source: KPMG (2025)

Limb prostheses

Eligible people requiring limb prostheses due to cancer or cancer treatment can access prostheses through national programs and schemes, including the NDIS and DVA. Individuals excluded from the NDIS (including all people aged 65 years and older) are reliant on jurisdiction-based limb schemes, as outlined in Figure 3. There is considerable variation between jurisdictional schemes, including differences in funding allocation, treatment approaches, prosthetic componentry and consumables provided. With the exception of NSW, most state and territory schemes do not fund high-grade prostheses, such as microprocessor knees and computerised components, which are funded under the NDIS for eligible individuals.

Prosthetic service providers are widely available in metropolitan and some regional areas; however, people living in rural and remote areas are typically reliant on mobile clinics or financial assistance to travel to metropolitan areas. Access to limb prostheses requires a prescription or referral from a rehabilitation physician or specialist. A prosthetist is responsible for ensuring the limb fits correctly and meets the individual's functional needs.

Figure 3: Overview of limb prostheses services, programs and schemes in Australia



Source: KPMG (2025)

Other prostheses

There is no national program or scheme that funds voice prostheses, except for the DVA, which provides coverage for voice prostheses for eligible veterans. Access to public funding for voice prostheses varies across jurisdictions, with some states, including Victoria, New South Wales and Tasmania, offering limited support. The remainder of jurisdictions provide little to no coverage, leaving individuals to cover the full cost of voice prostheses themselves.

The DVA provides coverage for external male reproductive prostheses for eligible veterans. Outside of this, there are no national or jurisdictional programs or schemes that fund these prostheses, leaving most individuals who wish to explore this option to cover the full cost themselves.

Oral prostheses[2] are largely excluded from public funding, except for those eligible through the DVA. Limited coverage is provided under most private health insurance policies, while there are no consistent national or jurisdictional schemes in place that cover oral prostheses. This results in significant out-of-pocket costs for most individuals who require oral prostheses, such as prosthetic teeth, due to cancer or cancer treatment.

Prostheses services, programs and schemes in other countries

The prostheses services, programs and schemes in four other countries, selected due to similarities between their health systems and Australia's, were compared to those available in Australia:

- Canada
- The Netherlands
- New Zealand
- The United Kingdom.

Facial prostheses

In contrast to the limited availability of publicly funded facial prostheses services in Australia, Canada, the Netherlands, New Zealand, and the UK, all provide access to facial prostheses through national or provincial programs. New Zealand, the Netherlands, and the UK offer fully funded prostheses, while Canada provides partial public funding.

Breast prostheses

External breast prostheses programs in Australia, the UK, the Netherlands, New Zealand, and Canada are broadly similar in providing funding for breast prostheses after mastectomy but differ in their funding models and coverage of supplementary items. Australia, New Zealand, and Canada use reimbursement models, while the UK and the Netherlands provide prostheses directly with no upfront cost to individuals. Notably, New Zealand's program is more comprehensive, funding supplementary items such as mastectomy bras and swimwear.

Limb prostheses

In comparison to the significant variation that can occur in Australia when accessing limb prostheses, depending on age and location, Canada, the Netherlands, New Zealand, and the UK have nationally consistent approaches, with eligibility based on clinical need. While Canada and the Netherlands generally only fund basic prostheses and have limited support for advanced technology, New Zealand and the UK fully fund microprocessor knees and provide comprehensive support services for those who meet clinical criteria.

Other prostheses

Key findings from the international comparative analysis for other prostheses types were as follows:

- **Voice prostheses:** Canada, the Netherlands, and the UK have structured provincial or national programs in place that cover voice prostheses. The Netherlands and the UK offer comprehensive coverage for voice prostheses, while Canada provides partial funding.
- **Male reproductive prostheses:** The UK is the only country that offers public funding for male reproductive prostheses. Canada and New Zealand rely primarily on self-funding, while there is no publicly available information for the Netherlands.
- **Oral prostheses:** Canada and the Netherlands offer structured reimbursement models for oral prostheses, while New Zealand and the UK provide fully funded oral prostheses for individuals meeting specific clinical criteria, which includes those affected by cancer.

[2] Oral prostheses are typically considered to be implants and / or part of dental care and were determined by the Department to be out of scope for this review. Supports are currently in place for people impacted by cancer to access to dental services under the MBS. Options for improving access to dental and oral health treatment and restorative services for cancer patients will be considered by the Australian Government in response to recommendations from the 2024 Senate inquiry into the Provision of and Access to Dental Services in Australia.

Equity of access to prostheses for people living with or post a cancer diagnosis

A range of barriers were identified for people living with or who have lived experience of cancer in accessing prostheses services. These barriers were identified through a variety of sources, including desktop research and mapping of available schemes and programs for prostheses, consultation with stakeholders such as clinicians involved in prostheses services and people living with or who have lived experience of cancer, and stakeholder survey responses. The identified barriers to accessing prostheses services included:

- **System navigation and access issues,** including unclear care pathways and system complexity, a lack of awareness of existing services and schemes and issues relating to eligibility criteria for existing schemes such as the NDIS.
- **Availability of prostheses services,** including a lack of prostheses services, particularly in regional, rural and remote areas, long wait times to access existing prostheses services, including both publicly funded and private services and limited culturally safe and accessible prostheses services for Aboriginal and Torres Strait Islander and CALD communities.
- Workforce issues**,** including a shortage of skilled prosthetic providers, particularly for facial prostheses, no clear or formal education and qualification pathways for providers of facial prostheses and a lack of regulation and accreditation standards for providers of facial prostheses.
- **Cost and funding models,** including out-of-pocket costs for prostheses not covered by existing schemes, upfront payments required under existing reimbursement models and travel costs for patients who cannot access prostheses services where they live.

In considering these barriers, several equity issues for people living with or who have lived experience of cancer in accessing prostheses services have been identified. These include:

1. Differences in equitable access between different types of prostheses

- **1A. Inconsistent availability of national programs and schemes**: There is no national program or scheme currently in place for facial prostheses, unlike limbs (NDIS) and external breast prostheses (EBPRP).
- **1B. Inconsistent funding models used by existing national programs and schemes**: The EBPRP requires an upfront payment to access breast prostheses, while there is no upfront payment required to access a prosthetic limb under the NDIS.

2. Differences in equitable access for the same type of prostheses

- **2A. Variability in availability of facial prostheses services between jurisdictions:** Some jurisdictions provide publicly funded facial prostheses services, while in others, either only private services or no services are available.
- **2B. Variability in prostheses available under the NDIS and jurisdictional limb schemes**: People under 65 years can access high-grade limbs through the NDIS, while people over 65 years are reliant on jurisdictional limb schemes, which typically offer basic limbs and componentry only

3. Additional access issues experienced by priority population groups

- **3A. Limited services available in rural and remote areas:** Most prostheses services are only available in metropolitan areas, with limited and inconsistent availability of mobile or outreach prostheses services.
- **3B. Significant financial barriers for people in lower socioeconomic groups:** There are significant financial barriers for individuals who require facial prostheses who live in jurisdictions where there are no publicly funded services available. Additionally, the reimbursement model of the EBPRP presents a barrier to access for people in lower socioeconomic groups due to the upfront payment required.
- **3C. Additional financial burden for young people requiring facial prostheses:** The need for more frequent replacement prostheses to accommodate anatomical changes due to growth and ageing, placing an additional financial burden on young people who require facial prostheses and live in jurisdictions with no publicly funded services available.

Options and considerations for a national cancer prostheses program

Based on the review findings, three options have been identified for a potential national cancer prostheses program, aimed at addressing the identified equity issues. These options build on each other to expand access across different types of prostheses. The options include:

- **Option 1**: Establish a national program that provides funding for **facial prostheses** that are required as a result of cancer or cancer treatment
- **Option 2:** Establish a national program that, in addition to the funding provided under Option 1, also provides funding to ensure that individuals who require an **external breast prosthesis** as a result of cancer or cancer treatment can access one without needing to make an upfront payment
- **Option 3**: Establish a national program that, in addition to the funding provided under Option 2, also provides funding to ensure that **individuals aged 65 years and older who require a limb prosthesis** as a result of cancer or cancer treatment can access a prosthesis that meets their needs. This would include high-grade prostheses such as microprocessor knees, if clinically indicated

The successful and sustainable implementation of a potential national cancer prostheses program would be dependent on a range of factors including:

- **Delivery and funding model:** The choice of delivery and funding models will shape how prostheses services are administered, coordinated, and financed. Delivery options include centralised national administration, state and territory-based coordination, or contracted third-party providers. Funding models include direct provider payments, block-funding, and reimbursement models. Each approach has different strengths and considerations in terms of responsiveness, consistency and equity.
- **Workforce supply and regulation:** Professionals such as anaplastologists and ocularists are in limited supply and are currently unregulated. Mechanisms to ensure that safe and high-quality services are provided under a potential new program will require consideration.
- **Care pathways, education and awareness:** Clearly defining and communicating the care pathway for accessing cancer prostheses under the new program will be critical. This will help to ensure that clinicians, as well as people with living or lived experience of cancer and their carers, to understand when, how and where they can access prostheses services.
- **Cultural safety and inclusion:** Consideration should be given to how a new national program could be designed to ensure culturally safe and accessible care is provided for Aboriginal and Torres Strait Islander people, CALD communities, and other priority groups.
- **Rural and remote access:** As part of a potential new program, strategies could be considered to improve access to prostheses services in rural and remote locations. This may include travel support schemes, outreach or mobile clinics, and the use of telehealth or virtual care models.
- **Data collection and evaluation:** The establishment of a monitoring and evaluation framework, as well as mechanisms to collect robust data on prosthesis needs, access, outcomes, and costs, would be important to enable ongoing accountability and continuous improvement of a national program.

Cost implications of a national cancer prostheses program

The potential implementation of a national prosthesis scheme may affect the supply and demand in the marketplace and send price signals to prosthetic manufacturers. Currently, there is no data available to determine the number of people who may currently require a prosthesis but do not have one. The implementation of a national scheme may lead to a surge in demand for prostheses, potentially resulting in either higher prices charged by manufacturers or longer waitlists for prostheses.

In establishing a national scheme, the price set by the Australian Government would send a price signal to the market about what a prosthesis “should” cost and the acceptable amount for manufacturers to charge. This could lead to prices clustering around the set price. Setting the price of prostheses too high could lead to increased costs to government through these clustering effects, while setting the price too low could have a detrimental impact on the delivery of services and lead to providers exiting the market.

There is limited data available to describe the types of cancer that may lead to individuals requiring a prosthesis, the number of people that will require a prosthesis following treatment for cancer and the costs associated with each prosthesis type.

The average cost of an external breast prosthesis was reported to be $400, which is in line with the reimbursement amount under the EBPRP. Costs associated with facial prostheses were reported to vary significantly due to their highly customised nature. The average cost reported for a facial prosthesis was $6,000, although stakeholders suggested some may cost more than $10,000. The cost of a prosthetic limb was reported to range from less than $15,000 for a basic limb through to $250,000 for a highly advanced limb. Data to describe the distribution of costs within this range was not available. Detailed limitations to the cost model are available in Section 6.3.1 with assumptions and model inputs available in Appendix H.

Cost modelling for a national cancer prostheses program indicated:

- Option 1 would cost $51.63 million over 10 years for facial prostheses, including ears, eyes, noses and hemi-facial prostheses.
- Option 2 would cost $123.38 million over 10 years. This includes $51.63 million for facial prostheses and $71.76 million for external breast prostheses, noting that the Australian Government already funds the EBPRP.
- Option 3 would cost $209.75 million over 10 years. This includes $51.63 million for facial prostheses, $71.76 million for external breast prostheses and $86.37 million for prosthetic limbs.

01

Introduction

1 Introduction

In response to recommendations from a recent enquiry conducted by the Senate Community Affairs References Committee, the Department of Health, Disability and Ageing (the Department) engaged KPMG to undertake an independent review of cancer prostheses equity in Australia. The purpose of the review was to understand the current programs, schemes and approaches in place across Australia to support people with lived or living experience of cancer to access external prostheses. The review also aimed to identify gaps and barriers to equitable access, providing evidence to consider the cost implications of a potential new national program designed to address these gaps.

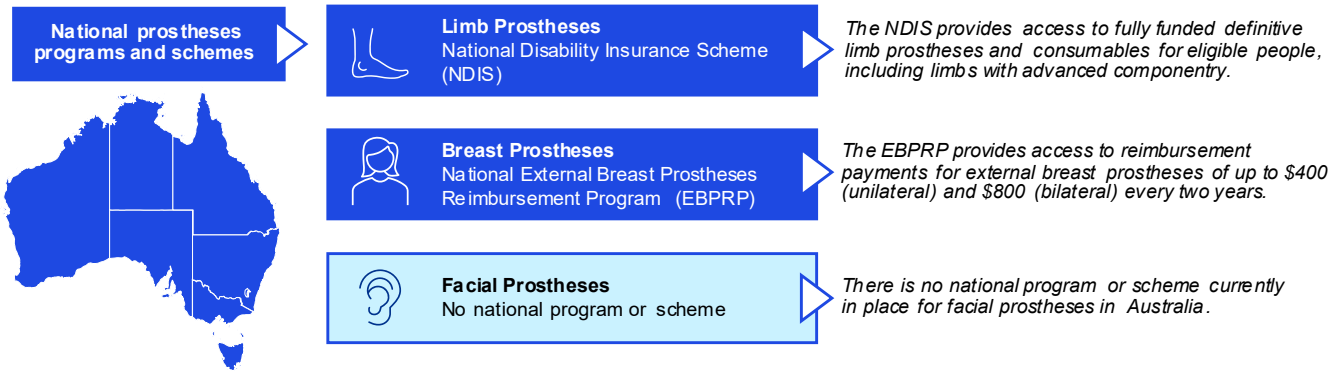
This report outlines the key findings from the review. This introductory section of the report provides a brief overview of the background and context for the review, the review purpose, methodology, scope and limitations, as well as the structure of the document.

1.1 Background

Cancer is currently the leading cause of death in Australia, with an estimated 165,000 new cases diagnosed annually.[3] While recent advancements in medical treatments have improved survival rates, cancer continues to be the most significant contributor to disease burden in Australia, with many people experiencing long-term impacts to their physical health and emotional wellbeing. These impacts can be particularly significant for individuals who have undergone an amputation or resection of a part of their body to treat or manage their cancer. For these individuals, prostheses play a crucial role in helping to maintain their quality of life, restore functionality, foster independence, and support psychological wellbeing.[4]

Access to publicly funded prostheses services and supports in Australia varies significantly depending on the type of prosthesis. As shown in Figure 4 below, individuals requiring limb prostheses due to cancer or cancer treatment may be eligible for funding through the National Disability Insurance Scheme (NDIS), while those requiring a breast prosthesis can access financial support through the External Breast Prosthesis Reimbursement Program (EBPRP).[5] In contrast, there is currently no national funding program or scheme available for facial prostheses for individuals with living or lived experience of cancer. As a result, people who require facial prostheses are often left to pay significant out-of-pocket costs, with limited or no public financial support.[6]

Figure 4: National services, programs and schemes for cancer prostheses



Source: KPMG (2025)

[3] Australian Institute of Health and Welfare. (2024). *Cancer*. https://www.aihw.gov.au/reports/australias-health/cancer
[4] American Cancer Institute. (2024). *Prostheses*. https://www.cancer.org/cancer/managing-cancer/side-effects/prostheses.html
[5] Department of Health, Disability and Ageing. (2024). *External Breast Prostheses Reimbursement Program Evaluation*. https://www.health.gov.au/sites/default/files/2024-09/external-breast-prostheses-reimbursement-program-evaluation-june-2024.pdf
[6] Parliament of Australia. (2024). *Equitable access to diagnosis and treatment for individuals with rare and less common cancers, including neuroendocrine cancer*. https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Cancerdiagnosis/Report

These differences in the current funding schemes for prostheses have been highlighted by several recent federal reviews and strategies. These include:

- **Recommendations from the Senate Community Affairs References Committee**: Recommendation 14 from the enquiry into Equitable access to diagnosis and treatment for individuals with rare and less common cancers, including neuroendocrine cancer was for the Australian Government to work with State/Territory Governments to identify the barriers faced by cancer patients requiring rehabilitation, prosthetics and implants as a result of their treatment, with a view to ensuring they have financial support for those services[7]
- **Evaluation of the External Breast Prosthesis Reimbursement Program**: This evaluation examined access to the EBPRP as well as the financial impact and effectiveness of the program in supporting individual's post-mastectomy. The evaluation highlighted notable barriers that limit equitable access to external breast prostheses through the program, including the need for an up-front payment. It was noted that these barriers are significant for priority population groups, including First Nations and CALD communities. [8]
- **The Australian Cancer Plan:** The Australian Cancer plan outlines the strategic objectives, ambitions, goals, and priority actions for cancer care in Australia. The strategic objectives of the plan include reducing inequities and disparities in cancer care, particularly for priority populations. [9]

1.2 Purpose of this review

KPMG was engaged by the Department to conduct an independent review of cancer prostheses equity in Australia to help to inform the future provision of services for individuals requiring prostheses due to cancer. The objectives of the review included:

- Establishing a clear view of current prostheses service delivery across Australia, including programs currently delivered by state and territories, as well as those available in comparable countries, to identify key gaps.
- Gaining a comprehensive understanding of the current barriers and challenges faced by people living with or who have lived experience of cancer in accessing prostheses.
- Developing strategies to address current gaps and barriers, in alignment with the objectives of the Australian Cancer Plan and with consideration for the needs of priority population groups and Aboriginal and Torres Strait Islander people.
- Identifying funding options and determining the cost implications of a potential program that supports access to all necessary prostheses for people living with or have lived experience of cancer.

1.3 Review methodology

A mixed-methods approach, guided by a set of Key Review Questions, was adopted for this review. Figure 5 below provides a high-level overview of the review approach.

[7] Parliament of Australia. (2024*). Equitable access to diagnosis and treatment for individuals with rare and less common cancers, including neuroendocrine cancer*. https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Cancerdiagnosis/Report
[8] Department of Health, Disability and Ageing. (2024). *External Breast Prostheses Reimbursement Program Evaluation*. https://www.health.gov.au/sites/default/files/2024-09/external-breast-prostheses-reimbursement-program-evaluation-june-2024.pdf
[9] Cancer Australia. (2023). *Australian Cancer Plan*. https://www.canceraustralia.gov.au/australian-cancer-plan

Figure 5: Overarching review approach

Source: KPMG (2025)

Alt text for Figure 5 available at Appendix I.

Appendix A provides further detail regarding each KRQ, including the sub-questions and data sources considered for each. Both primary and secondary data was collected to inform the review via a range data collection activities including:

- Stakeholder consultation with 70 individuals including representatives from:
  - Department of Health, Disability and Ageing, including the Technology Assessment and Access Division, and Medicare Benefits and Digital Health Division.
  - State and territory health departments, including members and / or nominees identified by members of the Cancer and Population Screening (CAPS) committee
  - Clinicians involved in the delivery of prostheses services.
  - National Disability Insurance Agency (NDIA) and Department of Social Services (DSS).
  - Department of Veterans' Affairs (DVA).
  - Individuals who are living with or who have lived experience of cancer and their carers.
  - Prostheses retailers including clinicians who make custom made prostheses.
  - Peak bodies and advocacy groups, including Cancer Australia, Head and Neck Cancer Australia, Rare Cancers Australia, National Community Controlled Health Organisation (NACCHO), and Federation of Ethnic Communities' Council of Australia (FECCA).
- Stakeholder surveys including:
  - People living with or who have lived experience of cancer and their carers (61 respondents)
  - Clinicians involved in the delivery of prostheses services (57 respondents).
- Review of publicly available documents, including peer-reviewed and grey literature sources, relating to the current provision of prostheses services, programs and schemes in Australia and internationally.
- Review of publicly available quantitative data relating to the incidence of cancer in Australia, the need for prostheses as a result of cancer and the cost of prostheses.

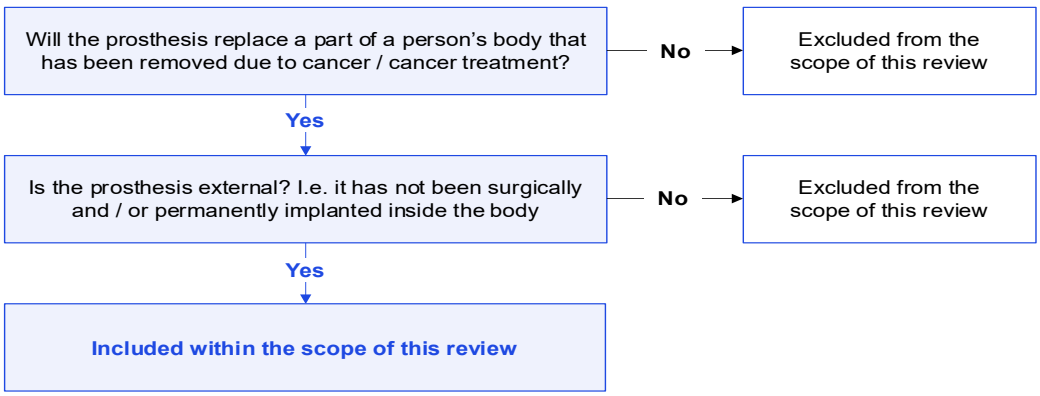
Further detail regarding data collection is provided in Appendix B including a full list of stakeholders consulted, survey questions and results, the literature scan search protocol and a list of documents reviewed.

1.4 Review scope

For the purposes of this review, the term 'prosthesis' referred to an external device that replaces a part of a person's body that was removed due to cancer and / or cancer treatment. All types of cancer that could lead to the need for prosthesis were considered in-scope. Surgically implanted prostheses were not considered as part of the review.

The scope of this review was provided by the Department and was agreed and validated with key stakeholders as part of a review design workshop. The stakeholders involved in the workshop is outlined in Appendix B. The decision tree outlined in Figure 6 below illustrates the criteria used for determining whether a prosthesis was considered within the scope of this review. Examples of in-scope and out-of-scope types of prostheses are outlined in Table 1 over page.

Figure 6: Decision tree for the scope of the review



Source: KPMG (2025)

Table 1: In-scope and out-of-scope prostheses

In-scope prostheses	Out-of-scope prostheses
For this review, the term 'prosthesis' referred to external prostheses, including: • External breast prostheses • Facial prostheses including: - Prosthetic ears, noses, eyeballs - Orbital prostheses - Hemi-facial prostheses • Limb prostheses including: - Arm prostheses fitted at, above or below the elbow, including hand and finger prostheses - Leg prostheses fitted at, above or below the knee, including foot and toe prostheses.	For this review, the term 'prosthesis' did not refer to surgically implanted prostheses, such as: • Bones or joints (e.g. a hip replacement) • Breast implants or breast reconstructions • Cochlear implants • Dental implants [10] • Implanted male reproductive prostheses • Replacement heart valves.

Source: KPMG (2025)

Throughout the course of the review, several other types of prostheses were discussed by stakeholders that were considered to be outside the agreed review scope. This included oral prostheses, which are typically considered to be implants and / or part of dental care, and prostheses where further work is required to determine if they meet the definition of an external prosthesis including non-indwelling voice prostheses and male reproductive prostheses. While not considered in-scope, these prostheses types have been included within Sections 2 and 3 of this report for completeness, however were not considered in the development of options and costings for a potential national cancer prostheses program. The inclusion of these prostheses types could be considered by the Government in future expansions of a potential national program.

In acknowledgement that significant disparities in cancer outcomes exist between different population groups in Australia [11], and in alignment with the objectives of the Australian Cancer Plan [12], access to prostheses for priority population groups was considered throughout the review. For the purposes of this review, the term "priority population groups" included:

- Aboriginal and Torres Strait Islander people.
- Patients people living in rural and remote areas.
- Lesbian, Gay, Bisexual, Transgender, Intersex, Queer and Asexual people (LGBTIQA+) people.
- People from Culturally and Linguistically Diverse (CALD) backgrounds.
- People living with disability.
- People in lower socioeconomic groups.
- People living with a mental illness.
- Older people.
- Adolescents and young adults.
- Children.

[10] Dental implants are considered intraoral prostheses and were determined by the Department to be out of scope for this review. Supports are currently in place for people impacted by cancer to access dental services, including a range of oral and maxillofacial medical services that attract rebates under the Medicare Benefits Schedule (MBS) when performed by a medical practitioner or an approved oral and maxillofacial surgeon. MBS reconstructive items that may also be applicable to survivors of head, neck, and oral cancers include but are not limited to microvascular head and neck reconstruction items, maxilla and mandible reconstruction items, and intra-oral implantation and fixation items. Options for improving access to dental and oral health treatment and restorative services for cancer patients will be considered by the Australian Government in response to recommendations from the 2024 Senate inquiry into the Provision of and Access to Dental Services in Australia
[11] Australian Institute of Health and Welfare. (2024). Cancer. https://www.aihw.gov.au/reports/australias-health/cancer
[12] Cancer Australia. (2025). Australian Cancer Plan. https://www.australiancancerplan.gov.au

1.5 Limitations of this review

When considering the findings outlined within this report, it is important to note the following limitations.

Availability and quality of publicly available information

The ability to report on cancer prostheses services, schemes and programs currently in place across Australia was limited by the availability and quality of publicly available information. Where publicly available information was not available or was incomplete, qualitative insights from stakeholder consultation were relied on to supplement documentation. Additionally, the variability in the delivery and funding of cancer prostheses services, schemes and programs across Australia, both between states and territories and within states and territories, meant that the availability and nature of documentation and reporting available varied significantly. This variability limited the ability to describe, analyse and / or assess the delivery of cancer prostheses services across each state and territory in a uniform way, with stakeholder insights relied on to fill information gaps.

Representativeness of stakeholder views

As described above, qualitative data collected through consultation with key stakeholder groups was relied on to augment the findings from the desktop review. Stakeholder perceptions used to inform this report were limited to the stakeholders who were willing and able to attend consultations with KPMG during the consultation period and may not necessarily represent the diverse views or experiences of all who have an interest in, or interaction with cancer prosthesis programs or services. The views shared by stakeholders reflected their own position, role and experience and may differ from the perspectives of other stakeholders who will not be directly consulted in this review.

The method used to develop this report did not include verification whether stakeholders' perceptions aligned with actual events or practice. In reading this report, sources of information have been specified, and these should be considered in interpreting the findings presented.

Cost modelling

Limited public quantitative data was available to support the development of cost estimates, with input from stakeholders relied upon to inform cost modelling. In considering the cost estimates outlined within the report, it is important to note the following:

- Cost inputs were sourced through stakeholder engagement activities, with no publicly available cost sources identified. Accordingly, no assurance regarding the completeness or accuracy of the data supplied by stakeholders can be provided. The cost model and results rely on the representations, assertions and data submissions provided by stakeholders.
- Noting the data limitations, cost estimates should be considered as an approximate order of magnitude estimate.
- The cost model relies on a range of assumptions. Assumptions have been tested and validated with the Department and stakeholders to ensure they are appropriate.
- The model estimates direct financial impacts to the Australian Government only and does not consider the broader impacts of options (e.g., other service systems, economic impacts, competition and price-related market impacts).
- The cost model does not consider quality of prostheses or outcomes delivered for people with cancer.

Detailed limitations to the cost model are available in Section 6.3.1 with assumptions and model inputs available in Appendix H.

1.6 Structure of this report

The structure of this report is as follows:

- **Section 1: Introduction** (this section) details the background for the review as well as the review purpose, methodology, scope and limitations.
- **Section 2: Current prostheses services, programs and schemes in Australia** outlines the review findings related to KRQ 1, KRQ 2 and KRQ 3. The findings in this section are presented according to prosthesis type including, facial prostheses, breast prostheses, limb prostheses, and other prostheses including voice, male reproductive and oral prostheses.
- **Section 3: Prostheses services, programs and schemes in other countries** outlines the review findings related to a sub-question under KRQ 1 regarding how prostheses services, programs and schemes in Australia compare to those available in other countries. In line with Section 2, the finding in this section are also presented by prosthesis type.
- **Section 4: Equity of access to prostheses for people living with or post a cancer diagnosis in Australia** outlines the review findings related to KRQ 4, KRQ 5 and KRQ 6. The findings in this section include the barriers identified in accessing prostheses for people living with or with lived experience of cancer, as well as issues relating to equitable access.
- **Section 5: Options and considerations for a potential national cancer prostheses program** outlines the review findings related to several sub-questions included under KRQ 4, KRQ 6 and KRQ 7 regarding how a national cancer prostheses program could address barriers and equity issues, as well as the key enablers that should be considered to support the implementation of a potential future national program.
- **Section 6: Cost implications of a potential national cancer prostheses program** outlines the review findings related to KRQ 7 and includes key cost considerations, the potential market implications of introducing a new national program and the costing of options for a national cancer prosthesis program.
- **Appendix A** details the KRQs, including the sub-questions and data sources considered for each, and in which section of the report each KRQ and sub-question is addressed.
- **Appendix B** includes materials related to the various data collection activities undertaken as part of this review, including a list of stakeholders consulted, survey questions and results, the literature scan search protocol and a list of documents reviewed.
- **Appendix C** provides additional details regarding the publicly funded facial prostheses services, programs and schemes available via the DVA and in the ACT, QLD, VIC and WA.
- **Appendix D** provides additional details regarding external breast prostheses services, programs and schemes available in Australia.
- **Appendix E** provides additional details regarding limb prostheses services, programs and schemes available in Australia.
- **Appendix F** provides additional details regarding state and territory-accredited amputee clinics and prosthetic service providers.
- **Appendix G** provides additional details regarding each equity issue outlined in Section 4, as well as case studies developed to illustrate equity issues further.
- **Appendix H** details the key inputs used for the cost modelling outlined in Section 6.
- **Appendix I** detailed alt text for Figure 5: Overarching review approach.

02

Current prostheses services, programs and schemes in Australia

2 Current prostheses services, programs and schemes in Australia

This section outlines findings related to the following review questions.

- **KRQ 1:** What prostheses services / schemes are currently available to people living with or who have lived experience of cancer?
- **KRQ 2**: What role do state, territory and commonwealth governments currently play in providing access to cancer prostheses?
- **KRQ 3**: In what health setting/s are people living with or have lived experience of cancer accessing cancer prostheses?

The findings in this section are presented according to prosthesis type:

- Section 2.1: Facial prostheses
- Section 2.3: Breast prostheses
- Section 2.1: Limb prostheses
- Section 2.4: Other prostheses, including voice prostheses, male reproductive prostheses and oral prostheses.

A summary of the key findings outlined within this section is provided below.

Summary of findings

- There is no national program or scheme currently in place for individuals requiring a facial prosthesis due to cancer or cancer treatment. Some publicly funded facial prostheses services are available in Victoria, Queensland, Western Australia and the Australian Capital Territory. Residents of other jurisdictions are reliant on private providers or are required to travel interstate.
- In contrast, people requiring external breast or limb prostheses can access prostheses through national programs funded by the Australian Government.
- The primary program for breast prostheses is the External Breast Prostheses Reimbursement Program (EBPRP). Additional breast prostheses supports are provided by non-government organisations (NGOs) in some jurisdictions including Queensland, New South Wales, and South Australia.
- Limb prostheses can be accessed through the National Disability Insurance Scheme (NDIS). For individuals who are ineligible for the NDIS, state and territory-funded artificial limb schemes are available. These schemes vary significantly by jurisdiction including differences in funding allocation, treatment approaches, prosthetic componentry and consumables provided.
- Most types of prostheses are covered under the Department of Veterans' Affairs (DVA) for eligible individuals. Some private health insurance policies provide limited coverage for prostheses, however, as external prostheses are not included on the Prescribed List, private health insurers are not required to pay benefits for these items.
- Prostheses providers are typically available through metropolitan-based providers, with some access in regional centres. However, people in rural and remote areas often rely on mobile services, online retailers, or are required to travel to access services in metropolitan or interstate locations.
- People requiring voice, male reproductive, or oral prostheses currently have no access to a national program, except for those eligible for the DVA. Publicly funded support varies significantly across jurisdictions, and as a result, many individuals are left to cover the full cost of these prostheses out-of-pocket.

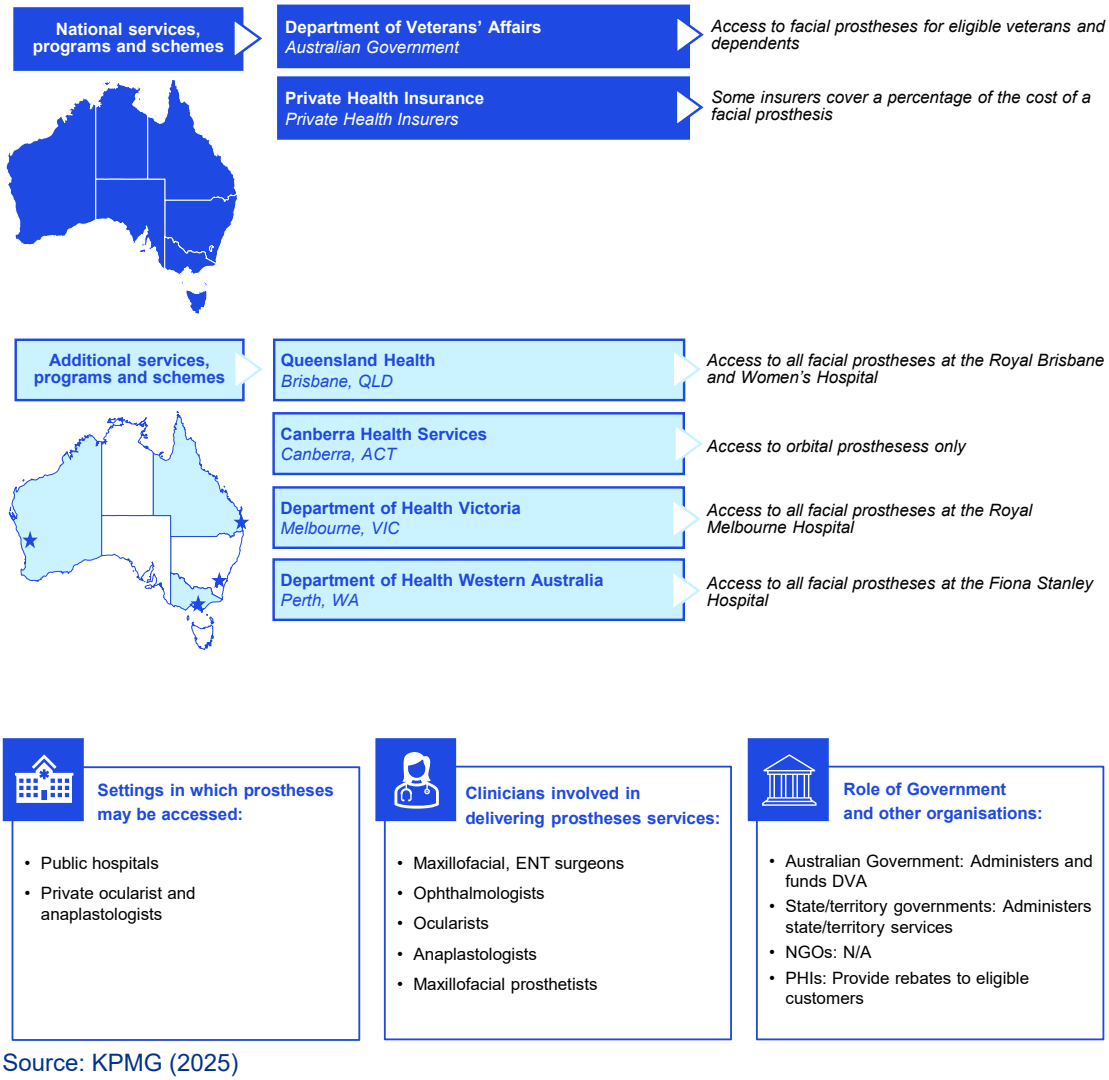
2.1 Facial prostheses services, programs and schemes

The following section outlines facial prostheses services, programs and schemes available to people in Australia. A summary of the key findings presented within this section is provided below.

Summary of facial prostheses services, programs and schemes

- There is no national program or scheme that provides broad coverage for facial prostheses. A small proportion of people may be eligible to receive funding through the DVA or their private health insurance. The NDIS typically does not typically fund facial prostheses as they fall outside the scheme's criteria.
- There is significant variation across jurisdictions in the availability of publicly funded facial prostheses services. In VIC, QLD and WA, some major public hospitals provide facial prostheses services. In the ACT, only ocular prostheses are available through publicly funded services. In NSW, SA, TAS and NT, there are no publicly funded facial prostheses services and therefore individuals must travel interstate to access prostheses, where they can face long wait times or incur high out-of-pocket costs for private services.
- Where available, publicly funded facial prostheses services are only located in large public hospitals in metropolitan areas Therefore, people living in regional, rural and remote areas are typically required to travel to metropolitan areas.
- Access to facial prostheses generally requires a prescription or referral from a maxillofacial surgeon, ophthalmologist or other medical specialist. The design and fabrication of facial prostheses is undertaken by anaplastologists, maxillofacial prosthetists, and ocularists. With the exception of TAS and the NT, there is at least one ocularist currently practising in all states and territories. In contrast, maxillofacial prosthetists and anaplastologists are currently only available in NSW, QLD, VIC and WA.

Figure 7: Summary of facial prostheses services, programs and schemes available in Australia



Source: KPMG (2025)

2.1.1 About facial prostheses

In Australia, more than 5,000 people are diagnosed with head and neck cancer each year, with over 17,000 people estimated to be living with head and neck cancer[13]. Treatment for head and neck cancer often involves a combination of surgery, radiation therapy and chemotherapy, depending on the location and stage of cancer. In some cases, extensive surgery is required, which can result in the removal or disfigurement of facial structures such as the nose, ear, eye (orbit), or jaw, leading to significant functional, psychological and social impacts.[14]

Facial prostheses are used to restore both appearance and function when surgical reconstruction is not possible. These custom-made external devices are designed to replicate a missing part of the face and are tailored to match the individual's skin tone, eye colour and facial contours. Facial prostheses improve not only appearance, but also social confidence, comfort and quality of life. Facial prostheses are typically designed and created by specialised health professionals, including:

- Anaplastologists who specialise in the creation of custom external facial prosthetics, including nasal, ear, and orbital prostheses.[15]
- Maxillofacial prosthetists who specialise in the creation of intraoral and extraoral prostheses and work closely with oral and maxillofacial surgeons, dentists, and ear, nose and throat (ENT) specialists. They may produce nasal, ear, orbital, hemifacial, palatal, and dental prostheses and are typically qualified as dental prosthetists or technicians.[16]
- Ocularists who specialise in the creation of prosthetic eyes.[17]

See Table 2 below for more information on the different types of external facial prostheses.

Table 2: Types of facial prostheses

Prosthesis type	Description	Clinicians involved
Nasal prosthesis	• Replaces whole or part of the nose after surgical removal • Removable and attached either using spectacles, adhesive glue or bone-anchored implants • Typically made from medical-grade silicone to match skin tone and facial contour	• Maxillofacial prosthetist • Anaplastologist
Ocular prosthesis	• Used when an eyeball has been removed • Removable and made to fit the eye socket, or as a thin shell over an unseeing, cloudy eye • Typically made from acrylic to match the colour of the opposing eye	• Ocularist
Orbital prosthesis	• Replaces the eye and the surrounding eyelid and skin • Removable and includes a prosthetic eye and adjacent facial structures • Attached using a variety of different methods depending on individual anatomy	• Maxillofacial prosthetist • Anaplastologist
Ear prosthesis	• Replaces whole or part of the ear after surgical removal • Removable and attached using adhesive glue or bone-anchored implants • Typically made from medical-grade silicone	• Maxillofacial prosthetist • Anaplastologist
Hemi-facial prosthesis	• Combination of different types of external prosthesis such as eye, nose and cheek	• Maxillofacial prosthetist • Anaplastologist

Source: Adapted from Head and Neck Cancer Australia (n.d.)[18]

[13] Cancer Australia. (2024). Head and neck cancer in Australia statistics. https://www.canceraustralia.gov.au/cancer-types/head-and-neck-cancer/head-and-neck-cancer-australia-statistics
[14] Head and Neck Cancer Australia. (n.d.). *What is Head and neck Cancer.* https://www.headandneckcancer.org.au/head-and-neck-cancer-definition/what-is-oral-cancer/
[15] The Australian Orthotic Prosthetic Association. (n.d.). *Anaplastologist: an emerging speciality*. https://www.aopa.org.au/events/event/clinical-anaplastology-an-emerging-specialty#:~:text=Anaplastology%20is%20an%20allied%20health,of%20the%20face%20or%20body.
[16] American Academy of Maxillofacial Prosthetics. (n.d.). *What is a maxillofacial prosthodontics*. https://www.maxillofacialprosthetics.org/referring_physicians/what_is_mp/#:~:text=Maxillofacial%20Prosthetics%20is%20a%20subspecialty,due%20to%20disease%20or%20trauma.
[17] James H Morphett. (n.d.). *Overview of Artificial Eye Services provided by an ocularist*. https://jameshmorphett.com.au/overview-artificial-eye-services-ocularist/#:~:text=Ocularists%20are%20skilled%20professionals%20who,confidence%20in%20their%20everyday%20lives.
[18] Head and Neck Cancer Australia. (n.d.). *Facial Prosthetics*. https://www.headandneckcancer.org.au/health-wellbeing/facial-prosthetics/

2.1.2 National prostheses services, programs and schemes

There is currently no national program or scheme in place that provides broad coverage for facial prostheses to people across Australia. A small proportion of people may be eligible to receive funding for facial prostheses under the DVA or through their private health insurance. Further details regarding coverage for facial prostheses via these two pathways are provided in this section.

The NDIS is often a pathway people living with or who have lived experience of cancer explore when seeking to access a facial prosthesis. Facial prostheses are typically not funded under the NDIS, however, as they do not meet the current eligibility criteria for prosthetic supports. This section also provides details regarding NDIS access for facial prostheses.

Department of Veterans' Affairs

The DVA provides funding for facial prostheses to eligible veterans and dependents who have undergone an amputation as a result of cancer. Funding is delivered through the Rehabilitation Appliances Program (RAP), which supplies aids and appliances to support the health and independence of veterans with medical or functional needs. The RAP covers a range of facial prosthetic supports, including ear, eye, and nose prostheses.

To access the program, eligible individuals must obtain a prescription or recommendation from a general practitioner or a specialist. The health professional submits a RAP form to the DVA, including supplier details and a quote. As there are no contracted suppliers for facial prostheses, the prescribing health professional can select a retailer based on the patient's needs and preferences. See Appendix C for further details on facial prostheses provided under DVA.[19]

Private health insurance

Coverage for facial prostheses by private health insurers in Australia varies significantly between funds, as facial prostheses are not listed on the Prescribed List[20]. Therefore, funding is dependent on the level of cover, policy type, and specific fund rules. Where coverage is available, it typically does not cover the full cost of the prosthesis, leaving individuals to pay a substantial out-of-pocket contribution. As detailed in Table 3, of a sample of private health insurers, only Bupa's Super or Top Extras policy included coverage for facial prostheses, up to an annual maximum benefit of $500.

Table 3: Facial prostheses coverage by private health fund

Private Health Insurer	Level of cover	Orbital prosthesis	Nose, ear, hemifacial prosthesis	Replacement period	Waiting period	Annual benefit limit
Bupa [21]	Super extras or Top extras	Yes	Yes	Not specified	12 months	Up to $500 annual maximum
Emergency Services Health [22]	Gold Hospital Cover or Gold Combined Cover	No	No	N/A	N/A	N/A
HIF [23]	Advanced extras or Top extras	No	No	N/A	N/A	N/A
Medibank [24]	Top Extra's 60/70/75	No	No	N/A	N/A	N/A

Source: Medibank (2025), Bupa (2025), HIF (2025), Nib (2025). Emergency services health (2023)

[19] The Department of Veterans Affairs. (2023). *RAP National Schedule of Equipment*. https://www.dva.gov.au/sites/default/files/2023-06/RAPSchedule-June2023.pdf
[20] The Department of Health, Disability and Ageing. (2025). *Medical devices and human tissue products covered under private health insurance*. https://www.health.gov.au/topics/private-health-insurance/what-private-health-insurance-covers/medical-devices-and-human-tissue-products-covered-under-private-health-insurance
[21] Bupa. (2025). *Health Aids and Appliances FAQs*. https://www.bupa.com.au/health-insurance/understanding-your-health-cover/health-aids-and-appliances
[22] Emergency Services Health. (2023). *Gold Hospital Cover.* https://www.eshealth.com.au/health-insurance/gold-hospital-cover/
[23] HIF. (2025). Extras cover table. https://www.hif.com.au/health-insurance/extras-cover/extras-cover-table
[24] Medibank. (2025). *Top extras*. https://www.medibank.com.au/health-insurance/cover/top-extras/

Stakeholders consulted as part of this review highlighted that insurers typically classify facial prostheses as "cosmetic" rather than "functional". This classification often results in limited or no reimbursement under private health insurance policies, leaving individuals to cover substantial out-of-pocket costs.

The classification of prostheses as being either "functional" or "cosmetic" is typically made based on the primary purpose of the prosthesis. If the primary purpose of the prosthesis is to provide a life-like representation of a body part that has been removed, the prosthesis is typically classified as being "cosmetic" or "passive". If the primary purpose is to replicate or restore function, such as walking, the prosthesis will likely be classed as "functional".[25]

Stakeholders consulted as part of this review noted that while the primary purpose of a facial prosthesis is often to restore appearance, they can also serve important functional purposes. For example, without an orbital prosthesis, the eyelid can collapse into the empty socket, causing the eyelashes to rub against the surrounding skin, leading to irritation, abrasions, and further complications, such as infection. Similarly, individuals who use an eye patch instead of an orbital prosthesis may be at a higher risk of developing fungal infections due to poor ventilation and moisture buildup.

Other examples stakeholders provided of the functions that facial prostheses may serve included:

- Protecting underlying tissues and reducing the risk of infection.
- Helping to secure eyewear (nose and ear prostheses).
- Helping to capture sound by replacing the lost external ear anatomy (ear prostheses).

Many stakeholders highlighted that the classification of facial prostheses as "cosmetic" fails not only to acknowledge the functional roles that facial prostheses can serve, but also the critical psychosocial role they can play, such as supporting social participation, mental wellbeing, return to work, and overall quality of life.

National Disability Insurance Scheme

The NDIS is a national program that provides funding for reasonable and necessary supports to individuals under the age of 65 who have significant and permanent disabilities. Managed by the NDIA, the scheme was introduced in 2013 to deliver individualised funding packages based on a participant's personal goals and functional needs. Facial prostheses are typically not funded under the NDIS, as they do not meet the current eligibility criteria for prosthetic supports. Specifically, the NDIS defines eligible prostheses as:

"Assistive products externally applied to replace, wholly or in part, an absent or deficient body segment which assists participant control and functioning of their neuromuscular skeletal systems".

Facial prostheses are often not considered to support neuromuscular or skeletal function and are therefore excluded from this definition. Additionally, stakeholders reported that facial prostheses are frequently classified by the NDIS as being "cosmetic" rather than functional, which means:

- They are not included in the NDIS Assistive Technology product list, and
- They are not considered essential for improving day-to-day functions as defined by the NDIS Act and therefore fall outside the scope of what the NDIS deems "reasonable and necessary supports".[26]

As a result, it was reported that applications for facial prosthesis funding are not typically approved, and individuals are often required to self-fund or seek alternative support through other schemes, if available.

2.1.3 Additional prostheses services, programs and schemes

In the absence of a national program or scheme, there is significant variability in support available for individuals requiring facial prostheses across Australia. Publicly funded facial prostheses services are currently only available in some jurisdictions. Table 4 and Table 5 below provides a summary of the facial prostheses available in each state and territory, including both public and private services. Further details regarding the services available in each jurisdiction are provided in this section.

[25] The Australian Orthotic Prosthetic Association. (n.d). *Clinical Specialties in Orthotics and Prosthetics*. https://www.aopa.org.au/documents/item/724#:~:text=If%20the%20primary%20purpose%20of,from%20birth%2C%20often%20wear%20prosthses.

[26] NDIS. (n.d.). *Supports that are NDIS supports*.

Table 4: Comparison of ocular facial prostheses schemes and services available across jurisdictions

Jurisdiction	Publicly funded services are available	Private services available
ACT	Yes	Yes
NSW	No	Yes
NT	No	No
QLD	Yes	Yes
SA	No	Yes
TAS	No	No
VIC	Yes	Yes
WA	Yes	Yes

Source: KPMG using information from Canberra Health Services (2023)[27]Royal Brisbane and Women's Hospital (2022)[28], The Royal Melbourne Hospital (2023).[29]

Table 5: Comparison of ear, nasal and hemi-facial prostheses schemes and services available across jurisdictions

Jurisdiction	Publicly funded services are available	Private services available
ACT	No	No
NSW	No	Yes
NT	No	No
QLD	Yes	Yes
SA	No	No
TAS	No	No
VIC	Yes	Yes
WA	Yes	Yes

Source: KPMG using information from Canberra Health Services (2023)[30], Royal Brisbane and Women's Hospital (2022)[31], The Royal Melbourne Hospital (2023).[32]

Stakeholders consulted as part of this review noted that in most cases where publicly funded facial prostheses are available, the service is not delivered through a dedicated or structured state-wide program. Instead, services are often clinician-led and hospital-dependent, relying on the initiative of an individual clinician or local health service to advocate and secure funding for the service. Without a formalised program or scheme in place, funding is vulnerable to changes in hospital budgets or service priorities, leading to concerns regarding service sustainability for both clinicians and people with living or lived experience of cancer.

[27] Canberra Health Services. (2023). *Provision of Prosthetic Eyes (Adults and Children).* https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.canberrahealthservices.act.gov.au%2F__data%2Fassets%2Fword_doc%2F0005%2F1981607%2FProvision-of-Prosthetic-Eyes.docx&wdOrigin=BROWSELINK
[28] Royal Brisbane and Women's Hospital. (2022). *Oral and Maxillofacial Surgery*. https://metronorth.health.qld.gov.au/rbwh/healthcare-services/oral-maxillofacial#professional
[29] The Royal Melbourne Hospital. (2023). *Maxillofacial Prosthetics.* https://www.thermh.org.au/services/maxillofacial-prosthetics
[30] Canberra Health Services. (2023). *Provision of Prosthetic Eyes (Adults and Children).* https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.canberrahealthservices.act.gov.au%2F__data%2Fassets%2Fword_doc%2F0005%2F1981607%2FProvision-of-Prosthetic-Eyes.docx&wdOrigin=BROWSELINK
[31] Royal Brisbane and Women's Hospital. (2022). *Oral and Maxillofacial Surgery*. https://metronorth.health.qld.gov.au/rbwh/healthcare-services/oral-maxillofacial#professional
[32] The Royal Melbourne Hospital. (2023). *Maxillofacial Prosthetics.* https://www.thermh.org.au/services/maxillofacial-prosthetics

Australian Capital Territory

In the ACT, orbital prostheses are publicly funded through the Canberra Health Service (CHS). All other facial prostheses, including ear, nose, and hemifacial prostheses, are not currently covered, with no maxillofacial prosthetists or anaplastologists currently based in the ACT. Stakeholders consulted as part of this review highlighted that, as a result, individuals requiring facial prostheses, excluding orbital prostheses, are typically referred to interstate services.

Table 6 on Page 38 and Appendix C provide further details regarding the CHS Prosthetic Eye Scheme, including eligibility criteria. Under the prosthetic eye scheme, the CHS funds the initial purchase of a prosthetic eye (or eyes, if required bilaterally). Replacement prostheses are also covered if the eye is over five years old or deemed clinically unsatisfactory, for example, if it causes irritation or does not fit properly. Individuals may choose their preferred ocularist, although additional expenses for services provided outside the ACT, such as travel and accommodation, are not funded by the CHS.[33] Currently, only one ocularist service is available in metropolitan Canberra, as listed by Artificial Eyes. As a result, individuals living outside the metropolitan ACT region must travel to Canberra to access these services.[34]

New South Wales

In NSW, there are currently no publicly funded facial prosthesis services, schemes, or dedicated programs available. As a result, individuals requiring a facial prosthesis must either travel interstate to access publicly funded services in VIC or QLD, or seek private treatment, which is typically self-funded and involves significant out-of-pocket costs. Stakeholders consulted as part of this review noted that a small number of individuals living in NSW have received one-off funding from philanthropic or charitable organisations to help cover the out-of-pocket costs of facial prostheses. However, publicly available information on these funding sources and their availability is limited.

Currently, there is only one anaplastologist operating privately in NSW, located in Alstonville. The anaplastologist has a visiting clinic at the Chris O'Brien Lifehouse, as well as in Brisbane and Newcastle. While this service provides access to specialised care within the state, it is limited in capacity and not publicly funded, requiring individuals to pay out of pocket. Additionally, there are currently five privately operated ocularist services available in metropolitan Sydney, Newcastle and Orange[35]. Individuals living outside these areas are typically required to travel to access these services.

Northern Territory

In the Northern Territory, there are currently no publicly funded facial prosthesis services, schemes, or dedicated programs available. As a result, individuals requiring a facial prosthesis must either travel interstate to access publicly funded services in VIC or WA, or seek private treatment, which is typically self-funded. Additionally, there are no anaplastologists or maxillofacial prosthetists currently operating in the NT, and therefore individuals must also travel interstate to access these services privately.

There is currently no permanent ocularist service operating in the NT.[36] However, stakeholders consulted as part of this review noted that an ocularist business based in Perth conducts a mobile clinic in Darwin three to four times per year. This service is reported to meet the demand and needs of most individuals requiring ocular prostheses in the NT. However, this service is privately run and not publicly funded, meaning individuals must cover the full cost out of pocket.

Queensland

In Queensland, there is a publicly funded service that provides facial prosthesis at the Royal Brisbane and Women's Hospital. Table 6 on Page 38 and Appendix C provide further details regarding this facial prosthesis service, which provides comprehensive coverage for a range of facial prostheses, including ocular, orbital, ear, nasal and hemifacial prostheses.[37]

The Royal Brisbane and Women's Hospital is based in metropolitan Brisbane, meaning individuals living in regional or remote areas of Queensland must travel to Brisbane to access treatment and fittings. Stakeholders consulted as part of this review noted that due to limited service capacity, wait times of over a year to receive a prosthesis are commonly experienced. Specifically for ocular prostheses, stakeholders noted that the current waitlist is comprised of over 200 people, and it can take up to 12 months to secure an initial appointment.

[33] Canberra Health Services. (2023). *Provision of Prosthetic Eyes (Adults and Children).* https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.canberrahealthservices.act.gov.au%2F__data%2Fassets%2Fword_doc%2F0005%2F1981607%2FProvision-of-Prosthetic-Eyes.docx&wdOrigin=BROWSELINK
[34] James H Morphette. (n.d.). *Woden ACT Clinic*. https://jameshmorphett.com.au/locations/woden/
[35] James H Morphett. (n.d.). *Our Clinics*. https://jameshmorphett.com.au/locations/orange/
[36] Artificial Eyes. (n.d.). *Ocularists in Australia.* https://artificialeyes.net/ocularists/australia/
[37] Royal Brisbane and Women's Hospital. (2022). *Oral and Maxillofacial Surgery*. https://metronorth.health.qld.gov.au/rbwh/healthcare-services/oral-maxillofacial#professional

In addition to the publicly funded services at the Royal Brisbane and Women's Hospital service, there is currently one privately operating ocularist service in Brisbane.[38] A privately operating anaplastologist based in New South Wales also offers a mobile clinic in Brisbane. As these services are privately run and not publicly funded, individuals must cover the full cost of their prosthesis.

South Australia

In South Australia, there are currently no publicly funded facial prosthesis services, schemes, or dedicated programs available. As a result, individuals requiring a facial prosthesis must either travel interstate to access publicly funded services in VIC or QLD, or seek private treatment, which is typically self-funded.

There is currently one ocularist service in metropolitan Adelaide[39]. This service also offers a mobile clinic in Mt Gambier twice a year to support individuals living in southern SA. However, this service is privately run, meaning individuals must cover the full cost out of pocket. In contrast, there are no private maxillofacial prosthetists or anaplastologists currently based in SA. Stakeholders reported that as a result, individuals are typically referred to interstate services, most commonly to the Royal Melbourne Hospital in Victoria.

Tasmania

In Tasmania, there are currently no publicly funded facial prosthesis services, schemes, or dedicated programs available. As a result, individuals requiring a facial prosthesis must either travel interstate to access publicly funded services in VIC or seek private treatment, which is typically self-funded. Additionally, there are currently no anaplastologists, maxillofacial prosthetists, or ocularists operating in Tasmania; therefore, individuals must also travel interstate to access these services privately.

Victoria

In Victoria, a publicly funded facial prosthesis service is available at the Royal Melbourne Hospital. Table 6 over page and Appendix C provide further details regarding the service, which offers comprehensive coverage for a range of facial prostheses, including ocular, orbital, ear, nasal and hemifacial prostheses.[40]

The Royal Melbourne Hospital is based in metropolitan Melbourne, meaning individuals living in regional or remote areas of Victoria must travel to Melbourne to access treatment and fittings. Stakeholders consulted as part of this review noted that funding for facial prostheses at the Royal Melbourne Hospital is drawn from the Prosthetics and Orthotics department and other internal hospital funding sources. As such, access to funding is dependent on the availability and prioritisation of resources from other services within the hospital.

In addition to the publicly funded services at the Royal Melbourne Hospital, there is one private ocularist service in Melbourne.[41] As this service is privately operated, individuals are responsible for covering the full cost of their prosthesis.

Western Australia

In Western Australia, a publicly funded facial prostheses service is delivered through Fiona Stanley Hospital. Table 6 over page and Appendix C provide further details regarding the facial prosthesis service available in WA. While publicly available information is limited, stakeholders consulted as part of this review reported that this service provides comprehensive coverage for a range of facial prostheses, including ocular, orbital, ear, nasal and hemifacial prostheses.[42]

The Fiona Stanley Hospital is based in metropolitan Perth, which means individuals living in regional or remote areas of WA must travel to Perth to access treatment and fittings. In addition to the publicly funded services at the Fiona Stanley Hospital, there is currently one privately operating ocularist service in Perth.[43] However, as the service is privately run and not publicly funded, individuals must cover the full cost out of pocket.

[38] Artificial Eyes Queensland. (n.d.). *Custom prosthetic eyes in Queensland.* https://www.artificialeyesqueensland.com.au/prosthetic-eyes-brisbane
[39] Artificial Eyes. (n.d.). *Ocularists in Australia.* https://artificialeyes.net/ocularists/australia/
[40] The Royal Melbourne Hospital. (2023). *Maxillofacial Prosthetics.* https://www.thermh.org.au/services/maxillofacial-prosthetics
[41] Artificial Eyes. (n.d.). *Ocularists in Australia.* https://artificialeyes.net/ocularists/australia/
[42] Royal Brisbane and Women's Hospital. (2022). *Oral and Maxillofacial Surgery*. https://metronorth.health.qld.gov.au/rbwh/healthcare-services/oral-maxillofacial#professional
[43] Artificial Eyes Queensland. (n.d.). *Custom prosthetic eyes in Queensland.* https://www.artificialeyesqueensland.com.au/prosthetic-eyes-brisbane

Table 6: Facial prostheses services available in each Australian state / territory

Details	ACT	NSW	NT	QLD	SA	TAS	VIC	WA
Eligibility criteria	ACT resident Ophthalmologist referral The remaining eye (if present) examined within the last two years	N/A	N/A	Medicare card	N/A	N/A	Medicare card	Medicare card Custom-made prosthesis required as an external substitute for a partially or totally absent facial part
Products and services included	Ocular prostheses only	Nil	Nil	Ocular, orbital, ear, hemifacial and nasal prostheses	Nil	Nil	Ocular, orbital, ear, hemifacial and nasal prostheses	Ocular, orbital, ear, hemifacial and nasal prostheses
Settings where prostheses may be accessed	Ocularist of the individual's choice	N/A	N/A	Royal Brisbane and Women's Hospital (RBWH)	N/A	N/A	Royal Melbourne Hospital (RMH)	Fiona Stanley Hospital
Funding source	ACT Government	N/A	N/A	QLD Government	N/A	N/A	VIC Government	WA Government
Role of Australian Government	None	N/A	N/A	None	N/A	N/A	None	None
Role of jurisdictional government	Provides funding and administers the prosthetic eye scheme through CHS	N/A	N/A	Provides funding to RBWH	N/A	N/A	Provides funding to RMH	Provides funding to Fiona Stanley Hospital

Source: KPMG (2025)

2.2 Breast prostheses services, programs and schemes

The following section outlines breast prostheses services, programs and schemes available to people in Australia. A summary of the key findings presented within this section is provided below.

Summary of breast prostheses services, programs and schemes

- People requiring external breast prosthesis due to cancer or cancer treatment can access interim and definitive prostheses through national programs and schemes, including the EBPRP funded by the Australian Government and the My Care Kit program delivered by Breast Cancer Network Australia and Berlei.
- In some states and territories, additional supports are available through NGOs, including financial assistance for the up-front payment required under the EBPRP.
- External breast prostheses are typically accessed through specialist external breast prostheses retailers. These retailers are widely available in metropolitan and some regional areas; however, people living in rural and remote areas are typically reliant on online retailers.
- A prescription or referral from a medical practitioner is not required to receive an external breast prosthesis. Trained external breast prostheses fitters, such as breast care nurses, will typically assist with measuring and fitting the prosthesis. However, prostheses can also be ordered online without support from a trained fitter.

Figure 8: Summary of breast prostheses services, programs and schemes available in Australia

Source: KPMG (2025)

2.2.1 About external breast prostheses

Breast cancer is the most commonly diagnosed cancer among Australian women, accounting for approximately 28% of all new cancer cases. One in seven Australian women are diagnosed with breast cancer over a lifetime, compared to one in 556 men. Breast cancer risk increases with age, with the average age at diagnosis being 62 years, with around 80 per cent of new diagnoses occurring after the age of 50.[44]

Approximately 40 per cent of women diagnosed with breast cancer will undergo a mastectomy, a surgical procedure to remove one (unilateral) or both (bilateral) breasts to eliminate or prevent the spread of breast cancer. Following a mastectomy, an external breast prosthesis is one option available for post-operative care. These prostheses are artificial breast forms designed to be worn inside mastectomy bras, specialised swimsuits or attached directly to the skin.[45]

External breast prostheses are available in a range of materials and styles, depending on the type of surgery, stage of recovery and personal preference. To obtain a prosthesis, it is recommended that women consult a trained prostheses fitter to help find the right prosthesis that suits their body shape and frame. External breast prostheses can be purchased from specialist stores that sell only breast prostheses and related products, the undergarment section of some major department stores, and some boutiques. External breast prostheses can also be purchased from online retailers and mailed to the individual's house.

2.2.2 National external breast prostheses services, programs and schemes

This section outlines the external breast prostheses services, programs, and schemes available nationally to people across Australia. These include:

- External Breast Prostheses Reimbursement Program
- My Care Kit
- Knitted Knockers Australia
- Department of Veterans Affairs
- Private health insurance.

External Breast Prostheses Reimbursement Program

The External Breast Prostheses Reimbursement Program (EBPRP) was established in 2008 by the Australian Government to provide financial support for women who have undergone breast surgery due to breast cancer to access external prostheses. The program operates as a reimbursement model, where individuals purchase an external breast prosthesis from their preferred retailer and then submit a claim through Medicare to receive reimbursement. [46]

Appendix D provides further details regarding the EBPRP, including eligibility criteria. The EBPRP covers all types and styles of external breast prostheses. Reimbursement can be claimed once every two years and is capped at $400 for a unilateral mastectomy and $800 for a bilateral mastectomy. The program is funded by the Australian Government and is administered through Services Australia.

For those with coverage for external breast prostheses under their private health insurance, Services Australia will reimburse any remaining out-of-pocket costs not covered by private health insurance up to the reimbursement cap. Further details regarding coverage through private health insurance for external breast prostheses is provided on Page 42.

[44] Breast Cancer Network Australia. (2024). *Breast statistics cancer in Australia.* https://www.bcna.org.au/resources/about-breast-cancer/breast-statistics-cancer-in-australia/
[45] Breast Cancer Network Australia. (2021). Breast Reconstruction in Australia. https://www.bcna.org.au/media/31fl0gyg/bcna_breast-reconstruction-report_2021.pdf
[46] Services Australia. (2024). *External Breast Prostheses Reimbursement Program*. https://www.servicesaustralia.gov.au/how-to-claim-external-breast-prosthesis-reimbursement-program?context=21976

In February 2024, an independent evaluation of the EBPRP was undertaken to assess the program's effectiveness and accessibility, particularly for priority populations. It was identified through this evaluation that the reimbursement model, which requires program participants to make an upfront payment, presents a significant barrier to access for many people.[47] While some people, such as those receiving Centrelink payments, may be eligible for an advance payment to help offset the upfront out-of-pocket cost, this support is reportedly not widely promoted or accessed.[48]

Stakeholders consulted as part of this review also highlighted that the reimbursement model creates a barrier to access, as well as low awareness of the program and access to in-person fittings. Barriers to access are further detailed in Section of this report.

Figure 9 shows the locations of external breast prosthesis retailers across Australia. The information presented is based on services listed on the Breast Cancer Network Australia (BCNA) service register.[49] In-person external breast prosthesis retailers are available across Australia; however, access varies significantly both between and within states and territories.

Figure 9: Locations of external breast prostheses retailers across Australia

Source: KPMG using information from BCNA, 2025

Appendix D outlines the locations of retailers by jurisdiction. The Modified Monash Model (MMM) Classification is also provided for each location, indicating the availability of retailers across metropolitan areas (MM1), major regional centres (MM2), large rural towns and medium rural towns (MM3 to MM4) and small rural and remote areas (MM5 to 7).

All capital cities, including Brisbane, Melbourne, Sydney, Adelaide, Perth, Hobart, Darwin and Canberra, have at least one in-person retailer offering in-person fittings for external breast prostheses. Retailers are also located in some regional centres in New South Wales, Queensland, Victoria and Tasmania. People living in rural and remote areas across Australia, however, have limited access to in-person retailers and often rely on online services to order external breast prostheses and related products.

In some states, mobile fitting services are available. In Far North Queensland, Figgers Mobile Service provides in-home fittings for mastectomy bras, prostheses, and swimwear in the Cairns area. Meanwhile, Tracey G Prosthetics and Lingerie offers a mobile fitting service covering Toowoomba and surrounding areas, allowing people to be fitted in the comfort of their own homes. Individuals in more remote and rural parts of Queensland do not have access to in-person external breast prosthesis retailers; however, they are reliant on online retailers.

Similarly, in Western Australia, mobile fitting service Papillon Lingerie supports people in the southwest region, operating out of Busselton. However, coverage remains limited across the broader state, particularly in remote areas. In South Australia, remote areas rely on mobile services, such as South Australia Mobile Breast Care, which

[47] Department of Health, Disability and Ageing. (2024). *External Breast Prostheses Reimbursement Program Evaluation*. https://www.health.gov.au/sites/default/files/2024-09/external-breast-prostheses-reimbursement-program-evaluation-june-2024.pdf
[48] Services Australia. (2024). *External Breast Prostheses Reimbursement Program*. https://www.servicesaustralia.gov.au/how-to-claim-external-breast-prosthesis-reimbursement-program?context=21976
[49] Breast Cancer Network Australia. (2025). Service Register. https://www.bcna.org.au/services-and-support-groups/

provides occasional visits to Broken Hill, Port Pirie, and Murray Bridge; however, service coverage and frequency are limited.

In Victoria, retailers offering in-person fittings are available in Melbourne, Geelong, and regional centres such as Mornington, Warrnambool, Sale, Gippsland, and Bendigo. Tasmania has limited in-person services, with fittings available only in Launceston and Hobart. Similarly, in the Australian Capital Territory, the only in-person retailer of breast prostheses is located in Canberra. In the Northern Territory, access is particularly limited, with just one in-person retailer operating in Darwin and no other in-person or mobile services available in regional or remote areas.

My Care Kit

My Care Kit is a national service provided by BCNA, in partnership with Berlei. The kit includes an interim breast prosthesis and a specially designed post-surgery bra for women who have recently undergone breast cancer surgery. The interim prosthesis provided through *My Care Kit* is lightweight and can be used immediately after surgery or radiation treatment. This prosthesis is designed to be used for up to 12 weeks, after which a definitive prosthesis can be fitted.[50]

Measurements for the interim prosthesis and post-surgery bra are typically taken by a clinician, such as a breast care nurse, who then places an order on behalf of their patient through the BCNA website. The kit can either be delivered to the healthcare professional who placed the order or directly to the person's home. Each person is eligible for one kit under the program. See Appendix D for additional details on *My Care Kit*.

Knitted Knockers Australia

Knitted Knockers Australia, delivered by not-for-profit organisation Burwood Neighbourhood House, provides knitted cotton breast prostheses free of charge to people who have undergone a mastectomy due to breast cancer. The prostheses are handmade by volunteers and can be ordered online via the organisation's website based on the person's bra cup size. They can be delivered directly to the person's home or collected from a local branch. Knitted Knockers has a branch in every state and territory, with most located in metropolitan or large regional centres such as Goolwa in SA, Geraldton and Albany in WA, Lismore and Grafton in NSW, and Mildura and Horsham in VIC. However, the availability of branches decreases in rural and remote locations, where access to services may be more limited.

Stakeholders noted that while Knitted Knockers are valuable for restoring the appearance of a breast, they are not weighted. As a result, it was reported that knitted breast prostheses are not recommended for long-term use due to the risk of musculoskeletal issues, particularly for women who have undergone a partial or unilateral mastectomy. Appendix D outlines further details on the Knitted Knockers Australia program.

Department of Veterans' Affairs

The DVA provides funding for external breast prostheses to eligible veterans and dependents who have undergone a mastectomy.[51] Prostheses are available through the Rehabilitation Appliances Program (RAP), which supplies aids and appliances to support the health and independence of veterans with medical or functional needs.

The RAP covers external breast prostheses and accessories, including mastectomy bras. To access the program, eligible individuals must obtain a prescription or recommendation from a medical practitioner or registered nurse. The health professional submits a RAP form to the DVA, including supplier details and a quote. As there are no contracted suppliers for breast prostheses, the prescribing health professional can choose a retailer based on the patient's needs and preferences. Individuals are eligible to receive a breast prosthesis every two years and up to four mastectomy bras per year, with no out-of-pocket costs. See Appendix D for further details on breast prostheses provided under DVA.

Private health insurance

Coverage for external breast prostheses by private health insurers in Australia varies significantly between funds and is dependent on the level of cover, policy type, and specific fund rules. If covered under the policy, funds will generally pay a percentage of the cost of an external breast prosthesis up to a maximum benefit per prosthesis. If the private health insurance does not cover the full cost of the external breast prosthesis, the gap can be claimed under the EBPRP.

Table 7 over page provides a comparison of a sample of private health insurance policies that include coverage for external breast prostheses.

[50] Breast Cancer Network Australia. (2025). *My Care Kit*. https://www.bcna.org.au/my-care-kit/
[51] The Department of Veterans Affairs. (2023). *Cancer and pulmonary TB care*. https://www.dva.gov.au/get-support/providers/programs-services/cancer-pulmonary-tb-care#:~:text=If%20they%20meet%20eligibility%20criteria,Liability%20Health%20Care%20(NLHC).

Table 7: External Breast Prostheses coverage by private health fund

Private Health Insurer	Level of cover	External breast prostheses	Post-mastectomy bra	Replacement period	Waiting period	Annual benefit limit
Medibank[52]	Top Extra's 60/70/75	Yes	Yes	24 months	Two months	Up to $500
Bupa[53]	Super extras or Top extras	Yes	No	Not specified	12 months	Up to $500 or up to 70% of the charge
HIF[54]	Advanced extras or Top extras	Yes	No	Not specified	12 months	Up to $800 or up to 75% of the charge
Emergency Services Health[55]	Gold Hospital Cover or Gold Combined Cover	Yes	Yes	24 months	12 months	Up to $300 for prostheses or up to 80% of the charge Up to $100 for a bra (up to 80% of charge)

Source: Medibank (2025), Bupa (2025), HIF (2025), Nib (2025). Emergency services health (2023).

2.2.3 Additional external breast prostheses programs, services and schemes

Prior to the establishment of the EBPRP in 2008, reimbursement for external breast prostheses was managed independently by each state and territory. These programs were phased out with the introduction of the EBPRP, which was implemented to ensure a consistent, national approach to the claims process and reimbursements provided across Australia.[56]

Despite this, additional services remain available in some states and territories, delivered through not-for-profit organisations and charities. This section outlines the availability of additional services in each jurisdiction.

New South Wales

Access to breast prostheses in New South Wales is supported by a mix of local services and community-led outreach initiatives, in addition to the national programs outlined in Section 2.2.2**.** Charities providing free external breast prostheses include:

- Pink Angels, a not-for-profit organisation based in Dubbo, which provides free support to women undergoing breast cancer treatment, including breast care packs, external breast prostheses, post-operative garments, fuel and meal vouchers, accommodation, and travel assistance[57]. Their service area includes Wellington, Narromine, Trangie, Warren, Nevertire, Nyngan, Girilambone, Cobar, Brewarrina, Bourke, Lightning Ridge, Coonamble, Coonabarabran, Gilgandra and Gulargambone.
- Hunter Breast Cancer Foundation (HBCF) supports individuals in Newcastle, Lake Macquarie, and the broader Hunter region. HBCF provides mastectomy bra fittings, transport to treatment and financial assistance for prostheses. Notably, HBCF covers the up-front cost of prostheses, allowing individuals to claim reimbursement through the EBPRP and then repay the foundation once they receive the rebate. This approach eliminates the initial financial barrier of paying out of pocket, a common challenge faced by those using the EBPRP. The HBCF also contribute up to $100 toward the purchase of swimwear prostheses[58].

[52] Medibank. (2025). *Top extras*. https://www.medibank.com.au/health-insurance/cover/top-extras/
[53] Bupa. (2025). *Health Aids and Appliances FAQs*. https://www.bupa.com.au/health-insurance/understanding-your-health-cover/health-aids-and-appliances
[54] HIF. (2025). Extras cover table. https://www.hif.com.au/health-insurance/extras-cover/extras-cover-table
[55] Emergency Services Health. (2023). External Breast Prostheses Benefit Guide. https://www.eshealth.com.au/information-hub/benefit-guides/external-breast-prostheses-benefit-guide/
[56] Department of Health, Disability and Ageing. (2024). *External Breast Prostheses Reimbursement Program Evaluation*. https://www.health.gov.au/sites/default/files/2024-09/external-breast-prostheses-reimbursement-program-evaluation-june-2024.pdf
[57] Pink Angels. (2018). Who we are. https://pinkangels.org.au/who-we-are
[58] Hunter Breast Cancer Foundation. (n.d.). Prosthesis Financial Support. https://hbcf.org.au/prosthesis-financial-support/

Queensland

In Queensland, Be Uplifted Inc. is the only known provider of additional services related to external breast prostheses beyond the national programs outlined in Section 2.2.2. This Brisbane-based breast cancer charity provides free crocheted breast prostheses, through its Boondall and Gympie opportunity shops, market stalls, or online store, which will be sent by mail, with postage as the only cost[59]. The organisation also provides financial assistance for household expenses, transport, and medical costs for people living in north Brisbane.

South Australia

In South Australia, Cancer Council SA runs a Breast Prosthesis Volunteer Program, which provides free, temporary breast prostheses to women with breast cancer who have had a mastectomy. However, there is limited public information on the eligibility criteria for this program or how to access this service.[60]

ACT, Victoria, Western Australia, Northern Territory and Tasmania

There are no additional programs for external breast prostheses, beyond the national programs outlined in Section 2.2.2 in the ACT, Victoria, Western Australia, the NT or Tasmania.

[59] Be Uplifted Inc. (n.d.). Our Crocheted Knockers. https://www.beuplifted.org.au/our-crocheted-knockers/
[60] Cancer Council SA. (2022). *Michele's making an impact, one stich at a time.* https://www.cancersa.org.au/blog/micheles-making-an-impact-one-stitch-at-a-time/

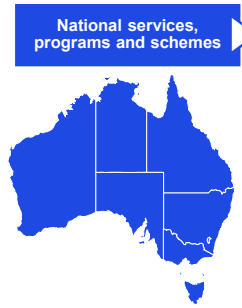
2.3 Limb prostheses services, programs and schemes

The following section outlines limb prostheses services, programs and schemes available to people in Australia. A summary of the key findings presented within this section is provided below.

Summary of limb prostheses services, programs and schemes

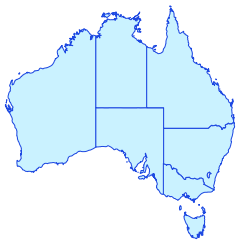
- Eligible people requiring a limb prosthesis due to cancer or cancer treatment can access prostheses through national programs and schemes including the NDIS and DVA, which both fund a wide range of limb prostheses including high grade prostheses and componentry.
- Individuals excluded from the NDIS (including all people aged 65 years and older) are reliant on jurisdiction-based limb schemes. There is considerable variation between jurisdictional schemes, including differences in funding allocation, treatment approaches, prosthetic componentry and consumables provided. With the exception of NSW, high-grade prostheses and componentry are not funded through jurisdictional limb schemes
- Access to limb prostheses requires a prescription or referral from a rehabilitation physician or specialist. A prosthetist is responsible for ensuring the limb fits correctly and meets the individual's functional needs. Physiotherapists play a key role in supporting mobility, gait training, and rehabilitation throughout the prosthetic fitting and adjustment process.
- Interim prostheses are generally accessed through public hospital amputee clinics and rehabilitation centres. Definitive prostheses are fitted either through an associated prosthetic service provider or through the public hospital rehabilitation centres. Prosthetic service providers are widely available in metropolitan and some regional areas; however, people living in rural and remote areas are typically reliant on mobile clinics or are required to travel to metropolitan areas.

Figure 10: Summary of limb prostheses services, programs and schemes available in Australia



National services, programs and schemes

- **National Disability Insurance Scheme** *Australian Government* — *Access to free definitive limb prostheses and consumables (people under 65 years), including advanced componentry*
- **Department of Veterans' Affairs** *Australian Government* — *Access to limb prostheses and consumables for eligible veterans and dependents*
- **Private Health Insurance** *Private Health Insurers* — *Some insurers cover a percentage of the cost of a limb prosthesis*



Additional services, programs and schemes

- ACT Artificial Limb Scheme
- Western Australia Limb Service for Amputees (WALSA)
- EnableNSW Prosthetic Limb Service*
- Northern Territory Public Limb Service
- Queensland Artificial Limb Service
- South Australian Amputee Limb Service
- Victoria Public Limb Services
- Orthotic Prosthetic Services Tasmania

* *Advanced componentry available including microprocessor knees*

Settings in which prostheses may be accessed:

- Public hospitals with rehabilitation centres
- Accredited amputee clinics
- Private prosthetic service providers

Clinicians involved in delivering prostheses services:

- Rehabilitation physicians
- Prosthetists
- Physiotherapists
- Occupational therapists

Role of Government and other organisations:

- Australian Government: Administers and funds NDIS, DVA, and administers state/territory limb schemes
- State/territory governments: Administers state/territory limb schemes
- NGOs: N/A
- PHIs: Provide rebates to eligible customers

Source: KPMG (2025)

2.3.1 About limb prostheses

A limb prosthesis is an artificial limb that replaces a limb, such as an arm, leg, hand, foot, or digit, helping to restore function and improve mobility and quality of life. Cancers that may lead to a limb amputation and subsequent prosthesis use include bone cancers such as osteosarcoma and Ewing sarcoma, as well as soft tissue sarcomas.[61]

People who experience an amputation due to cancer often spend a period of time in acute hospital settings recovering from the surgery, after which, in most cases, they are transferred to rehabilitation facilities to learn to adjust to the loss of the limb. The rehabilitation team may include a surgeon, a prosthetist, a physiotherapist, and an occupational therapist.

People are usually first fitted with an interim prosthesis, which is a temporary prosthesis used during the initial stages of recovery. This allows for early mobility, helps shape and prepare the residual limb, and accommodates changes in limb size as swelling reduces and muscles adapt. After healing and stabilisation, a definitive prosthesis is custom-made for long-term use. Assessment and fittings are personalised, with the type of prosthesis depending on the level of amputation, functional goals and lifestyle needs.[62]

As outlined in Table 8 below, lower limb prostheses are classified via a grading system, the K-level classification, which is based on mobility and activity. The system uses a rating scale ranging from 0 to 4, indicating a person's ability to use a lower limb prosthetic device.[63]

Table 8: K- level classification for lower limb prostheses

Grade	Description	Types of typical prostheses
K0	Does not have the ability or potential to ambulate or transfer safely with or without assistance and a prosthesis does not enhance their quality of life or mobility.	• A cosmetic limb
K1	Suitable for use on level surfaces at steady speeds e.g. someone who only walks indoors.	• Mechanical knee • Basic socket designs • Single-axis ankle • Basic prosthetic foot (e.g., solid ankle cushion heel (SACH))
K2	Suitable for outdoor use but at a low activity level e.g., someone who manages steps and slopes, but walks limited distances and may use a stick or other gait aid	• Hydraulic and pneumatic knee • Multiaxial foot • Hydraulic ankle
K3	Suitable for general outdoor use but not including sports and other high impact activities e.g., someone who walks in most encountered environments, at varying speeds, long distances when required and usually without a gait aid.	• Energy-storing feet • Microprocessor-controlled and fluid-controlled knees
K4	Suitable for high-impact use. For those people who have unrestricted mobility and may impose higher than usual forces on their prosthesis e.g., someone involved in sports, manual work.	• Advanced dynamic response feet • High performance knees (computerised) • Sports-specific prosthetics

Source: Adapted from Limbs for Life[64] [65]

[61] Cancer Research UK. (2025). *Surgery to remove a limb for bone cancer*. https://www.cancerresearchuk.org/about-cancer/bone-cancer/treatment/surgery/surgery-remove-limb-amputation#:~:text=A%20limb%20amputation%20means%20removing,bone%20(primary%20bone%20cancer).
[62] MSD Manual. (2025). *Overview of Limb Prosthetics*. https://www.msdmanuals.com/home/special-subjects/limb-prosthetics/overview-of-limb-prosthetics
[63] Limbs4life. (n.d.). *Prosthetic Funding in Australia Overview*. https://www.limbs4life.org.au/uploads/files/Limbs-4-Life-Prosthetic-Funding-Australia.pdf
[64] Ibid
[65] Limbs4life. (n.d.). *Lower limb feet and knees*. https://www.limbs4life.org.au/prosthetics/directory/lower-limb

People with upper limb amputations may decide not to use a prosthesis at all or may only wear a prosthesis for certain activities such as driving a car, working around the home, or riding a bike. There are four types of upper limb prostheses, classified according to how movement of the prostheses is controlled:

- **Passive prosthesis:** These upper limb prostheses do not provide any active movement but are life-like in appearance.
- **Body powered prosthesis:** These prostheses use of a harness around the shoulder to capture upper body movement and translate the movement through a cable to a terminal device.
- **Externally powered prosthesis:** These prostheses have components that are moved by motors and powered by batteries. The system is controlled by a microprocessor that receives signals from the body to determine the prosthesis's actions. Signals can be generated by body movement, or by electric signals generated by the person's muscles (myoelectric prostheses).
- **Hybrid prosthesis:** These prostheses use the features of both body-powered and externally powered prostheses.[66]

2.3.2 National prostheses services, programs and schemes

Several programs, services and schemes were identified through which people living with or who have lived experience of cancer may access limb prostheses. This section outlines the limb prostheses services, programs and schemes that are available nationally to people across Australia, including:

- National Disability Insurance Scheme.
- Department of Veterans Affairs.
- Private health insurance.

National Disability Insurance Scheme

As described in Section 2.1, the NDIS provides funding for reasonable and necessary supports to individuals under the age of 65 who have significant and permanent disabilities. Individuals who have experienced limb loss as a result of cancer typically meet the NDIS eligibility criteria due to the permanent and substantial impact on their functional capacity. The key reasons for this include:

- Limb loss due to cancer results in a permanent physical impairment that substantially reduces functional capacity in mobility, self-care, and participation in community life
- Most people with limb loss require ongoing disability-specific supports such as prosthetic limbs, rehabilitation, and assistive devices to complete daily activities
- The permanent nature of limb loss and the associated functional limitations directly satisfy the NDIS eligibility requirements for a physical disability.

Under the NDIS, limb prostheses are funded as part of assistive technology where they are considered “reasonable and necessary” and represent “value for money”. The scheme defines eligible prosthetic items as “assistive products externally applied to replace, wholly or in part, an absent or deficient body segment which assists participant control and functioning of their neuromuscular skeletal system”. This includes the design, manufacture and fit of customised functional prostheses.[67]

The NDIS considers several factors when determining the level of funding for prostheses including the persons weight, goals and aspirations, their ability to use, put on and remove the prosthesis, their ability to care for the prosthesis and their medical needs, that is, residual limb shape, fixed deformity to be accommodated, skin integrity and alignment-relevant co-morbidities.

The NDIA typically funds a range of limb prostheses tailored to a person’s functional classification (K-level) and clinical need. The prostheses must be prescribed by a health professional who is designated and accredited by the artificial limb scheme in the state or territory where the person resides.

[66] The Australian Orthotic Prosthetic Association. (2016). Prosthe*ses to improve participation and function in people with upper limb loss.* https://www.aopa.org.au/documents/item/522
[67] NDIS. (n.d.). *Supports that are NDIS supports*.

The types of prostheses funded include:

- Entry-level or standard-grade prostheses for participants up to K2 classification
- Higher grade prostheses for people up to K3 and K4 classification, where functional benefits justify the cost. This includes microprocessor joints and computerised components for people with a K4 classification, if no other means can deliver equivalent benefits. Stakeholders consulted as part of this review highlighted that these limbs cost upwards of $200,000; however, they provide significant benefits to both function and quality of life.
- Ancillary costs related to prosthetic use, such as residual limb socks and sheaths, as well as prosthetic limbs external to osseointegrated implants.
- Upper limb myoelectric prostheses may be funded for bilateral amputees or individuals with contralateral overuse syndrome, provided there is demonstrated commitment and success in using a training device. [68]

Appendix E outlines the limb prostheses listed on the Assistive Technology Guide, including the supports commonly funded under participant plans, as well as additional details regarding the NDIS, including eligibility criteria.

Stakeholders consulted as part of this review highlighted several key challenges related to accessing limb prostheses through the NDIS. A significant barrier to access identified by this review is the age-related eligibility criteria, which excludes individuals aged 65 years and over from accessing the NDIS. As a result, older adults must typically rely on state-based artificial limb schemes to access limb prostheses (further described in Section 2.3.3).

Additional barriers reported by stakeholders related to accessing limb prostheses via the NDIS are further explored in Section 4. These barriers include:

- The complexity of the NDIS application and approval process
- Long wait times for plan approval and funding allocation
- Limited access to accredited prosthetists, especially in rural and remote areas.

Department of Veterans' Affairs

The DVA provides funding for limb prostheses to eligible veterans and dependents who have undergone an amputation as a result of cancer. Funding is delivered through the RAP, which covers a range of limb prosthetic supports, including everyday prostheses, stump socks, silicone liners, and silicone knee sleeves. A secondary prosthesis, such as a shower leg, water arm or leg, sports leg, occupational limb or cosmetic limb, may be provided when the primary limb is for occupational purposes. Additionally, DVA will fund footwear if it is deemed an essential component of the prosthetic limb, with a maximum of two pairs of shoes funded at any one time. [69]

Accessing the program requires a clinical assessment by a multidisciplinary prosthetic team, typically supported by an amputee clinic or specialist. The application must include clearly defined functional goals, evidence of clinical appropriateness, and a prosthetic evaluation and review. As outlined in Section 42.1.2, the prescribing clinician is responsible for submitting a RAP form to DVA, which must include supplier details and a cost quotation. Since there are no contracted suppliers for limb prostheses under the DVA, health professionals are free to select a supplier that best meets the needs and preferences of their patients. See Appendix E for further details on limb prostheses provided under DVA.[70]

Private health insurance

Coverage for limb prostheses by private health insurers in Australia varies significantly between funds as limb prostheses are not listed on the Prescribed list[71]. Therefore, funding is dependent on the level of cover, policy type, and specific fund rules. Table 9 provides a comparison of a sample of private health insurance policies that include coverage for limb prostheses. Of the three insurers identified that provide coverage for prosthetic limbs, the annual benefits are notably small in proportion to the likely cost of a prosthesis.

[68] National Disability Insurance Scheme. (2024). *Including Specific Types of Supports in Plans Operational Guideline - Prosthetic limbs.* https://www.ndis.gov.au/operational-guidelines/including-specific-types-supports-plans-operational-guideline/including-specific-types-supports-plans-operational-guideline-prosthetic-limbs
[69] The Department of Veterans Affairs. (2023). *RAP National Schedule of Equipment*. https://www.dva.gov.au/sites/default/files/2023-06/RAPSchedule-June2023.pdf
[70] The Department of Veterans Affairs. (2023). *RAP National Schedule of Equipment*. https://www.dva.gov.au/sites/default/files/2023-06/RAPSchedule-June2023.pdf
[71] The Department of Health, Disability and Ageing. (2025). *Medical devices and human tissue products covered under private health insurance*. https://www.health.gov.au/topics/private-health-insurance/what-private-health-insurance-covers/medical-devices-and-human-tissue-products-covered-under-private-health-insurance

Table 9: Limb prostheses coverage by private health fund

Private Health Insurer	Level of cover	Limb prosthesis	Additional componentry	Replacement period	Waiting period	Annual benefit limit
Medibank[72]	Top Extra's 60/70/75	No	No	N/A	N/A	N/A
Bupa[73]	Super extras or Top extras	Yes	Yes	Not specified	12 months	Up to $500 annual maximum
HIF[74]	Advanced extras or Top extras	Yes	No	Not specified	12 months	Up to $800 annual maximum
Emergency Services Health[75]	Gold Hospital Cover or Gold Combined Cover	Yes	No	N/A	N/A	N/A
Australian Unity[76]	Top extras	Yes	No	2 years	12 months	Up to $500 annual maximum

Source: Medibank (2025), Bupa (2025), HIF (2025), Nib (2025). Emergency services health (2023). Australian Unity (2024)

2.3.3 Additional prostheses services, programs and schemes

In all states and territories, funding for the provision of limb prostheses is either managed by an Artificial Limb Scheme funding manager or by hospital departments. Individuals who experience limb loss due to cancer or cancer treatment and are excluded from the NDIS, typically due to the age eligibility criteria, are generally reliant on these state-based artificial limb schemes to access limb prostheses. While funding for each state and territory's scheme is provided by the Australian Government, the funding allocation per person, treatment approaches, and supply of prosthetic componentry and associated consumables differ between jurisdictions. Table 10 over page provides a summary of the features of each jurisdictional limb service, with further details by jurisdiction provided within this section.

Table 10: Comparison of limb prostheses schemes and services available across jurisdictions

Jurisdiction	Dedicated limb program	Upper and lower limbs covered	Digits covered	Advanced componentry covered	Rural and remote access	Outreach services
ACT	Yes	Yes	No	No	No	No
NSW	Yes	Yes	No	Yes	Yes	No
NT	No	Yes	No information available	-	Yes	Yes
QLD	Yes	Yes	No	No	Yes	Yes
SA	Yes	Yes	No	No	Yes	Yes
TAS	Yes	Yes	No information available	No	Yes	No
VIC	No	Yes	No information available	No	No	No
WA	Yes	Yes	No information available	No	No	No

Source: KPMG using information from state and territory Artificial Limb Service websites

[72] Medibank. (2025). *Top extras*. https://www.medibank.com.au/health-insurance/cover/top-extras/
[73] Bupa. (2025). *Health Aids and Appliances FAQs*. https://www.bupa.com.au/health-insurance/understanding-your-health-cover/health-aids-and-appliances
[74] HIF. (2025). Extras cover table. https://www.hif.com.au/health-insurance/extras-cover/extras-cover-table
[75] Emergency Services Health. (2023*). Gold Hospital Cover.* https://www.eshealth.com.au/health-insurance/gold-hospital-cover/
[76] Australian Unity. (2024). *Top extras Cover.* https://www.australianunity.com.au/health-insurance/covers/top-extras?srsltid=AfmBOop-AKNBM5D_0ZeBwe9WGgc_cWHkeQSO4201k8dL68RdFe3rWIFp

As described in Section 2.3.2, jurisdictional limb schemes generally offer more limited support, funding, and a narrower range of prostheses compared to what is typically covered under the NDIS. With the exception of NSW, jurisdictional limb schemes do not fund higher-grade prostheses, such as microprocessor knees and computerised components. Stakeholders noted that lower-grade prostheses, such as mechanical knees, are heavier and lack safety features, including fall prevention mechanisms, which can pose significant risks, particularly for older adults who are not eligible for the NDIS and rely on state-based limb schemes.

Australian Capital Territory

In the ACT, the ACTALS manages and distributes funding for both interim and definitive prostheses for eligible individuals. Appendix E provides further details regarding the ACTALS, including eligibility criteria.

An interim prosthesis is provided to individuals undergoing active rehabilitation following limb loss. This may occur in inpatient, day therapy, or outpatient settings. Interim prostheses are supplied and maintained for a maximum of 12 months from the initial fitting, supporting functional recovery during the rehabilitation phase. Following rehabilitation, ACTALS funds the provision and maintenance of a definitive prosthesis. These devices are tailored to meet the individual's clinical and functional needs while ensuring cost-efficiency. A Rehabilitation Medicine Consultant must prescribe the prosthesis employed within the CHS. Specific information on the type of prosthetic limbs funded under the ACTALS is limited.

ACTALS does not fund cosmetic prostheses for digit loss, spare prostheses, or recreational prostheses, defined as prostheses used for activities unrelated to paid employment or formal study/training for employment. However, excluded items may be funded under extenuating circumstances.

A referring clinician may submit a written application to the ACTALS Advisory Committee requesting funding for a spare prosthesis if the following conditions are met:

- The individual resides more than three hours away from the Prosthetics and Orthotics Service,
- A delay in repairing the primary prosthesis is likely, and such a delay would result in:
  - Significant economic loss (e.g., inability to work),
  - Safety risks (e.g., the individual lives alone in an isolated area), or
  - The individual is stranded or immobilised.
- The individual works in an occupation that causes excessive wear and tear on their prosthesis, making it more prone to breakdown; and
- The current prosthesis does not meet the functional demands of the individual's workplace.[77]

ACTALS services are available at three hospitals and health clinics, all located within the Canberra area. As a result, individuals living outside the metropolitan ACT region must travel to Canberra to access these services.

New South Wales

EnableNSW Prosthetic Limb Service (PLS) manages and distributes funding for both interim and definitive prosthetic limbs to eligible residents in NSW and Lord Howe Island. Appendix E provides further details regarding the EnableNSW PLS, including eligibility criteria.

An interim prosthesis is prescribed through EnableNSW-accredited amputee clinics across NSW and is manufactured by the clinic's appointed PSP. People can choose their preferred PSP to supply their definitive prosthesis. PSPs operate on behalf of EnableNSW and include seven commercial limb manufacturers and two public limb services, each appointed to specific amputee clinics across LHDs. See Table 131 in Appendix F.1 for a list of EnableNSW-accredited clinics and PSPs.

Information on the specific types of prosthetic limbs funded under EnableNSW is limited. However, specialised components such as high-cost feet or microprocessor knees may be provided in exceptional circumstances. In addition, to support residents in rural and remote locations, EnableNSW may provide further assistance, such as funding for a spare prosthesis, particularly when the nearest clinic is more than three hours away by car and delays in repairs could significantly affect essential daily activities like hygiene, toileting, dressing, and mobility.

[77] ACT Government. (2021). ACT Artificial Limb Scheme. https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.canberrahealthservices.act.gov.au%2F__data%2Fassets%2Fword_doc%2F0004%2F1981057%2FACT-Artificial-Limb-Scheme-ACTALS-Adults-and-Children.docx&wdOrigin=BROWSELINK

EnableNSW PLS does not cover:

- Recreational or waterproof prostheses for adults
- Prosthetic devices for digit loss (distal to trans-metatarsal and trans-metacarpal level)
- Cosmetic covers or enhancements
- Prosthetic services for inpatients currently admitted to private hospitals.[78]

Northern Territory

In the Northern Territory, there is no dedicated artificial limb program; instead, funding is managed by each public hospital facility. Funds are allocated to the business unit of the hospital, and then a portion of the funding is distributed to the Prosthetic and Orthotic Head of Department for management. See Appendix E for further details regarding the prosthetic limb services in the Northern Territory, including eligibility criteria. Currently, only two facilities in the NT have access to funding for the provision of artificial limbs to public patients.[79] These include:

- Royal Darwin and Palmerston Hospital Prosthetics and Orthotics Department
- Alice Springs Prosthetics Department

The services provide the supply, manufacturing and fitting of prosthetic devices. Both departments typically offer prosthetic rehabilitation services and amputee clinics. However, publicly available information on the specific types of prosthetic limbs funded is limited, including whether it funds prostheses for digit loss. Consultations have indicated that high-end componentry, such as microprocessor knees, is not available to individuals requiring a limb prostheses due to cancer or cancer treatment under current funding arrangements.

Queensland

Queensland has two separate state-based schemes that fund limb prostheses: one for interim prostheses and another for definitive prostheses. Appendix E provides further details regarding the Queensland Artificial Limb Service (QALS), including eligibility criteria.

Interim prostheses are prescribed through rehabilitation programs in public hospital interim clinics, where individuals are assessed for their suitability. After completing the interim program, individuals can select a PSP for their ongoing prosthetic care.

QALS manages and distributes funding for basic definitive prosthetic limb services to eligible people through a network of contracted PSPs. PSPs must be registered with QALS and approved to provide services on behalf of QALS. See Table 134 in Appendix F.2 for a list of accredited amputee clinics and PSPs in QLD. Funding for definitive limb prostheses is determined by a matrix that depends on the limb type, the individual's weight and mobility level.

The QALS does not cover:

- Interim, secondary, spare/emergency, occupational, recreational, cosmetic/nonfunctioning limbs, including all associated supplies and services.
- Prosthetic devices for part of the body other than limbs (e.g. digits).
- Microprocessor or myoelectric limbs or components
- Financial assistance for travel, transport or parking to attend a PSP or Amputee Clinic, or for PSPs to visit an applicant's residence, nursing home or corrective service.[80]

South Australia

In South Australia, prosthetic limb funding and service delivery are managed by the South Australian Amputee Limb Service (SAALS). SAALS oversees the provision of both interim and definitive prostheses for eligible individuals, ensuring access through public hospitals and outreach services across the state. Appendix E provides details regarding the SAALS, including eligibility criteria.

[78] EnableNSW. (n.d.). *Prosthetic Limb Service.* https://www.enable.health.nsw.gov.au/about/publications/fact-sheets/pls#:~:text=The%20Prosthetic%20Limb%20Service%20(PLS,provides%20funding%20for%20prosthetic%20limbs.
[79] Limbs for Life. (n.d.) *Prosthetic Funding in Australia Overview*. https://www.limbs4life.org.au/uploads/files/Limbs-4-Life-Prosthetic-Funding-Australia.pdf
[80] Queensland Health. (2023). Guidelines for Queensland Artificial limb Service. https://www.health.qld.gov.au/__data/assets/pdf_file/0026/1161773/guidelines-QALS.pdf

Individuals are typically assessed at a prescribing amputee clinic, which are located within five public hospitals across SA. Following assessment, they will receive a prescription for a definitive prosthesis and may choose their preferred PSP.[81] See Table 135 in Appendix F.3 for a list of amputee clinics in SA.

SAALS supports the provision of one prosthesis that meets all or most of the person's daily needs. However, the SAALs does not cover prostheses for digit loss. The service may provide additional support or exceptions in cases involving:

- Geographic isolation
- Special occupational requirements
- Specific individual needs.

Tasmania

In Tasmania, the Tasmanian Artificial Limb Scheme funds and governs public prosthetic services. The scheme is administered by the Orthotic Prosthetic Services Tasmania (OPST), which provides inpatient and outpatient orthotic and prosthetic services, including the design, manufacture, and fitting of both interim and definitive prosthetic limbs. See Appendix E for further details regarding the OPST, including eligibility criteria.

OPST operates out of three public hospital facilities across the state:

- The Royal Hobart Hospital
- Launceston General Hospital
- North West Regional Hospital (Burnie).[82]

Most Prosthetic and Orthotic departments offer both prosthetic rehabilitation services and amputee clinics. However, there is limited publicly available information regarding the specific types of prosthetic limbs funded, including whether the program funds prostheses for digit loss.

Victoria

In Victoria, funding for limb prostheses is managed by each hospital facility, rather than a dedicated artificial limb program. Funds are allocated to the hospital's business unit, and then a portion of the funding is distributed to the Prosthetic and Orthotic Head of Department for management purposes. There are currently eleven hospitals in Victoria that have access to funding for providing artificial limbs to public patients. Appendix E provides details regarding the prosthetic limb services in Victoria, including eligibility criteria.[83]

Most Prosthetic and Orthotic departments offer both prosthetic rehabilitation services and amputee clinics. However, there is limited publicly available information regarding the specific types of prosthetic limbs funded, including whether the program funds prostheses for digit loss.

Western Australia

In Western Australia, the Western Australia Limb Service for Amputees (WALSA), managed by the South Metropolitan Health Service, oversees the funding and coordination of prosthetic limb services for eligible WA residents. WALSA supports both interim and definitive limbs through the Fiona Stanley Hospital Rehabilitation Unit, as well as accredited providers such as Orthopaedic Appliances Pty Ltd (OAPL), Orthotic Prosthetic Solutions (OPS), and TLCU. Appendix E provides details regarding the WALSA, including eligibility criteria.

People requiring an interim prosthesis are assessed at a participating WA public hospital amputee clinic for assessment and referral to a rehabilitation program. WALSA provides funding assistance for interim prostheses, including associated essential supplies. These include:

- Standard Solid Ankle Cushion Heel foot.
- Standard knee.
- Safety knee.

For a definitive prosthesis, people are assessed by an accredited PSP, who determines the level of appropriate componentry based on the individual's mobility classification. WALSA funds definitive prostheses using a fixed unit

[81] Amputees in Touch South Australia. (n.d.) *Artificial Limb Scheme (SAALS)*. https://amputeesintouch.org.au/amputee-support/artificial-limb-scheme/#:~:text=The%20Artificial%20Limb%20Scheme%20is,Amputee%20Limb%20Service%20(SAALS).
[82] Department of Health Tasmania. (2025). Orthotic and Prosthetic Services. https://www.health.tas.gov.au/health-topics/orthotics-and-prosthetics/orthotic-and-prosthetic-services
[83] Limbs for Life. (n.d.) *Prosthetic Funding in Australia Overview*. https://www.limbs4life.org.au/uploads/files/Limbs-4-Life-Prosthetic-Funding-Australia.pdf

price model, with funding limits based on four mobility classes[84]. There is limited publicly available information as to whether prostheses for digit loss are funded under the WALSA. See Appendix E for additional details.

In specific circumstances, WALSA may approve the funding of a second prosthesis upon application by the individual's PSP. This is considered when:

- The person works in an occupation that places additional physical demands on the prosthesis.
- The person would experience economic hardship if unable to work while the primary limb is under repair.
- The person lives alone in an isolated location, where not having a second limb could result in being stranded

Availability of accredited limb prostheses service providers across Australia

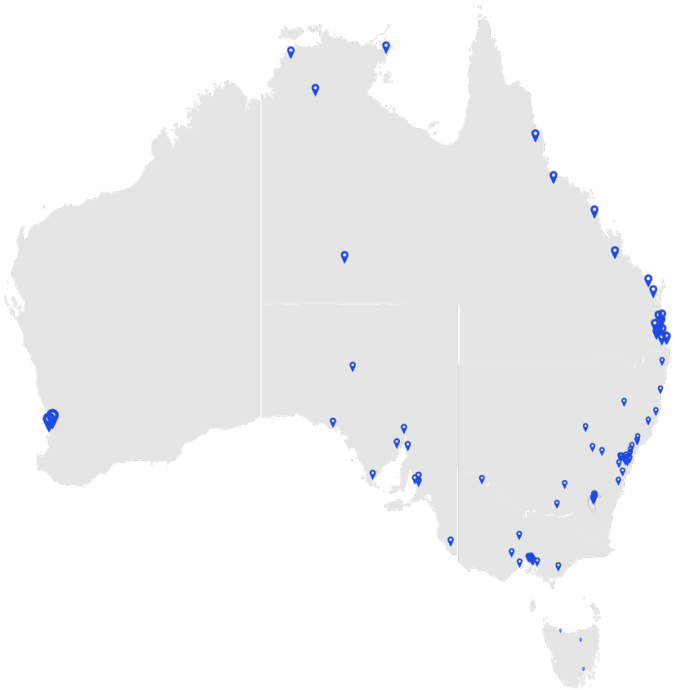
Figure 11 below outlines the locations of limb prostheses service providers across Australia. The information presented is based on services listed on the websites of each state and territory artificial limb scheme. Accredited limb prostheses service providers are available across Australia; however, access varies significantly both between and within states and territories.

Appendix E outlines the availability of prostheses providers by jurisdiction. The MMM Classification is also provided for each location, indicating the availability of prosthetic service providers (PSPs) across metropolitan areas (MM1), major regional centres (MM2), large rural towns and medium rural towns (MM3 to MM4) and small rural and remote areas (MM5 to 7).

In all states and territories, except the ACT and Western Australia, accredited limb prostheses service providers are available in both metropolitan areas and major regional centres. Accredited limb prostheses service providers are available in some large and medium-sized rural towns in most jurisdictions, excluding the ACT, Western Australia, and Tasmania. Access is limited in small rural towns and remote areas across the country.

Some jurisdictions in Australia provide outreach services to rural and remote areas; however, this varies across the country. In Queensland, clinics in Cairns, Townsville, and Mackay often service the broader northern and central regions through outreach services.[85] In South Australia, regional and remote access is provided through outreach clinics delivered by metropolitan teams, which operate in towns such as Whyalla, Port Lincoln, Port Augusta, Ceduna, Mount Gambier, and Coober Pedy on a weekly to quarterly basis.[86] In the Northern Territory, limited outreach services are available through the Royal Darwin and Palmerston Hospital, which conducts clinics approximately six times per year in Katherine and Nhulunbuy.

Figure 11: Locations of limb prostheses service providers across Australia



Source: KPMG (2025) using information from each state and territory Artificial Limb Service website

[84] HealthyWA. (2022). *Prostheses for amputees*. https://www.healthywa.wa.gov.au/Articles/N_R/Prostheses-for-amputees
[85] Queensland Health. (2023). Guidelines for Queensland Artificial limb Service. https://www.health.qld.gov.au/__data/assets/pdf_file/0026/1161773/guidelines-QALS.pdf
[86] Amputees in Touch South Australia. (n.d.) *Artificial Limb Scheme (SAALS)*. https://amputeesintouch.org.au/amputee-support/artificial-limb-scheme/#:~:text=The%20Artificial%20Limb%20Scheme%20is,Amputee%20Limb%20Service%20(SAALS).

2.4 Other types of prostheses services, programs and schemes

As noted in Section 1.4, throughout the review, several other types of prostheses were highlighted by stakeholders that were not considered within the agreed scope of the review. These prostheses included non-indwelling voice prostheses, external male reproductive prostheses, and oral prostheses such as prosthetic teeth. While not considered in-scope for this review, these other prostheses have been included in this section for completeness.

The following section outlines the services, programs and schemes available to people in Australia for these other types of prostheses. A summary of the key findings presented within this section is provided below.

Summary of other types of prostheses services, programs and schemes

- There is no national program or scheme that funds voice prostheses, excluding the DVA which provides coverage for voice prostheses for eligible veterans.
- Access to public funding for voice prostheses varies across jurisdictions. While some states, including Victoria, New South Wales and Tasmania, offer limited support, the remainder of jurisdictions provide little to no coverage, leaving many individuals to cover the full cost of voice prostheses themselves.
- There is no national program or scheme that funds external male reproductive prostheses. The DVA provides coverage for these prostheses for eligible veterans.
- There are also no state and territory programs or schemes that fund external male reproductive prostheses, leaving most individuals who wish to explore this option, to cover the full cost themselves.
- Oral prostheses are largely excluded from public funding outside of the DVA. Limited coverage is provided under most private health insurance policies.
- There are no consistent state or territory-level schemes available that cover oral prostheses, resulting in significant out-of-pocket costs for most individuals.

2.4.1 Voice prostheses

About voice prostheses

A voice prosthesis is an artificial communication device used to help people speak after a laryngectomy, a surgical procedure that removes the larynx, typically due to laryngeal cancer. Following the removal of the larynx, the windpipe (trachea) is brought to the surface of the neck to create a permanent breathing hole, called a tracheostoma, or stoma. A voice prosthesis is a one-way valve inserted between the trachea and oesophagus that allows air from the lungs to be directed into the mouth, producing sound that can be shaped into speech using the mouth and tongue. [87]

In Australia, voice prostheses are managed and fitted by a speech pathologist, who also provide ongoing care and assessment. Some types of prostheses are indwelling (clinician managed), while others are non-indwelling and can be removed and cleaned by the user. [88] While voice prostheses were not considered within the agreed scope of the review, non-indwelling voice prostheses were discussed by stakeholders during consultation. For completeness, these prostheses have been included within this section of the report. Further work is required to determine if voice prostheses meet the definition of an external prosthesis. As such, voice prostheses have not been considered within the options for a potential national cancer prostheses program outlined Section 5 or the costings outlined in Section 6.

National prostheses services, programs and schemes

There are limited national programs or schemes in Australia that fund voice prostheses. The DVA provides funding for voice prostheses to eligible veterans and dependents who are living with or post a cancer diagnosis. To access the program, eligible individuals must be assessed by a speech pathologist or relevant specialist, who determines the appropriate device through a functional and product assessment form. As outlined in Section 42.1.2, the health professional submits a RAP form to the DVA, which must include supplier details and a quote. Voice prostheses must be sourced from DVA-contracted suppliers, which the prescribing clinician can select based on clinical need and availability. [89]

[87] Cancer Research UK. (2024). Voice Prosthesis after laryngectomy. https://www.cancerresearchuk.org/about-cancer/laryngeal-cancer/living-with/speaking-after-laryngectomy/voice-prosthesis
[88] Cancer Research UK. (2024). Voice Prosthesis after laryngectomy. https://www.cancerresearchuk.org/about-cancer/laryngeal-cancer/living-with/speaking-after-laryngectomy/voice-prosthesis
[89] The Department of Veterans Affairs. (2023). *RAP National Schedule of Equipment*. https://www.dva.gov.au/sites/default/files/2023-06/RAPSchedule-June2023.pdf

Private health insurance typically does not cover voice prostheses under extras policies, as these prostheses are not included on the Prescribed List.[90]

Additional prostheses services, programs and schemes

Access to publicly funded voice prostheses services varies significantly across jurisdictions in Australia, resulting in inconsistent and inequitable access to communication aids for people who have undergone a laryngectomy. Table 11 over page provides further information on voice prosthesis schemes available in each state and territory, including eligibility criteria.

In Victoria, the Department of Health provides a range of voice aids, prostheses, and laryngectomy consumables through the State-Wide Equipment Program (SWEP) for people with permanent or long-term disabilities. This includes funding of up to $450 per non-indwelling voice prosthesis, up to three times per year, and up to $5,000 per year for laryngectomy consumables.[91] Similarly, in New South Wales, EnableNSW provides funding for voice prosthesis, electrolarynx and laryngectomy consumables for people with long-term needs[92]. In Tasmania, the Tasmanian Health Service offers dedicated funding for individuals living post-laryngectomy. This support covers essential health aids, including voice prostheses and related consumables, up to a maximum of $6,000 per year.[93]

In contrast, Queensland's Medical Aids Subsidy Scheme (MASS) provides funding for medical aids and equipment for eligible residents with permanent disabilities; however, voice prostheses are specifically excluded and considered an out-of-scope consumable. MASS does provide funding for related items such as heat moisture exchangers (HMEs) and other laryngectomy componentry. In the Northern Territory, South Australia, Western Australia, and the Australian Capital Territory, there was limited publicly available information to determine whether specific state or territory funding schemes exist for voice prostheses.

Additionally, stakeholders consulted as part of this review noted that, while some jurisdictions do offer funding schemes, these are often insufficient to meet the variable needs associated with voice prostheses replacement. The frequency with which a voice prosthesis needs to be replaced can vary depending on individual factors such as anatomy, infection, device malfunction, or increased leakage. As a result, annual caps on the number of funded prostheses may not be appropriate for people who require more frequent replacements. This can lead to prolonged use beyond the recommended period, increasing the risk of complications such as infection, thrush, or aspiration.

[90] The Department of Health, Disability and Ageing. (2025). *Medical devices and human tissue products covered under private health insurance*. https://www.health.gov.au/topics/private-health-insurance/what-private-health-insurance-covers/medical-devices-and-human-tissue-products-covered-under-private-health-insurance
[91] State-wide equipment program. (2021). *Practitioner Manual for Electronic Voice Aids/Voice Prostheses and Laryngectomy Consumables*. file:///C:/Users/ajackson14/Downloads/Electronic_Voice_Aids_Prescriber_Manual.pdf
[92] EnableNSW. (2023). *Electrolarynx, voice Prosthesis and laryngectomy Consumables Funding Criteria*. https://www.enable.health.nsw.gov.au/__data/assets/pdf_file/0010/806959/Electrolarynx,-Voice-Prosthesis-and-Laryngectomy-Consumables-Funding-Criteria.pdf
[93] Mainmed. (2025). *Funding supports*. https://mainmed.com.au/pages/funding-support

Table 11: Jurisdictional comparison of voice prostheses programs and schemes

Program details	Scheme name	Eligibility criteria	Products and services included	Funding source	Funding model	Process for accessing a prosthesis
ACT	No publicly available information	N/A	N/A	N/A	N/A	N/A
NSW	EnableNSW [94]	• Resident of NSW or Lord Howe Island, or an asylum seeker • Enrolled with Medicare • Assistive technology is prescribed to support a health need • Have a long-term disability (more than 12 months) • Not receiving funding under any other government scheme	Non-indwelling voice prostheses (up to 3 per year) Laryngectomy consumables	State government	Fully funded	Assessment by a speech pathology, prescription of a voice prostheses, submit form to EnableNSW
QLD	Medical Aids Subsidy Scheme [95]	• Permanent reside of Queensland, or hold a permanent protection visa, humanitarian visa or be an asylum seeker • Hold a current Medicare card • Undergone a surgical procedure for laryngectomy • Not receiving funding under any other government scheme	Laryngectomy consumables	State government	Fully funded	Speech pathology or otolaryngologists complete a prescription for the applicant s and submit an application on behalf of the applicant to Queensland Health
VIC	State-wide Equipment Program [96]	• Permanent resident in VIC, or hold a Government Visa, be an asylum seeker or hold a temporary protection visa • Have a disability of a permanent nature • Not receiving funding under any other government scheme • Undergone a surgical procedure for laryngectomy	Non-indwelling voice prostheses ($450 per voice prosthesis, up to three per year) Laryngectomy consumables ($5000 per annum)	State government	Subsidy-based scheme	Assessment by a speech pathology, application to SWPE,
SA	No publicly available information	N/A	N/A	N/A	N/A	N/A

[94] EnableNSW. (2023). *Electrolarynx, voice Prosthesis and laryngectomy Consumables Funding Criteria*. https://www.enable.health.nsw.gov.au/__data/assets/pdf_file/0010/806959/Electrolarynx,-Voice-Prosthesis-and-Laryngectomy-Consumables-Funding-Criteria.pdf
[95] Queensland Health. (2025). *Guidelines for Queensland HME Subsidy Scheme for Laryngectomy*. https://www.health.qld.gov.au/__data/assets/pdf_file/0034/847717/MASS-QHSSL-Guidelines.pdf
[96] State-wide equipment program. (2021). *Practitioner Manual for Electronic Voice Aids/Voice Prostheses and Laryngectomy Consumables*. file:///C:/Users/ajackson14/Downloads/Electronic_Voice_Aids_Prescriber_Manual.pdf

Program details	Scheme name	Eligibility criteria	Products and services included	Funding source	Funding model	Process for accessing a prosthesis
WA	No publicly available information	N/A	N/A	N/A	N/A	N/A
NT	No publicly available information	N/A	N/A	N/A	N/A	N/A
TAS	Public hospital system[97]	No information	Voice prostheses and laryngectomy consumables ($6000 per year)	State government	Subsidy-based scheme	Prescription by a speech pathology

Source: Adapted from EnableNSW (2023), Queensland Health (2025), SWEP (2021), Mainmed *(2025)*

[97] Mainmed. (2025). *Funding supports*. https://mainmed.com.au/pages/funding-support

2.4.2 Male reproductive prostheses

About male reproductive prostheses

Prostate cancer is the most commonly diagnosed cancer among men in Australia, with an estimated one in six men receiving a diagnosis by the age of 85. In 2024, over 26,000 cases were diagnosed. While survival rates are high, many men experience long-term side effects following treatment, including impotence and incontinence. This is a common consequence of prostate surgery or radiation therapy.[98]

Male reproductive prostheses are devices used to treat impotence following prostate cancer treatment. Some prostheses, such as implanted penile devices, are surgically inserted to manage impotence, while others are external, such as vacuum erection devices (VEDs). VEDs generally consist of a plastic cylinder, a manual or battery-operated pump to create a vacuum, and a constriction ring. They are typically prescribed by a urologist or a men's health specialist. [99]

While male reproductive prostheses were not considered within the agreed scope of the review, VEDs were discussed by stakeholders during consultation. For completeness, these prostheses are included in this section of the report. Further evaluation is required to determine if VEDs meet the definition of an external prosthesis. As such, they have not been considered within the options for a potential national cancer prostheses program outlined in Section 5 or the costings outlined in Section 6.

Department of Veterans' Affairs

There are limited national-level schemes that specifically fund male reproductive prostheses in Australia. The DVA provides funding for male reproductive prostheses to eligible veterans and dependents who are living with or post a cancer diagnosis. Funding is delivered through the RAP and covers VEDs. To access the program, eligible individuals must obtain a prescription or recommendation from a specialist. VEDs are only provided when alternative methods for overcoming impotence are not suitable.

As outlined in Section 2.1.2, a health professional submits a RAP form to the DVA, which must include supplier details and a quote. Male reproductive prostheses must be sourced from a DVA-contracted supplier, which the prescribing clinician can select based on clinical need and availability.[100]

In Australia, private health insurance typically does not cover male reproductive prostheses under extras policies, as these prostheses are not included on the Prescribed List[101].

Additional prostheses services, programs and schemes

There are no dedicated state or territory-level funding schemes currently supporting male reproductive prostheses. As such, outside of the DVA, individuals must self-fund the cost of these prostheses.

[98] Cancer Council. (2025). *Types of prostate cancer*. https://www.cancer.org.au/cancer-information/types-of-cancer/prostate-cancer
[99] Medline Plus. (2024). *Vacuum erectile devices*. https://medlineplus.gov/ency/patientinstructions/000985.htm
[100] The Department of Veterans Affairs. (2023). *RAP National Schedule of Equipment*. https://www.dva.gov.au/sites/default/files/2023-06/RAPSchedule-June2023.pdf
[101] The Department of Health, Disability and Ageing. (2025). *Medical devices and human tissue products covered under private health insurance*. https://www.health.gov.au/topics/private-health-insurance/what-private-health-insurance-covers/medical-devices-and-human-tissue-products-covered-under-private-health-insurance

2.4.3 Oral prostheses

About oral prostheses

Oral prostheses (also known as intra-oral prostheses) are artificial devices used to restore anatomy inside the mouth, including teeth, soft tissue and parts of the palate, following surgical treatment for cancers of the head and neck. These include dental prostheses, such as a prosthetic tooth (crown) attached to a dental implant, as well as a removable palatal prosthesis, often called plates or obturators, which replace or cover parts of the hard or soft palate. Oral prostheses help restore essential functions such as eating, swallowing, speaking and maintaining facial structure. [102]Oral prostheses are typically designed and fitted by specialised health professionals, including prosthodontists, maxillofacial surgeons and maxillofacial prosthetists.

Oral prostheses were considered out of scope for this review as they are typically considered to be implants and / or dental care. Oral prostheses may also be considered as part of broader Australian Government inquiries, such as the Senate enquiry into the Provision of and Access to Dental Services in Australia. However, stakeholders consulted as part of this review consistently highlighted the critical role oral prostheses play in cancer care and recovery. For completeness, these prostheses are included in this section of the report.

National prostheses services, programs and schemes

There are limited national-level schemes that fund oral prostheses in Australia. The DVA provides funding for oral prostheses to eligible veterans and dependents who are living with or post a cancer diagnosis. This includes removable dentures, partial plates, and prosthetic teeth. To access the program, the service must be claimed and submitted by a dentist or dental specialist. [103]

In Australia, private health insurance may provide limited coverage for certain types of oral prostheses under extras policies, typically within the “major dental” category. However, coverage varies significantly between insurers and policy levels, as oral prostheses are not eligible for inclusion on the Prescribed List. Where benefits are available, they are often subject to annual limits, waiting periods, and exclusions, meaning individuals may still face substantial out-of-pocket costs.

Stakeholders consulted as part of this review noted that while the surgical placement of dental implants is covered under Medicare, the prosthetic components that sit on top of the implants, such as prosthetic teeth, are not. Therefore, individuals are often required to pay the full cost of the prostheses out of pocket. This disconnect between what is surgically funded and what is functionally needed places a substantial financial burden on individuals and undermines the value of the initial procedure, as the intended outcome may remain incomplete or unattainable.

Additional prostheses services, programs and schemes

Publicly available information on state and territory-level funding for oral prostheses is limited. Outside of the DVA, there appear to be no consistent or dedicated public schemes for oral prostheses across jurisdictions. Consequently, individuals ineligible for DVA support must often self-fund their oral prostheses.

[102] Head and Neck Cancer Australia. (n.d.). *Facial Prosthesis*. https://www.headandneckcancer.org.au/health-wellbeing/facial-prosthetics/
[103] The Department of Veterans Affairs. (2025). *Fee Schedule of Dental Services for Dentists and Dental Specialists*. https://www.dva.gov.au/sites/default/files/2025-01/dentalfees-1-jan-2025.pdf

03

Prostheses services, programs and schemes in other countries

3 Prostheses services, programs and schemes in other countries

This section outlines findings related to the following sub-question under KRQ 1: What prostheses services / schemes are currently available to people living with or who have lived experience of cancer?

- How do prostheses services / schemes available to people living with or have lived experience of cancer in Australia compare to those available in other, comparable countries?

This section is structured as follows:

- Section 3.1: Countries selected for international comparative analysis
- Section 3.2: International comparison of facial prostheses services, programs and schemes
- Section 3.3: International comparison of breast prostheses services, programs and schemes
- Section 3.4: International comparison of limb prostheses services, programs and schemes
- Section 3.5: International comparison of other prostheses services, programs and schemes, including voice, male reproductive and oral prostheses.

A summary of the key findings outlined within this section is provided below.

Summary of findings

- The prostheses services, programs and schemes in Canada, the Netherlands, New Zealand and the United Kingdom were compared to those available in Australia. These countries were selected for inclusion in this analysis due to similarities between their health systems and Australia's.
- In contrast to the limited availability of publicly funded facial prostheses services in Australia, Canada, the Netherlands, New Zealand, and the UK, all provide access to facial prostheses through national or provincial programs. New Zealand, the Netherlands, and the UK offer fully funded prostheses, while Canada provides partial public funding.
- External breast prostheses programs in Australia, the UK, the Netherlands, New Zealand, and Canada are broadly similar in providing funding for breast prostheses after mastectomy but differ in their funding models and coverage of supplementary items. Australia, New Zealand, and Canada use reimbursement models, while the UK and the Netherlands provide prostheses directly with no upfront cost to individuals. Notably, New Zealand's program is more comprehensive, funding supplementary items such as mastectomy bras and swimwear.
- In comparison to the significant variation that can occur in Australia in accessing limb prostheses depending on age and location, Canada, the Netherlands, New Zealand, and the UK have nationally consistent approaches with eligibility based on clinical need. While Canada and the Netherlands generally only fund basic prostheses and have limited support for advanced technology, New Zealand and the UK fully fund microprocessor knees and provide comprehensive support services for those who meet clinical criteria.
- Unlike Australia, Canada, the Netherlands, and the UK have structured provincial or national programs in place that cover voice prostheses. The Netherlands and the UK offer comprehensive coverage for voice prostheses, while Canada provides partial funding.
- The UK was the only country of those considered that offers public funding for male reproductive prostheses. Canada and New Zealand rely primarily on self-funding, while there is no publicly available information for the Netherlands.
- In contrast to the largely self-funded model in Australia, Canada, and the Netherlands offer structured reimbursement models for oral prostheses, while New Zealand and the UK provide fully funded oral prostheses for individuals meeting specific clinical criteria, which includes those affected by cancer.

3.1 Countries selected for comparative analysis

For each prostheses type included within this section, the delivery of prostheses services in the following countries have been compared to Australia:

- Canada
- Netherlands
- New Zealand
- United Kingdom.

These countries were selected for inclusion in this analysis due to similarities between their health systems and Australia's. These countries represent high-income nations where universal healthcare is provided, there is strong regulatory oversight of the health system and there is a mix of public and private care available. A brief overview of the health systems in each country is provided in Table 12 below.

Table 12: Overview of the health systems in countries included in the international comparator analysis outlined in this section

Country	Overview of health system and similarities to Australia
Canada	Like Australia, Canada operates a publicly funded universal health insurance system (also called Medicare) that provides access to essential healthcare services for all citizens. Canada's system is managed at the provincial level, leading to some regional variation in service delivery. Each Canadian province and territory has its own health insurance plan, with coverage provided for medically necessary hospital, physician and some surgical-dental services.[104]
Netherlands	The Dutch system combines universal mandatory health insurance with private provision, offering a high level of access, efficiency, and health outcomes. This system is similar to Australia's dual public-private approach. Dutch residents are required to purchase insurance from private health insurers, who are required to accept all applicants. Benefits typically include hospital, physician, home nursing, and mental health care, as well as prescription medication.[105]
New Zealand	New Zealand's health system shares many features with Australia, including universal coverage, a mix of public and private providers, and similar regulatory standards. The New Zealand government is responsible for setting an annual budget and benefit package while District health boards plan, purchase and provide health services at the local level. The Medical Council of New Zealand explicitly lists Australia as a comparable system to their own.[106,107]
United Kingdom	The United Kingdom's (UK) National Health Service (NHS) provides universal healthcare across the UK. The NHS is funded through taxation and shares similar characteristics to Australia's Medicare. A UK government agency, NHS England, oversees and allocates funding to 191 Clinical Commissioning Groups. These groups are responsible for governing and paying for health service delivery at the local level, including hospital, physician, and mental health care.[108]

Source: KPMG (2025)

[104] Government of Canada. (2025). About Canada's health care system. https://www.canada.ca/en/health-canada/services/canada-health-care-system.html
[105] The Commonwealth Fund. (2025). International Health Care System Profiles – Netherlands. https://www.commonwealthfund.org/international-health-policy-center/countries/netherlands
[106] The Commonwealth Fund. (2025). International Health Care System Profiles – New Zealand. https://www.commonwealthfund.org/international-health-policy-center/countries/new-zealand
[107] Medical Council of New Zealand. (2025). Comparable health system criteria. https://www.mcnz.org.nz/registration/getting-registered/registration-policy/comparable-health-system-criteria/
[108] The Commonwealth Fund. (2025). International Health Care System Profiles – England. https://www.commonwealthfund.org/international-health-policy-center/countries/england

3.2 International comparison of facial prostheses services, programs and schemes

As outlined in Section 2.1, there is no national program or scheme that funds facial prostheses for individuals with a living or lived experience of cancer in Australia. Prostheses services are primarily self-funded, with only limited public support available in some jurisdictions. In contrast, Canada, the Netherlands, New Zealand, and the UK all provide access to facial prostheses under national or province-based models, with clear eligibility criteria based on residency and clinical needs. Details of each program are outlined in Table 13.

Compared to Australia, New Zealand, the Netherlands, and the UK have a national program that funds facial prostheses for individuals with a living or lived experience of cancer. These include orbital, ocular, nasal, ear and hemi-facial prostheses. New Zealand provides funding for individuals requiring ocular and orbital prostheses through the national New Zealand Prosthetic Eye Service, ensuring consistent and affordable access. In the Netherlands, statutory health insurance covers the cost of facial prostheses, with no upfront costs when individuals access prostheses through contracted providers. Similarly, in the UK, the NHS delivers comprehensive, no-cost prostheses services for individuals meeting the clinical need criteria.[109] Similarly, Canada offers partial public funding for facial prostheses through provincial programs, such as Ontario's Assistive Devices Program, which covers up to 75% of the costs. [110]

In summary, Australia's fragmented approach to funding facial prostheses differs from more unified and consistent models seen in the other four countries. While some limited public funding may be available in Australia, the lack of a formal policy or funding framework for facial prostheses results in a system that is heavily reliant on self-funding and access that is hospital- or clinician-dependent. This contrasts with the partial reimbursement or fully funded models available in Canada, the Netherlands, New Zealand, and the UK, where the financial cost of facial prostheses does not pose as significant a barrier to access.

[109] King's College Hospital NHS Foundation Trust. (2024). Maxillofacial prosthetics and reconstruction. https://www.kch.nhs.uk/services/services-a-to-z/maxillofacial-prosthetics-and-reconstruction/
[110] Government of Ontario. (n.d.). Application for Funding Maxillofacial Extraoral Prostheses. https://www.ontario.ca

Table 13: International comparison of facial prostheses programs and schemes

Program details	Australia	Canada	Netherlands	New Zealand	UK
Program / scheme name	N/A	Provincial programs (e.g., Ontario ADP)	Basic Health Insurance	New Zealand Prosthetic Eye Service	NHS Prosthetic Services
National or regional model	N/A	Regional (provincial)	National	National	National
Eligibility criteria	N/A	Provincial residency, valid health card, specialist referral (e.g., plastic surgeon, oncologist)	Insured under statutory health insurance, referral from GP / surgeon, post-surgical healing (3+ months)	NZ residency; ACC claim or MoH approval; referral from ophthalmologist/optometrist	Must be registered with the NHS, have a referral from GP / specialist, clinical need (e.g., post-cancer, trauma)
Products and services included	Limited public funding available for prosthetic eyes, ears, noses and orbital prostheses	Auricular prostheses Nasal prostheses Orbital prostheses Orbitomaxillary prostheses	Custom silicone facial prostheses (nose, ear, eye) with glue or implant retention	Prosthetic eyes Scleral shells Orbital prostheses	Custom facial prostheses (eyes, ears, noses)
Funding source	Mostly self-funded, partial funding from some state governments	Provincial governments	Statutory health insurance	Government funding (free for approved patients)	NHS (public funding)
Funding model	Mostly self-funded	Partial reimbursement model, ~75% of costs	Fully funded (no upfront cost if contracted provider)	Fully funded	Fully funded
Process for accessing a prosthesis	Referral, multidisciplinary assessment, prosthesis fabrication, fitting [111]	Specialist referral, prosthetist assessment, application to ADP, prosthesis fabrication and fitting [112]	Referral, assessment by maxillofacial team, prosthesis design/fitting [113]	Free consultation, custom fabrication [114]	GP / specialist referral, hospital-based maxillofacial team appointment, prosthesis fabrication and fitting [115]

Source: KPMG (2025)

[111] Head and Neck Cancer Australia. (2024). Cancer patients wait for facial prosthetics funding ahead of election. https://www.headandneckcancer.org.au
[112] Government of Ontario. (n.d.). Application for Funding Maxillofacial Extraoral Prostheses. https://www.ontario.ca
[113] Antoni Van Leeuwenhoek. (n.d.). Facial Prosthetics. https://www.avl.nl/en/preparing-for-your-appointment/departments-and-centers/facial-prosthetics/
[114] NZ Prosthetic Eye Service. (n.d.). Services Introduction. https://www.prosthetic-eyes.co.nz/services-introduction/
[115] King's College Hospital NHS Foundation Trust. (2024). Maxillofacial prosthetics and reconstruction. https://www.kch.nhs.uk/services/services-a-to-z/maxillofacial-prosthetics-and-reconstruction/

3.3 International comparison of breast prostheses services, programs and schemes

External breast prostheses programs across Australia, UK, the Netherlands, New Zealand and Canada are broadly similar, with some variations in how the programs are implemented. Table 14 overleaf outlines the external breast prostheses programs in each of the five countries. Three of the four international comparators, the Netherlands, New Zealand, and the UK, use a national model for the provision of external breast prostheses, similar to Australia's EBPRP. In contrast, Canada uses a regional model where eligibility, services, and funding vary by province or territory. This aligns with Canada's overall health system, where health services are managed at the provincial level.

The most notable variations between countries relate to the products and supplementary items offered as part of their external breast prostheses programs. Breast prostheses are funded under each national external breast prostheses program; however, there is variability in the funding available for supplementary items. Similar to Australia, the external breast prosthesis schemes in the Netherlands and the UK do not cover supplementary items such as mastectomy bras and swimwear, meaning individuals must pay for these items out of pocket.[116] In contrast, New Zealand's Breast Prosthesis Subsidy program provides funding for these supplementary items, as well as for additional items like prosthetic nipples and further prosthetic modifications.[117] In Canada, coverage varies by province, with some provinces funding mastectomy bras within their provincial programs.[118]

Another key difference in external breast prosthesis programs across the five countries is the funding models. As outlined in Section 2.2.2, the EBPRP in Australia operates under a reimbursement model, requiring individuals to pay upfront for their prostheses and then claim the amount for reimbursement through the national program. This is similar to the external breast prostheses in Canada, which have a similar funding model but offer only reimbursement for part of the cost, with amounts varying by province. New Zealand also uses a reimbursement model; however, unlike Australia and Canada, claims can be submitted either by the individuals or by the prostheses provider, which helps reduce the administrative burden on individuals requiring a prostheses.

In contrast, the UK and the Netherlands' external breast prostheses programs require no upfront payment by the individual. Instead, prostheses are fully funded and provided directly through the public health system or approved providers, allowing individuals to access prostheses without financial barriers at the point of care. In the Netherlands, if an individual chooses a non-contracted provider, a reimbursement model applies, generally offering partial reimbursement.

In summary, Australia's external breast prostheses program is comparable in many ways to those in other countries, particularly in its national approach and commitment to funding breast prostheses. However, compared to the more comprehensive offerings in some countries, such as New Zealand's inclusion of supplementary items in its funding model, Australia's program is more narrowly focused on core prostheses. The reimbursement model used in Australia is similar to the models used in New Zealand and Canada; however, it may present financial and administrative challenges for individuals, unlike the more direct access models seen in the UK and the Netherlands. These differences highlight that while the EBPRP shares similarities with international models, it is not as expansive or streamlined as some of its global counterparts.

[116] HollandZorg. (2025). Reimbursements breast prosthesis. https://www.hollandzorg.com/insured/reimbursements2025/breast-prosthesis
[117] Health New Zealand. (2022). Breast prosthesis subsidy. https://www.tewhatuora.govt.nz/for-health-providers/claims-provider-payments-and-entitlements/breast-prosthesis-subsidy
[118] Government of Ontario. (n.d.). Breast prostheses and artificial limbs. https://www.ontario.ca/page/breast-prostheses-and-artificial-limbs

Table 14: International comparison of external breast prostheses programs and schemes

Program details	Australia	Canada	Netherlands	New Zealand	UK
Program / scheme name	National External Breast Prostheses Reimbursement Program (EBPRP)	Provincial programs (e.g., Ontario: Assistive Devices Program, Nova Scotia: Breast Prosthesis Program)	Basic Health Insurance	Breast Prosthesis Subsidy	NHS External Breast Prostheses Provision
National or regional model	National	Regional (provincial)	National	National	National
Eligibility criteria	Must be enrolled in Medicare and have undergone breast surgery due to cancer or other medical conditions requiring prostheses	Eligibility varies by province. Generally requires a prescription or proof of surgery, must be resident in the province	Requires a prescription from a general practitioner or nurse; insured under the statutory health insurance scheme.	Requires a medical certificate from a GP or specialist, must be a resident eligible for public health service	Must be registered with the NHS and have undergone breast surgery; referral or fitting arranged by breast care nurse or specialist
Products and services included	External breast prostheses (new and replacement) Supplementary items (e.g., bras) are not covered	External breast prostheses Some provinces include mastectomy bras	External breast prostheses	Breast prostheses Swim forms Surgical bras Prosthetic nipples Modifications	Wide range of breast prostheses Bras and swimwear are not routinely covered
Funding source	Australian Government	Provincial governments	Statutory health insurance	Federal government	NHS (public funding)
Funding model	Reimbursement model (up to $400 per prosthesis, every 2 years)	Partial reimbursement model (amounts vary by province)	Fully funded for contracted providers, 75% reimbursement for non-contracted providers	Reimbursement model (up to $ 613.33 per side every 4 years)	Fully funded
Process for accessing a prosthesis	Purchase from retailer, pay upfront, claim reimbursement [119]	Purchase from approved provider, pay upfront, claim partial reimbursement [120]	Obtain prescription, visit contracted provider to obtain prosthesis. If non-contracted provider, pay upfront, claim reimbursement [121]	Purchase from supplier, supplier or patient submits claim, subsidy [122]	Fitting arranged by breast care nurse at hospital or specialist clinic, prostheses provided [123]

Source: KPMG (2025)

[119] Australian Government Department of Health and Aged Care. (2023). National External Breast Prostheses Reimbursement Program. https://www.health.gov.au/our-work/national-external-breast-prostheses-reimbursement-program
[120] Government of Ontario. (n.d.). Breast prostheses and artificial limbs. https://www.ontario.ca/page/breast-prostheses-and-artificial-limbs
[121] HollandZorg. (2025). Reimbursements breast prosthesis. https://www.hollandzorg.com/insured/reimbursements2025/breast-prosthesis
[122] Health New Zealand. (2022). Breast prosthesis subsidy. https://www.tewhatuora.govt.nz/for-health-providers/claims-provider-payments-and-entitlements/breast-prosthesis-subsidy
[123] NHS Supply Chain. (n.d.). External breast prosthesis and chest support. https://www.supplychain.nhs.uk/product-information/contract-launch-brief/external-breast-prostheses-and-associated-products/

3.4 International comparison of limb prostheses services, programs and schemes

As outlined in Section 2.3, the NDIS is the primary scheme through which limb prostheses are accessed in Australia. However, due to the age eligibility criteria, people over the age of 65 are reliant on jurisdictional artificial limb schemes. As a result, access to limb prostheses, including advanced componentry and high-grade prostheses, can vary significantly depending on an individual's age and location. In contrast, Canada, the Netherlands, New Zealand, and the UK all employ either nationally consistent or province-based systems with consistent eligibility based on residency, clinical need, or registration with their respective health service. Details of each program are outlined in Table 15.

Canada and the Netherlands provide access to basic limb prostheses through their national program and are more limited in their funding for advanced technologies compared to the NDIS in Australia, as well as limb prostheses programs in New Zealand, and the UK. In Canada, some provinces partially fund microprocessor knees.[124] Similarly, in the Netherlands, microprocessor knees may be funded if deemed medically necessary, however individuals require approval by an insurer.[125,126] Maintenance support is also limited, potentially affecting long-term device use.

In contrast, limb prostheses programs in New Zealand and the UK fully fund microprocessor knees for individuals who meet clinical criteria. This reflects both countries' health systems' recognition of the long-term benefits associated with the advanced components of microprocessor knees, including reduced fall risk, fewer hospital admissions, improved mobility and better downstream socioeconomic outcomes.[127] In addition to funding microprocessor knees, both New Zealand and the UK also fund support services, including repairs, rehabilitation, and supplementary accessories. [128]

[124] Government of Nova Scotia. (n.d.). Arm and Leg Prosthesis Program. https://novascotia.ca/dhw/arm-and-Leg-prostheses-program/
[125] Geertzen, J., et al. (2015). Dutch evidence-based guidelines for amputation and prosthetics of the lower extremity: Rehabilitation process and prosthetics. Part 2. Prosthetics and Orthotics International, 39(5), 361–371. https://journals.sagepub.com/doi/pdf/10.1177/0309364614542725
[126] Amputee Care Center. (n.d.)., Applying for prosthesis reimbursement from Dutch health insurance. https://amputeecarecenter.com/en/blog/applying-for-prosthesis-reimbursement-from-dutch-health-insurance
[127] Limbs4Life. (2020). A new National Disability Strategy. Submission: Stage 2 consultations. https://www.limbs4life.org.au/uploads/banner/National-Disability-Strategy-Submission-Limbs-4-Life-OCT-2020.pdf
[128] New Zealand Parliament. (2018). Artificial Limb Service Act 2018. https://www.legislation.govt.nz/act/public/2018/0034/8.0/whole.html

Table 15: International comparison of limb prostheses programs and schemes

Program details	Australia	Canada	Netherlands	New Zealand	UK
Program / scheme name	NDIS and state-based limb schemes	Provincial programs	Basic Health Insurance	Peke Waihanga Artificial Limb Service	NHS Prosthetic Limb Service
National or regional model	Mixed	Regional (provincial)	National	National	National
Eligibility criteria	NDIS: Under 65 years, permanent disability State schemes: Over 65 years, residency, Medicare, rehab completion	Provincial residency, medical prescription, amputation at or above trans-metatarsal / carpal	Requires a prescription from a general practitioner or specialist, insured under the statutory health insurance scheme.	NZ residency, medical referral, congenital limb deficiency or amputation	Must be registered with the NHS, have an amputation/ congenital limb deficiency and clinical referral
Products and services included	Prostheses (interim and definitive) Advanced limbs available through NDIS and some state schemes Repairs and maintenance Accessories (e.g., socks)	Conventional / externally powered prostheses Some provinces partially fund high-grade prostheses Sockets and components Repairs	Basic prostheses High-grade prostheses can be funded if clinically justified, subject to insurer approval and medical necessity Osseointegration Limited maintenance	Prostheses Repairs Stump socks Sports limbs and high-grade prostheses available subject to clinical review and funding limits	Prostheses (custom) Advanced limbs funded by NHS for eligible users Repairs Accessories Rehabilitation services
Funding source	Federal and state governments	Provincial governments	Statutory health insurance	Federal government	NHS (public funding)
Funding model	Fully funded	Fully funded	Fully funded	Fully funded	Fully funded
Process for accessing a prosthesis	Referral to accredited amputee clinic, multidisciplinary assessment, prescription by prosthetist, approval by funder (NDIS or state), prosthesis manufactured and fitted, follow-up and adjustments [129]	Prescription from physician or nurse practitioner, assessment by licensed prosthetist, application to provincial program, device fabricated and fitted, reimbursement or direct payment by province [130]	Assessment by rehabilitation physician and prosthetist, prescription based on mobility/activity level, submission to insurer for approval, prosthesis manufactured and fitted, follow-up and evaluation [131, 132]	Hospital or GP referral to Artificial Limb Centre, multidisciplinary team assessment, measurements/casting, custom prosthesis made and fitted, multiple fittings and follow-up appointments [133, 134]	Referral by hospital or GP to specialist limb centre, multidisciplinary team assessment, prescription and fitting by prosthetist, prosthesis manufactured and fitted, follow-up, repairs, and reviews [135]

Source: KPMG (2025)

[129] Limbs 4 Life. (n.d.). State and Territory Artificial Limb Schemes. https://www.limbs4life.org.au/funding/artificial-limb-schemes
[130] Government of Nova Scotia. (n.d.). Arm and Leg Prosthesis Program. https://novascotia.ca/dhw/arm-and-Leg-prostheses-program/
[131] Amputee Care Center. (n.d.)., Applying for prosthesis reimbursement from Dutch health insurance. https://amputeecarecenter.com/en/blog/applying-for-prosthesis-reimbursement-from-dutch-health-insurance
[132] Geertzen, L., et al. (2015). Dutch evidence-based guidelines for amputation and prosthetics of the lower extremity: Rehabilitation process and prosthetics – Part 2. Prosthetics and Orthotics International, 39(5) 361 – 371. https://journals.sagepub.com/doi/pdf/10.1177/0309364614542725
[133] Peke Waihanga Artifical Limb Service. (2025). Services. https://www.pw.co.nz/services
[134] New Zealand Parliament. (2018). Artificial Limb Service Act 2018. https://www.legislation.govt.nz/act/public/2018/0034/8.0/whole.html
[135] NHS (2023). Prosthetic limbs: Amputation. https://www.nhs.uk/tests-and-treatments/amputation/#:~:text=If%20you%20have%20a%20prosthetic,wheelchair%20ramp%20or%20a%20stairlift.

3.5 International comparison of other prostheses services, programs and schemes

As described previously in this report, other prostheses, including non-indwelling voice prostheses, external male reproductive prostheses and oral prostheses, fell outside the scope of this review; however, they have been included in the international comparative analysis for completeness.

3.5.1 Voice prostheses

In Australia, funding for voice prostheses is limited primarily to select jurisdictions (NSW, VIC, QLD, and TAS), leaving individuals in other states and territories without public support. In contrast, Canada, the Netherlands, and the UK operate under more consistent models that provide formal pathways to access and more explicit eligibility criteria. These programs are administered either provincially or nationally. Table 16 provides further detail on the national voice prostheses programs and schemes available in each country.

Canada uses a partial reimbursement model, covering up to 75% of costs for voice prostheses. Eligibility is based on residency, health coverage, and specific clinical needs, which include individuals who have both an inability to communicate verbally and an inability to communicate through writing.[136] The Netherlands and the UK have more comprehensive public funding models. In the Netherlands, access to voice prostheses is provided through the statutory health insurance system, with up to six prostheses and related devices funded annually. Individuals in the Netherlands pay a fixed annual contribution towards healthcare costs, after which additional fees are reimbursed by the system.[137] In the UK, the NHS provides fully funded prostheses and consumables to eligible individuals based on clinical need. Currently, there is no publicly available information on how access to voice prostheses is funded or delivered in New Zealand.

[136] Government of Ontario. (n.d.). Communication aids. https://www.ontario.ca/page/communication-aids
[137] Van der Molen, L., et al. (2013). Practice of laryngectomy rehabilitation interventions: a perspective from Europe / the Netherlands. https://pure.uva.nl/ws/files/2022455/126203_review_practice_of_laryngectomy_rehab_NKI_LvdMolen_2013.pdf

Table 16: International comparison of voice prostheses programs and schemes

Program details	Australia	Canada	Netherlands	New Zealand	UK
Program / scheme name	N/A	Provincial programs (e.g., Ontario ADP)	Basic Health Insurance	No information available	NHS
National or regional model	N/A	Regional (provincial)	National	No information available	National
Eligibility criteria	N/A	Provincial residency, valid health card, inability to speak, inability to use a pen and paper to write due to disability	Insured under statutory health insurance, treatment by physician	No information available	Must be registered with the NHS, have a referral from GP / specialist, clinical need (e.g., post-cancer, trauma)
Products and services included	Voice prostheses (up to 3 per year) and laryngectomy consumables – only available in NSW, VIC, QLD, TAS	Voice prostheses Electrolarynxes Voice amplifiers	Voice prostheses (up to 6 per year) Heat and moisture exchanger	No information available	Voice prostheses Heat and moisture exchanger
Funding source	Mostly self-funded, partial funding from some state governments	Provincial governments	Self-funded and statutory health insurance	No information available	Fully-funded
Funding model	Mostly self-funded	Partial reimbursement model, ~75% of costs	Self-funded (for an annual fixed amount), then a reimbursement model for the remaining costs	No information available	NHS (public funding)
Process for accessing a prosthesis	Specialist assessment, specialist prescription	Examination by speech language pathologist or occupation therapist, prostheses fitting, application to ADP [138]	Specialist assessment, treatment through head and neck cancers [139, 140]	No information available	Part of laryngectomy operation [141, 142]

Source: KPMG (2025)

[138] Government of Ontario. (n.d.). Communication aids. https://www.ontario.ca/page/communication-aids
[139] Beck, A. C. C., et al. (2019). Patient access to voice prostheses and heat and moisture exchangers: Factors influencing physician's prescription and reimbursement in eight European countries. https://www.sciencedirect.com/science/article/pii/S1368837519300636
[140] Van der Molen, L., et al. (2013). Practice of laryngectomy rehabilitation interventions: a perspective from Europe / the Netherlands. https://pure.uva.nl/ws/files/2022455/126203_review_practice_of_laryngectomy_rehab_NKI_LvdMolen_2013.pdf
[141] Beck, A. C. C., et al. (2019). Patient access to voice prostheses and heat and moisture exchangers: Factors influencing physician's prescription and reimbursement in eight European countries. https://www.sciencedirect.com/science/article/pii/S1368837519300636
[142] Cancer Research UK. (2024). Voice prosthesis after laryngectomy. https://www.cancerresearchuk.org/about-cancer/laryngeal-cancer/living-with/speaking-after-laryngectomy/voice-prosthesis

3.5.2 Male reproductive prostheses

Australia, Canada and New Zealand offer limited or no public funding for external male reproductive prostheses, leaving most people requiring prostheses to navigate the system through self-funding. In Australia, public access is restricted only to eligible veterans through the DVA, with all other individuals having to pay for prostheses privately. Similarly, in Canada and New Zealand, individuals requiring external prostheses must pay the full out-of-pocket costs themselves. The Netherlands lacks publicly available information on whether any national or regional funding mechanisms exist, which may indicate the absence of a formalised public program for these prostheses.

In contrast, the UK allows access to external male reproductive prostheses through the NHS under defined clinical conditions. Eligibility is determined through GP assessment and based on whether the clinical need is due to a medical condition (which includes prostate cancer). Following the GP assessment, an NHS prescription is provided and the device is dispensed at a pharmacy.

In summary, the UK offers the most accessible public pathways for external male reproductive prostheses, guided by clinical need and provided at no cost to eligible patients. In contrast, Australia, Canada, and New Zealand rely on self-funding models, limiting access to those who can afford to pay privately. The absence of clear information from the Netherlands suggests a lack of formal public or privately-funded provision, highlighting international disparities in access to male reproductive prostheses.

Table 17: International comparison of male reproductive prostheses programs and schemes

Program details	Australia	Canada	Netherlands	New Zealand	UK
Program / scheme name	N/A (outside of the DVA)	N/A	No information available	N/A	NHS
National or regional model	N/A	N/A	No information available	N/A	National
Eligibility criteria	N/A (outside of the DVA, where veterans and dependents are eligible)	N/A	No information available	N/A	Clinical need, cause of erectile dysfunction is due to a specific set of medical conditions (including prostate cancer)
Products and services included	Vacuum erection devices	Vacuum erection devices Constrictive bands	No information available	Vacuum erection devices	Vacuum erection devices
Funding source	Self-funded (outside of the DVA)	Self-funded	No information available	Self-funded	Fully-funded
Funding model	Self-funded (outside of the DVA)	Self-funded	No information available	Self-funded	NHS (public funding)
Process for accessing a prosthesis	Specialist assessment, surgical implant [143]	Available without a prescription or a doctor's referral [144]	No information available	GP assessment, prescription [145, 146]	GP assessment, NHS prescription, dispensed at pharmacy [147, 148]

Source: KPMG (2025)

[143] The Department of Veterans Affairs. (2023). *RAP National Schedule of Equipment*. https://www.dva.gov.au/sites/default/files/2023-06/RAPSchedule-June2023.pdf
[144] Healthwise Alberta. (2024). Vacuum devices for erection problems. https://myhealth.alberta.ca/Health/pages/conditions.aspx?hwid=hw111500
[145] HARDFacts – Boston Scientific. (n.d.). Non-surgical treatments I Vacuum Erection Devices or Pump. https://www.hardfacts.co.nz/treatment-options/vacuum-erection.html
[146] HARDFacts – Boston Scientific. (n.d.). Frequently asked questions about erection dysfunction. https://www.hardfacts.co.nz/resources/faq.html
[147] iMedicare. (n.d.). Available on Prescription. https://www.mypelvichealth.co.uk/en/info/soma-information/availabilty-on-prescription-new/
[148] NHS Cambridge University Hospitals NHS Foundation Trust. (2022). Vacuum erection assistance devices: frequently asked questions. https://www.cuh.nhs.uk/patient-information/vacuum-erection-assistance-devices-frequently-asked-questions/

3.5.3 Oral prostheses

Access to oral prostheses in Australia is limited within the public system, and funding is only available to those eligible under the DVA scheme. Outside of the DVA, individuals must rely on self-funding or private health insurance to access oral prostheses. This gap in funding access contrasts with the more structured and inclusive models seen in other countries.

Canada and the Netherlands offer structured reimbursement models through their national health systems. Unlike other prostheses programs, Canada uses a national scheme to fund oral prostheses, the Canadian Dental Care Plan (CDCP). This scheme is available to all Canadian residents with an income below a certain threshold. Eligibility for oral prostheses funded by the CDCP is based on clinical need. The Netherlands similarly includes prosthetic dental care through its statutory health insurance. Individuals can receive up to 75% reimbursement after obtaining a referral from a dental professional.

New Zealand and the UK operate fully funded public models for oral prostheses, but with relatively narrow clinical eligibility criteria. In New Zealand, District Health Boards cover oral prostheses. Still, they are only available for individuals diagnosed with head and neck cancer, and only when prosthetics are deemed the most appropriate treatment to restore function and appearance. The NHS in the UK also fully funds oral prostheses for individuals who have lost their teeth due to cancer. It has a comprehensive system available with relatively broad access.

In summary, Australia relies primarily on self-funding or private health insurance for access to oral prostheses, with public support limited to eligible veterans under the Department of Veterans' Affairs. In contrast, Canada, the Netherlands, New Zealand, and the UK offer varying degrees of public support through either partial reimbursement or full funding models. Canada's CDCP is particularly notable, as it targets individuals who face financial barriers to accessing oral prostheses, which is a significant barrier for Australians as well.

Table 18: International comparison of oral prostheses programs and schemes

Program details	Australia	Canada	Netherlands	New Zealand	UK
Program / scheme name	N/A (outside of the DVA)	Canadian Dental Care Plan (CDCP)	Basic Health Insurance	N/A	NHS
National or regional model	N/A	National	National	National	National
Eligibility criteria	N/A (outside of the DVA, where veterans and dependents are eligible)	Registered under the CDCP, clinical need	Insured under statutory health insurance, referral from dentist, dental surgeon or orthodontist	Diagnosis of head and neck cancer, if prostheses are the most appropriate treatment modality to restore form and function	Must be registered with the NHS, lost teeth due to cancer
Products and services included	Dentures (complete and partial) Partial plates Prosthetic teeth	Dentures (complete and partial)	Prostheses	Prostheses Crown and bridge	Dentures (complete, partial, removable, overdenture)
Funding source	Self-funded, private health insurance, or through DVA	National government	Statutory health insurance	District Health Boards (public funding)	NHS (public funding)
Funding model	Self-funded, private health insurance, or through DVA	Reimbursement model, based on income and cost of services	Reimbursement model (up to 75%)	Fully funded	Fully funded
Process for accessing a prosthesis	Dentist referral, specialist assessment, fitting [149]	Dentist referral, specialist assessment, fitting [150, 151]	Impression taking, fitting and testing, permanent testing [152, 153]	Dentist referral, specialist assessment, impression taking [154]	Specialist assessment, impression taking, adjustments, permanent fitting [155, 156]

Source: KPMG (2025)

[149] The Department of Veterans Affairs. (2025). *Fee Schedule of Dental Services for Dentists and Dental Specialists*. https://www.dva.gov.au/sites/default/files/2025-01/dentalfees-1-jan-2025.pdf
[150] Government of Canada. (2025). Canadian Dental Care Plan: What services are covered. https://www.canada.ca/en/services/benefits/dental/dental-care-plan/coverage.html
[151] Canadian Dental Association. (2025). Dental Implants – Replacing Missing Teeth. https://www.cda-adc.ca/en/oral_health/procedures/dental_implants/
[152] Lassus Tandartsen. (n.d.). Dentures. https://lassustandartsen.nl/amsterdam/en/specialisatie/dentures/
[153] Expatica. (2025). Dutch dentists: dental care in the Netherlands. https://www.expatica.com/nl/healthcare/healthcare-services/dutch-dental-care-104612/
[154] Cancer Society NZ. (2020). Oral health services for cancer patients. https://healthcodesign.org.nz/assets/Documents/OIA/2020/09-September/oral-health-services-for-cancer-patients.pdf
[155] NHS UK. (2022). Dental treatments. https://www.nhs.uk/live-well/healthy-teeth-and-gums/dental-treatments/
[156] Implant Center UK. (n.d.). Denture, Prosthesis. https://implantcenter-dentistry.co.uk/our-services/prosthetic-dentistry/denture-prosthesis/

04

Equity of access to prostheses for people living with or post a cancer diagnosis

4 Equity of access to prostheses for people living with or post a cancer diagnosis

This section outlines findings related to the following review questions.

- **KRQ 4:** What are the current barriers faced by people living with or who have lived experience of cancer in accessing prostheses?
- **KRQ 5:** Are there particular prosthesis types that are more difficult than others to access? Are there particular prosthesis types that are not covered by any existing support schemes?
- **KRQ 6:** Is there a gap in equity and access to prosthetics for individuals living with or post a cancer diagnosis?

The findings in this section are presented as follows:

- Section 4.1: Barriers to accessing prostheses services
- Section 4.2: Equity issues.

A summary of the key findings outlined within this section is provided below.

Summary of findings

A range of barriers were identified for people living with or who have lived experience of cancer in accessing prostheses services. These included:

- **System navigation and access issues,** including unclear care pathways and system complexity, a lack of awareness of existing services and schemes and issues relating to eligibility criteria for existing schemes
- **Availability of prostheses services,** including a lack of services, particularly in regional, rural and remote areas, long wait times to access services and limited availability of culturally safe and accessible prostheses services for Aboriginal and Torres Strait Islander and CALD communities.
- **Workforce issues,** including a shortage of skilled prosthetic providers, particularly for facial prostheses, no clear or formal education and qualification pathways for providers of facial prostheses and a lack of regulation and accreditation standards for providers of facial prostheses.
- **Cost and funding models,** including out-of-pocket costs for prostheses not covered by existing schemes, upfront payments required under existing reimbursement models and travel costs for patients who cannot access prostheses services where they live.

In considering these barriers, issues related to equitable access to prostheses were identified, as follows:

- **Differences in equitable access between different types of prostheses,** including inconsistent availability of national programs and schemes, and inconsistent funding models used by existing national programs and schemes.
- **Differences in equitable access within the same type of prosthesis,** including variability in availability of facial prostheses services between jurisdictions, variability in prostheses available under the NDIS and jurisdictional limb schemes and variability between jurisdictional limb schemes, including funding per person, treatment approaches, prosthetic componentry and consumables provided.
- **Additional access issues experienced by priority population groups,** including limited services available in rural and remote areas, significant financial barriers for people in lower socioeconomic groups and additional financial burden for young people requiring facial prostheses as a result of the need for more frequent replacement prostheses as they grow.

4.1 Barriers to accessing prostheses for people living with or who have lived experience of cancer

In the survey distributed to people living with or with lived experience of cancer and their carers, almost two-thirds of respondents indicated that they had experienced barriers to accessing prostheses (37 out of 61 respondents or 61 per cent).

61% of survey respondents reported that they had experienced barriers to accessing prostheses

- KPMG survey of people living with or with lived experience of cancer and their carers

This section details the barriers identified for people living with or who have lived experience of cancer in accessing prostheses services, with supporting stakeholder quotes provided where relevant to illustrate the impact of these barriers. As outlined in Table 19 below, barriers have been themed into four categories:

- System navigation and access issues
- Availability of prostheses services
- Workforce issues
- Cost and funding models.

Barriers to accessing prostheses services were identified through a variety of sources, including desktop research and mapping of available schemes and programs for prostheses, consultations with stakeholders, including clinicians involved in prostheses service delivery and people living with or who have lived experience of cancer, and stakeholder survey responses.

Table 19: Summary of barriers to accessing prostheses for people living with or who have lived experience of cancer

Theme	Barriers to accessing prostheses services
System navigation and access issues	• Unclear care pathways and system complexity • Lack of awareness of existing services and schemes, including from both clinicians and people with lived experience • Eligibility criteria for existing schemes (e.g., NDIS).
Availability of prostheses services	• A lack of prostheses services, particularly in regional, rural and remote areas • Long wait times for existing prostheses services, including both publicly funded and private services • Limited culturally safe and accessible prostheses services for Aboriginal and Torres Strait Islander and CALD communities.
Workforce issues	• Shortage of skilled prosthetic providers, particularly for facial prostheses • Lack of clear or formal education and qualification pathways for providers of facial prostheses • Lack of regulation and accreditation standards, particularly for providers of facial prostheses.
Cost and funding models	• Out-of-pocket costs for prostheses not covered by existing schemes • Upfront payments required under existing reimbursement models • Travel costs for patients who cannot access prostheses services where they live.

Source: KPMG (2025)

4.1.1 System navigation and access issues

Several issues related to health system navigation and the ability to access existing prostheses services, schemes and programs were identified for people living with or who have lived experience of cancer. These issues included:

- Unclear care pathways and system complexity
- A lack of awareness of existing services and schemes
- Strict eligibility criteria for existing schemes.

Unclear care pathways and system complexity

As described in Section 2, the prosthesis service landscape is complex, with a range of different programs and schemes operating at both national and jurisdictional levels and fragmented services that can vary significantly both between and within states and territories. Both people with lived experience and clinicians described the care pathways for accessing prostheses as unclear and the system as complex, which can lead to confusion and delays in accessing necessary prosthetic devices.

Individuals with lived or living experience of cancer, clinicians and peak body representatives consistently described the significant mental burden associated with trying to understand, navigate and then access prostheses services and programs. It was highlighted that individuals and their carers are often already experiencing significant stress during this period of their lives, dealing with the shock of their diagnosis, the physical and emotional stress related to their other cancer treatments, as well as the distress caused by having a body part removed.

In addition to this stress, many individuals with living or lived experience of cancer described the process of trying to understand and access prostheses services as highly confusing and difficult to navigate. It was highlighted that there is often a lack of information available about referral pathways and eligibility criteria for programs and funding schemes, which can lead to confusion for people about their next steps following hospital discharge. It was reported that this often results in significant delays for people in accessing prostheses and, in some cases, means that people may miss out on support entirely.

This challenge was particularly notable for individuals requiring facial prostheses, where the pathway to accessing a prosthesis is seen as less clear than for other types of prostheses. It was reported that anaplastologists, ocularists, and prosthodontists are not typically involved in the multidisciplinary treatment team before surgery and that facial prostheses are often not discussed or planned for at the time of surgery. As a result, it was reported that people often face uncertainty about what to expect following their surgery and the rehabilitation process, including the role and availability of prostheses services.

" Sometimes patients don’t have the conversation with their clinical team about what happens next. The priority for them is to save this patient’s life, and not so much what support is offered to the patient afterwards. Like [a named person with lived experience] said, ‘I didn’t think about what would happen after the surgery,’ and she was shocked that there was no one providing support. "

- Representative from a peak body group

Lack of awareness of existing services and schemes

Similarly, it was reported that poor awareness of existing prostheses services and schemes is a major challenge. Many people with living or lived experience of cancer reported that they were unaware of existing services and funding schemes, or found out about them too late, which compounded their stress and financial burden. Some reported feeling abandoned after cancer treatment, as there was little guidance on next steps for prosthetic care. Furthermore, it was also noted that many clinicians lack up-to-date knowledge about available supports and where to refer their patients for prosthetic services.

In the survey distributed to people living with or with lived experience of cancer and their carers, respondents were asked to indicate their level of agreement with several statements on a scale of strongly disagree, somewhat disagree, neither agree nor disagree, somewhat agree and strongly agree. Less than half of all respondents (27 out of 61 respondents or 45 per cent) indicated that they strongly or somewhat agreed that clear information was provided regarding prostheses options, funding available and the process for obtaining a prosthesis.

55% of survey respondents did not agree that clear information was provided to them regarding prostheses options, funding available and the process for obtaining a prosthesis

- KPMG survey of people living with or with lived experience of cancer and their carers

It was reported that this challenge is especially pronounced for some priority population groups, including older adults, Aboriginal and Torres Strait Islander communities, and those from CALD backgrounds. For example, it was noted that there is poor awareness of the EBPRP within some CALD communities and that more targeted and specific communication strategies are required to ensure information is disseminated effectively.

Eligibility criteria for existing schemes

As described in Section 2, the eligibility criteria for existing prostheses programs and schemes vary and can lead to barriers in accessing some prostheses. For example, in addition to meeting a range of other eligibility criteria, for a person to receive funding under the NDIS for a prosthesis, the prosthesis must be "externally applied to replace, wholly or in part, an absent or deficient body segment which assists participant control and functioning of their neuromuscular skeletal systems."[157] The exclusion of prostheses not related to the control and functioning of the neuromuscular skeletal system means that many people have had their applications for facial and oral prostheses rejected by NDIS.

Similarly, people with living or lived experience of cancer reported having their applications rejected by private health insurers for facial and oral prostheses on the basis that they are "cosmetic" rather than functional. The Australian Government's Prescribed List lists the medical devices and human tissue products that private health insurers must cover for patients with appropriate insurance policies. External prostheses and prostheses deemed "cosmetic" rather than functional are not included on the Prescribed List, meaning private health insurers are not obligated to pay benefits for these prostheses.

Stakeholders expressed considerable frustration and distress that both the NDIS and private health insurers exclude facial and oral prostheses by classifying them as "cosmetic", despite their essential role in rehabilitation and quality of life for cancer survivors. Stakeholders consistently advocated for these prostheses to be recognised as medically necessary and for funding models to reflect their importance. The impact of this classification and the subsequent lack of funding means that many people have limited options for accessing prostheses that are financially viable. As a result, many are left without an option for accessing a prosthesis, which can significantly affect their quality of life, recovery, and ability to return to society.

"My Private Health says my prosthetic [nose] is considered 'cosmetic' and is not funded. The NDIS needs to fund all facial prosthetics. Mine allows me to function in society positively, as in I am able to work to provide for my family, and to socialise in a public place."

- Person with lived experience of cancer

"I don't consider my prosthetic ear to be 'cosmetic', it gave me the ability to go out in public and not be pointed at or spoken about behind cupped hands, it made me feel whole again."

- Person with lived experience of cancer

"A prosthetic eye doesn't make a child see again, so it doesn't matter according to the NDIS, but it does make them look like everyone else! Families are saying 'I don't need funding for occupational therapy… I just need an eye so that my child can go to the playground without being called a monster'"

- Clinician

[157] National Disability Insurance Scheme. (2024). *What does NDIS fund?* https://ourguidelines.ndis.gov.au/would-we-fund-it/what-does-ndis-fund

4.1.2 Availability of prostheses services

Several issues related to the availability of prostheses services were identified for people living with or who have lived experience of cancer. These issues included:

- A lack of prostheses services, particularly in regional, rural and remote areas
- Long wait times for existing prostheses services, including both publicly funded and private services
- Limited culturally safe and accessible prostheses services for Aboriginal and Torres Strait Islander and CALD communities.

Lack of prostheses services

As outlined in Section 2, the availability of prostheses services varies significantly across Australia and by prosthesis type. During consultation, stakeholders described prostheses services as being highly fragmented, with services typically centralised in metropolitan areas and limited or non-existent in regional, rural, and remote areas.

As described in Section 2, external breast prostheses retailers are widely available in most metropolitan and some regional areas; however, people living in rural and remote areas are typically reliant on online retailers or are required to travel to access an in-person fitting. Similarly, prosthetic limb service providers are widely available in metropolitan and some regional areas. People living in rural and remote areas are often required to travel to access limb services, however, some mobile clinics are available.

The availability of facial prostheses services differs significantly across states and territories. In some jurisdictions, some publicly funded facial prostheses services are available, while in others, either only private services are available or there are no services available at all, presenting significant barriers to access for people residing in these jurisdictions.

> "In South Australia, we don't offer any facial prosthetic services whatsoever. Unless someone was prepared to travel to interstate to have a prosthetic made, it's just not available."
>
> **- Clinician**

> "I live near Tamworth and every fortnight for some time I had to drive to Sydney to get my prosthesis modified which was a seventeen-hour day. It was exhausting – I can barely get through the day without a sit down or a nap as it is.
>
> **- Person with lived experience of cancer**

In the survey distributed to clinicians involved in prostheses service delivery, respondents were asked to identify the most significant barriers to accessing prostheses services for people living with or who have a lived experience of cancer. The majority of respondents (49 out of 57 respondents or 86 per cent) indicated that the availability of prostheses services was a significant barrier to access.

> 86% of survey respondents identified limited availability of prostheses services and / or skilled professions as a significant barrier for people living with or who have a lived experience of cancer to access prostheses
>
> **- KPMG survey of clinicians involved in prostheses service delivery**

In jurisdictions where publicly funded facial prostheses services are available, the service is often hospital-dependent and reliant on the initiative of an individual clinician or local health service to advocate for and secure funding for the service on a case-by-case basis. These services are therefore highly vulnerable to changes in hospital budgets and service priorities. There is also significant key-person risk if the individual clinicians who have secured funding for and established a service retire or relocate. This results in uncertainty for both clinicians and people with living or lived experience of cancer regarding the ongoing sustainability of the service.

" [prostheses services] are often just what passionate clinicians have cobbled together. This makes it highly individual to the clinician. That's not equitable or sustainable."

- Peak body representative

" I was a patient of the Sydney Dental Hospital for over 30 years, where I would have a new pair of prosthetic ears created every 2 years… They no longer provide this service and my only option is to pay almost $10,000 for a new pair of ears to be made."

- Person with lived experience of cancer

Long wait times for existing prostheses services

Many stakeholders reported experiencing significant delays in accessing prostheses, with wait times varying by the type of prosthesis and location. For some individuals requiring prostheses, the length of the process and the lack of clarity about wait times led to significant psychological distress and reduced overall engagement with the health system.

For people requiring facial prostheses, significant wait times were reported due to the ability of existing services to meet demand, with some people self-excluding from seeking a prosthesis due to the wait time required. It was reported that an initial appointment with a facial prosthetist or anaplastologist can take between six and nine months to secure in Victoria and New South Wales. In Queensland, it was reported that for those requiring an artificial eye, it can take up to 12 months to secure an appointment with an ocularist, with about 200 people on the wait list at any given time. Stakeholders highlighted that people living in regional and rural areas can face additional delays due to the additional time required to make travel arrangements.

"I lost my eye, nose, left maxillary bone along with teeth – 3 years 11 months and 22 days it took me to get a prosthetic. It may not be perfect, but it gives me back a bit of self-respect and dignity."

- Person with lived experience of cancer

Limb prosthesis users reported that NDIS approval processes can be lengthy, creating periods of discomfort or reduced function while waiting. The need for extensive documentation, functional assessments and multiple specialist appointments can reportedly add months to the process, with unclear eligibility criteria and guidelines regarding documentation requirements all contributing to delays and uncertainty for people. Several stakeholders reported that there can often be significant delays between receiving a temporary (interim) limb prosthesis and a permanent (definitive) limb. It was reported that interim prostheses, which are designed to be used for up to two months, are sometimes used for up to twelve months due to funding or approval delays.

Additionally, there can also be significant delays experienced in receiving replacement prostheses or componentry, such as with socket refits or upgrades, due to NDIS administrative and approval wait times. One individual reported that approval for a new prosthetic limb socket through the NDIS approximately six months, during which time they experienced significant pain and pressure sores.

In contrast to the delays experienced in accessing facial and limb prostheses, people requiring an external breast prosthesis are less likely to be affected by long wait times. A breast cancer nurse noted that those who are able to afford the $400 price tag upfront are typically able to receive a prosthesis immediately.

In the survey distributed to people living with or with lived experience of cancer and their carers, approximately half of all respondents (32 out of 61 respondents or 52 per cent) strongly or somewhat agreed that there was a long wait time to receive access to a prosthesis. There were some differences noted in the survey responses to this question by prosthesis type and location. For example, the 70 per cent of respondents requiring a facial prosthesis who strongly or somewhat agreed that there was a long wait time, while 75 per cent of respondents from South Australia strongly or somewhat agreed that there was a long wait time, compared to 56 per cent in New South Wales, 50 per cent in Queensland and 33 per cent in Victoria.

70% of survey respondents requiring a facial prosthesis agreed that there was a long wait time to receive access to a prosthesis

- KPMG survey of people living with or with lived experience of cancer and their carers

Limited culturally safe and accessible prostheses services

Stakeholders highlighted that in addition to a lack of prostheses services in general, there are limitations in the cultural safety and accessibility of prostheses services for some communities.

It is well established that Aboriginal and Torres Strait Islander people face significant barriers in accessing health services. These challenges were reported to be even more pronounced when considering cancer care and prostheses services, which rely on a limited and specialised workforce with limited services available outside of metropolitan areas. It was identified that a limited Aboriginal and Torres Strait Islander workforce in cancer care and prostheses decreases the likelihood of uptake of services. There are also specific considerations in cancer prostheses care that may impact access, such as breast prostheses being seen as “women’s business” only and an overall stigma around using prostheses.

It was also highlighted that some prostheses, for example, external breast prostheses, may not be readily available in a range of shades to suit different skin tones. This can be a significant barrier to access and may contribute to stigma around using prostheses.

Stakeholders described that enablers for these individuals to seek care could include having outreach services available on country, consideration of the role of Aboriginal and Torres Strait Islander Health Practitioners and Workers in the delivery of prostheses services, and access to social and emotional wellbeing supports for both the individual and their communities to reduce stigma around prostheses.

For CALD communities, a lack of awareness around available prostheses services and schemes is a significant barrier to access, as described previously. It was highlighted that the availability of translation services and information only being available in English were additional barriers to access for these communities.

4.1.3 Workforce issues

There were several challenges identified through this review related to the prostheses workforce that reportedly contribute to barriers to access for people living with or who have lived experience of cancer. These issues included:

- Shortage of skilled facial prosthesis providers
- Lack of clear or formal education and qualification pathways for providers of facial prostheses
- Lack of regulation and accreditation standards, particularly for providers of facial prostheses.

Shortage of skilled facial prosthesis providers

While an individual requiring a cancer prosthesis may be under the care of a multidisciplinary team (e.g., oncologists, surgeons, speech pathologists, physiotherapists etc.), this section mainly considers the workforce involved in prescribing, manufacturing, fitting and maintaining prostheses. This includes maxillofacial prosthetists, anaplastologists and ocularists.

Stakeholder sentiment revealed a shortage of skilled prosthetic providers across Australia, particularly those involved in the prescription and manufacture of facial prostheses. One clinician estimated that there are only twenty to thirty professionals (for all prostheses) across Australia, and that there are no facial prostheses professionals in some jurisdictions, including the ACT, South Australia and Tasmania. Another stakeholder described themselves as being the only facial prostheses professional servicing WA and some parts of the NT. At the same time, another noted they are the only anaplastologist currently working in New South Wales.

There is no official national registry or published workforce data specifying the exact number of facial prostheses providers currently practising in Australia. With such a small number of skilled professionals, the workforce has limited capacity to meet the existing demand for facial prostheses, even though the number of people requiring facial prostheses is relatively small when considered as a proportion of the entire Australian population.

"It's a rare job and there's not a lot of them around. There's a need and demand for that career path and there's only like twenty or thirty in Australia."

- Clinician

Lack of formal education and qualification pathways for facial prosthesis providers

There are no formal education or training pathways for facial prostheses providers in Australia. Instead, most Australian maxillofacial prosthetists, anaplastologists and ocularists have sought profession-specific postgraduate qualifications overseas, as there are no dedicated local training programs. For example, one anaplastologist described completing an international course at a cost of $90,000, adding that those interested in entering the profession face significant barriers due to the high costs of training and travel requirements.

It was also reported that the facial prostheses workforce faces challenges in gaining professional experience and advancing their skills due to limited opportunities for traineeships or apprenticeships with existing providers. This results in slower professional development and extended timeframes for building their skills compared to other fields. These factors can pose significant barriers to new entrants to the workforce, perpetuating the small number of qualified professionals.

Stakeholders highlighted that the currently ageing workforce further threatens the sustainability of the facial prostheses workforce, and that without adequate strategies and succession planning, this specialisation may soon face gaps in expertise and service continuity.

"There are limited professional development opportunities in Australia, with no formal education or training, a limited recruitment pool AND limited jobs available."

- Clinician

Lack of regulation and accreditation standards for facial prosthesis providers

Along with the absence of formal training or qualification pathways in Australia for providers specialising in facial prostheses, there is also no established national registration or accreditation scheme in place for this profession. While all health professionals must comply with the National Code of Conduct for Health Care Workers[158] stakeholders called for better regulation and oversight of facial prostheses providers to ensure that all practitioners meet minimum competency standards.

Multiple stakeholders stressed the importance of establishing a national body or regulatory agency for these professions to ensure high standards of care. This was highlighted as being particularly important when considering the potential implementation of a national program or scheme as the consequences of substandard facial prosthetic care can be significant. These consequences may include:

- Physical harm: For example, a poorly made prosthetic eye can damage the surrounding structures, such as the eyelid, which may lead to further complications such as infection and / or the need for surgical intervention.
- Psychosocial harm: Poorly made facial prostheses may lead to significant mental and emotional distress and can further contribute to the psychosocial impacts experienced by people who have undergone facial resection or amputation as a result of cancer.
- Financial impacts: The out of pocket costs of accessing facial prostheses through private providers were reported by stakeholders to range from $2,500 to $10,000 depending on the type of prosthesis required. With such a significant investment required, there can be considerable financial impacts for people if they subsequently receive a poorly made and / or unusable prosthesis."

[158]The National Code of Conduct for Health Care Workers sets the minimum standards of conduct and practice expected of health care workers. Complaints and breaches of the code of conduct are assessed by jurisdictional health complaints entities and adverse outcomes recorded against health professionals may result in conditions placed on their practice or prohibition of further practice.

4.1.4 Cost and funding models

As described in Section 2, the availability of public funding for prostheses varies. As a result, a number of challenges related to cost and funding models for prostheses were identified, including:

- Out-of-pocket costs for prostheses not covered by existing schemes.
- Upfront payments required under existing reimbursement models.
- Travel costs for patients who cannot access prostheses services where they live.

Out-of-pocket costs

As described in Section 2, funding schemes for prostheses vary considerably. Excluding external breast prostheses and limbs, for which national funding schemes are available, people who require other types of prostheses often face significant out-of-pocket expenses.

As outlined previously, the NDIS criteria stating that prostheses must be related to the control and functioning of the neuromuscular skeletal system means that many people with lived experience of head and neck cancer have had their applications for facial and oral prostheses rejected by NDIS. External prostheses are not listed on the Prescribed List; therefore, private health insurers are not required to pay benefits to their customers for these prostheses.

While some states and territories provide some publicly funded facial prostheses services, in others, either no services are available or only privately funded services are available. Additionally, while the surgical procedures performed prior to the fitting of external prostheses, such as limb amputations, mastectomies or facial resections, may attract rebates under the Medical Benefits Scheme (MBS)[159], the MBS does not provide rebates for the costs of products such as prostheses. This means that for many people who require facial or oral prostheses, significant out-of-pocket costs are involved.

> "The prosthesis is expensive and I will have to change it regularly so it is a big financial problem for me. I have to cut back on food, medicine and entertainment to save up for the prosthesis. I can't see my family and friends as much as I used to."
>
> **- Person with lived experience of cancer**

There is limited public information available about the cost of facial prostheses. Stakeholders reported that facial prostheses typically cost approximately $5,000 on average, with a range of $2,500 for an eye prosthesis to $10,000 for a more complex hemi-facial prosthesis. This estimated cost does not include the cost of consultations or maintenance services, which were estimated to cost $200 and $70, respectively.

In the survey distributed to clinicians involved in prostheses service delivery, the majority of respondents (50 out of 57 respondents, or 88 per cent) identified cost and / or access to funding as a significant barrier to accessing prostheses services for people living with or who have a lived experience of cancer.

> 88% of survey respondents identified cost and / or access to funding as a significant barrier for people living with or who have a lived experience of cancer to access prostheses
>
> **- KPMG survey of clinicians involved in prostheses service delivery**

[159] The Medicare Benefits Schedule (MBS) provides Medicare benefits (rebates) for privately provided health services. There are items listed on the MBS that provide a rebate for surgery, including reconstructive surgery, that may be undertaken prior to the fitting of external prosthesis. However the MBS does not cover the costs of products or goods such as prostheses.

In the survey distributed to people living with or with lived experience of cancer and their carers, approximately two-thirds of all respondents (40 out of 61 respondents or 66 per cent) strongly or somewhat agreed that the cost of their prosthesis impacted their decision-making or ability to obtain a prosthesis. The proportion of respondents who required a facial prosthesis who agreed with this statement was even higher at 74 per cent (29 out of 39 respondents).

74% of survey respondents who required a facial prosthesis agreed that the cost of their prosthesis impacted their decision making or ability to obtain a prosthesis

- KPMG survey of people living with or with lived experience of cancer and their carers

Stakeholders consistently highlighted the psychological distress experienced by many people who require a facial prosthesis and cannot access one due to the out-of-pocket costs involved. It was emphasised that the impact of this is far-reaching, with many people retreating from society, employment and even simple activities such as going to the grocery store due to their facial disfigurement. Many stakeholders spoke of the serious mental health impacts experienced as a result of this as well as the life changing impact access to a facial prosthesis can have.

“I did three years without a nose just a big hole in the middle of my face. The emotional and mental challenges I faced every day just to appear in public were almost overwhelming. People were shocked and horrified when they saw me. Self-esteem completely disappears. I quickly found there is no place in society for someone that looks like me. I became reclusive and contemplated suicide several times."

- Person with lived experience of cancer

“One of the universal experiences of people living with head and neck cancer is the shocking visual deformity that often occurs. This makes people unwilling to go out or even meet with family and close friends due to this shocking deformity. A prostheses can really help people live a more normal life by looking and feeling less disfigured."

- Person with lived experience of cancer

"Prosthetics for ears, noses and eyes, just simply needs to be a free service… It’s important for our mental health, for us to function every day, to go to work, to have people not stare at you when in public, to not feel embarrassed, or inferior because of missing body parts.”

- Person with lived experience of cancer

Clinicians also expressed their helplessness at not being able to support their patients in obtaining a facial prosthesis due to the out-of-pocket costs involved. Several clinicians consulted as part of this review highlighted their distress at having saved a person’s life by removing their cancer, only to leave them with profound facial disfigurement that has far-reaching impacts on their quality of life. Clinicians practising in jurisdictions with no publicly funded facial prostheses services available described that their only option is to refer their patients to private providers or interstate services, which are often inaccessible due to the out-of-pocket costs involved.

" We, by design, allow people to fall through cracks, allow them to enter seclusion and reclusion, because we don’t have the capacity to help them besides removing their cancer."

- Clinician

The ongoing out-of-pocket costs of accessing replacement prostheses were also highlighted by stakeholders, who reported that facial prostheses typically need to be replaced every two to three years. For people living in jurisdictions with no publicly funded services, this is a significant, ongoing financial burden. People with lived experience of cancer also emphasised that consumables associated with their prosthesis, such as adhesive, glues and cleaning products, also add additional costs.

"Ongoing costs need to be considered as my prosthesis needs replacing every two years or before. The ongoing costs of adhesive and cleaners and cost of ongoing appointments could be a restricting factor for some people."

- Person with lived experience of cancer

Upfront payments

While individuals are able to access external breast prostheses under the EBPRP, as outlined in Section 2, this program operates under a reimbursement model which requires them to make an upfront payment of $400 per prosthesis. Multiple stakeholders highlighted that the reimbursement model creates a significant barrier to access for some people, especially those on low incomes, Aboriginal and Torres Strait Islander people, and those who live in rural or regional areas.

Additionally, while reimbursement will be provided under the scheme, the process typically takes approximately two weeks, which can lead to financial stress and, in some cases, result in people delaying or deciding not to proceed with accessing a prosthesis at all. The inability to afford the upfront payment for a prosthesis can result in people using old, damaged, or prostheses not intended for long-term use, such as knitted prostheses, which can lead to other health issues.

Stakeholders consistently highlighted that the requirement for upfront payment disproportionately affects vulnerable groups, including those with lower socioeconomic status and Aboriginal and Torres Strait Islander women, who may not have access to resources to cover the initial cost. It was suggested by clinicians and people with lived experience of cancer that a fully funded model or access to an immediate rebate at the point of purchase should be considered to remove this barrier to access.

"The breast prosthesis rebate should be able to be claimed immediately at point of purchase. This would potentially help women who do not have cash up front to purchase and wait for rebate to be processed."

- Person with lived experience of cancer

“Putting the money upfront is a particular barrier for a lot of patients I see. One woman removed her bra and her prosthesis fell out. It was all covered in Band-Aids because she couldn't afford to get a new one."

- Clinician

Travel costs

Stakeholders also identified travel as a significant financial and logistical barrier to accessing prostheses, particularly for those living in regional, rural and remote areas. Many people with lived experience of cancer reported paying hundreds of dollars per trip, with some needing to travel hundreds of kilometres multiple times for prosthesis fittings and reviews.

While some jurisdictions offer partial reimbursement for travel costs related to medical care, these schemes often do not cover the full travel costs, leaving patients out of pocket. Additionally, some prosthesis types (e.g., oral prostheses) are excluded from travel schemes. Stakeholders also reported that there is a lack of awareness and promotion of travel schemes, with many only hearing about them through word of mouth. The cost involved in needing to travel long distances was reported to discourage some people from pursuing prosthetic care altogether, leading to self-exclusion and unmet health needs, especially among lower socioeconomic groups and priority populations such as those living in rural and remote areas and Aboriginal and Torres Strait Islander communities. Additionally, travel requirements were reported to add to the psychological burden of cancer recovery, with some patients describing the process as exhausting and demoralising.

4.2 Equity issues

In considering the barriers discussed in the previous section, several issues related to equitable access to prostheses have been identified. As outlined below, these issues have been grouped into three categories:

- Differences in equitable access between different types of prostheses
- Differences in equitable access within the same type of prosthesis
- Additional access issues experienced by priority population groups.

The equity issues were identified through a variety of sources, including desktop research and mapping of available schemes and programs for prostheses, consultation with stakeholders, such as clinicians involved in prostheses services and individuals living with or who have experienced cancer, and stakeholder survey responses.

The equity issues for people living with or who have lived experience of cancer in accessing prostheses include:

1. Differences in equitable access between different types of prostheses

1A. Inconsistent availability of national programs and schemes: There is no national program or scheme currently in place for facial prostheses, unlike limbs (NDIS) and external breast prostheses (EBPRP).

1B. Inconsistent funding models used by existing national programs and schemes: The EBPRP requires an upfront payment to access breast prostheses, while there is no upfront payment required to access a prosthetic limb under the NDIS.

2. Differences in equitable access for the same type of prostheses

2A. Variability in availability of facial prostheses services between jurisdictions: Some jurisdictions provide publicly funded facial prostheses services, while in others, either only private services or no services are available.

2B. Variability in prostheses available under the NDIS and jurisdictional limb schemes: People under 65 years can access high-grade limbs through the NDIS, while people over 65 years are reliant on jurisdictional limb schemes, which typically offer basic limbs and componentry only

3. Additional access issues experienced by priority population groups

3A. Limited services available in rural and remote areas: Most prostheses services are only available in metropolitan areas, with limited and inconsistent availability of mobile or outreach prostheses services.

3B. Significant financial barriers for people in lower socioeconomic groups: There are significant financial barriers for individuals who require facial prostheses who live in jurisdictions where there are no publicly funded services available. Additionally, the reimbursement model of the EBPRP presents a barrier to access for people in lower socioeconomic groups due to the upfront payment required.

3C. Additional financial burden for young people requiring facial prostheses: The need for more frequent replacement prostheses to accommodate anatomical changes due to growth and ageing, placing an additional financial burden on young people who require facial prostheses and live in jurisdictions with no publicly funded services available.

Appendix G provides additional details on each equity issue and includes case studies to illustrate the issue further. The case studies were developed based on the experiences and insights shared by stakeholders during consultation; however, they are not based on specific individuals.

05

Options and considerations for a potential national cancer prostheses program

5 Options and considerations for a potential national cancer prostheses program

This section outlines findings related to the following sub-questions under KRQs 4, 6 and 7.

- Could current equity gaps be addressed by a national Cancer Prostheses Program? If so, how?
- Could current barriers be addressed by a national Cancer Prostheses Program? If so, how? If not, why not?
- What would be the key enablers for successful implementation of a national Cancer Prostheses Program?
- What eligibility criteria should be considered for the program to ensure existing gaps are addressed?

The findings in this section are presented in the following order:

- 5.1: Options for a potential national cancer prostheses program
- 5.2: Considerations for the implementation of a potential national cancer prostheses program

A summary of the key findings outlined within this section is provided below.

Summary of findings

Based on the review findings, three options have been identified for a potential new national cancer prostheses program aimed at addressing the identified equity issues:

- **Option 1:** Establish a national program that provides funding for facial prostheses that are required as a result of cancer or cancer treatment.
- **Option 2:** Establish a national program that, in addition to the funding provided under option 1, also provides funding to ensure individuals requiring an external breast prosthesis as a result of cancer or cancer treatment are not required to make an upfront payment.
- **Option 3:** Establish a national program that, in addition to the funding provided under option 2, also provides funding to ensure that individuals aged 65 years and older who require a limb prosthesis as a result of cancer or cancer treatment can access a prosthesis that meets their needs.

Alongside these options, a number of implementation considerations were identified to support the delivery of a potential national cancer prostheses program:

- **Delivery and funding model:** The program could be delivered via centralised national administration, state and territory-based coordination, or through contracted third-party providers. Potential funding models could include direct provider payments, block-funding, and reimbursement models.
- **Workforce supply and regulation:** Professionals such as anaplastologists and ocularists are in limited supply and are currently unregulated. Mechanisms to ensure that safe and high-quality services are provided under a potential new program will require consideration.
- **Care pathways, education and awareness**: Clearly defining and communicating the care pathway for accessing cancer prostheses under a new program would be critical to ensure that clinicians and people requiring prostheses to understand when, how and where they can access prostheses services.
- **Cultural safety and inclusion**: Consideration should be given to how a new national program could be designed to ensure culturally safe and accessible care is provided for Aboriginal and Torres Strait Islander people, CALD communities, and other priority groups.
- **Rural and remote access:** As part of a potential new program, strategies could be considered to improve access to prostheses services in rural and remote locations. This may include travel support schemes, outreach or mobile clinics, and the use of telehealth or virtual care models.
- **Data collection and evaluation:** The establishment of a monitoring and evaluation framework, as well as mechanisms to collect robust data on prosthesis needs, access, outcomes, and costs, would be important to enable ongoing accountability and continuous improvement of a national program.

5.1 Options for a potential national cancer prostheses program

In considering whether a new national cancer prostheses program could address the barriers to access and equity issues outlined in Section 4, three options have been identified for consideration. These options have been developed by considering the areas of greatest need, in line with the equity issues outlined in Section , and differ by the types of prostheses that would be funded under a potential national program. The three options include:

- **Option 1:** Establish a national program that provides funding for facial prostheses that are required as a result of cancer or cancer treatment.
- **Option 2:** Establish a national program that, in addition to the funding provided under option 1, also provides funding to ensure that individuals who require an external breast prosthesis as a result of cancer or cancer treatment can access one without needing to make an upfront payment.
- **Option 3:** Establish a national program that, in addition to the funding provided under option 2, also provides funding to ensure that individuals aged 65 years and older who require a limb prosthesis as a result of cancer or cancer treatment can access a prosthesis that meets their needs. This would include funding for high-grade prostheses such as microprocessor knees, if clinically indicated.

Table 20 below illustrates the equity issues outlined in Section 4 that could be addressed through the implementation of each of the above three options for a national program. This section further details each option and how equity issues may be addressed.

Table 20: Equity issues able to be addressed by the three options for a national cancer prostheses program

Equity issue	Option 1	Option 2	Option 3
1A. Inconsistent availability of national programs / schemes	Yes	Yes	Yes
1B. Inconsistent funding models used by existing national programs / schemes	N/A	Yes	Yes
2A. Variability in availability of facial prostheses services between jurisdictions	Yes	Yes	Yes
2B. Variability in prostheses available under the NDIS and jurisdictional limb schemes	N/A	N/A	Yes
2C. Variability between jurisdictional limb schemes	N/A	N/A	Yes
3A. Limited services available in rural and remote areas	N/A	N/A	N/A
3B. Significant financial barriers for people in lower socioeconomic groups	Yes	Yes	Yes
3C. Additional financial burden for young people requiring facial prostheses	Yes	Yes	Yes

Source: KPMG (2025)

While oral prostheses were outside the scope of this review and have not been considered within the identified options for a national cancer prostheses program, stakeholders consulted as part of this review consistently raised concerns about the significant inequities experienced by individuals requiring oral prostheses due to cancer or cancer treatment. Many stakeholders advocated for oral prostheses to be considered as part of any future national prostheses program. Additionally, stakeholders suggested that the eligibility criteria for any future program should be inclusive of all people who require prostheses, not just those who require prostheses due to cancer or cancer treatment. As such, while out of scope for this review, oral prostheses and broader prosthetic needs are recognised as important considerations for future program development.

5.1.1 National cancer prostheses program option 1

Option 1 is to implement a national program that provides funding for facial prostheses required as a result of cancer or cancer treatment. This would include funding for orbital, ocular, nasal, ear, and hemi-facial prostheses. This option has been proposed to address the significant equity issue that exists for individuals who require facial prostheses, which, as described throughout this report, often means individuals are required to pay a significant out-of-pocket cost or are unable to access prostheses services altogether.

Table 21 below provides a summary of the equity issues that Option 1 would aim to address. These issues include:

- 1A: Inconsistent availability of national programs and schemes
- 2A: Variability in availability of facial prostheses services between jurisdictions
- 3B: Significant financial barriers for people in lower socioeconomic groups
- 3C: Additional financial burden for young people requiring facial prostheses.

Table 21: Summary of the equity issues aimed to be addressed through Option 1

Equity issue	If Option aims to address	Description
1A	Yes	Unlike for limb prostheses and external breast prostheses, no nationally funded program or scheme currently exists for facial prostheses. Option 1 would aim to address this gap by establishing a consistent national approach and dedicated funding for facial prostheses required as a result of cancer or cancer treatment.
1B	N/A	As Option 1 includes funding for facial prostheses only, the issues related to inconsistent funding models currently in place for existing national programs and schemes would not be addressed through this option.
2A	Yes	Access to publicly funded facial prostheses services currently varies significantly between states and territories. Option 1 would aim to support improved access to publicly funded prostheses services and promote consistency across jurisdictions.
2B	N/A	As Option 1 includes funding for facial prostheses only, the issues related to variability in the types of limb prostheses available under the NDIS and jurisdictional schemes would not be addressed through this option.
2C	N/A	Similarly, Option 1 would not address the issues related to variability in jurisdictional limb schemes.
3A	N/A	Service provision in rural and remote areas will depend on how the national program is implemented and delivered. Further details regarding considerations for implementation are outlined in Section 5.2.
3B	Yes	Without access to public funding, there are currently significant cost barriers for some individuals in accessing facial prostheses. Option 1 would aim to remove cost barriers by establishing dedicated funding for facial prostheses that are required as a result of cancer or cancer treatment..
3C	Yes	Younger people are often required to replace their facial prosthesis more frequently than adults, resulting in an additional financial burden for this cohort where publicly funded facial prostheses services are not available. Option 1 would aim to reduce these ongoing financial pressures currently experienced by some young people by establishing dedicated funding for both new and replacement facial prostheses that are required as a result of cancer or cancer treatment.

Source: KPMG (2025)

5.1.2 National cancer prostheses program option 2

Option 2 for a national cancer prostheses program builds on Option 1 by providing funding for facial prostheses required as a result of cancer or cancer treatment as well as funding to ensure that individuals who require an external breast prosthesis as a result of cancer or cancer treatment can access one without needing to make an upfront payment.

As outlined in Section 2.1, a significant barrier to accessing the current EBPRP is the reimbursement model, which requires individuals to make an upfront payment before receiving financial support. In contrast, other programs, such as the NDIS for limb prostheses, operate under a direct provider payment model, removing out-of-pocket costs and upfront payments for eligible individuals. Option 2 seeks to address this challenge by introducing a consistent national funding model across prosthesis types, thereby improving equity and accessibility for people requiring prostheses due to cancer or cancer treatment.

Table 22 below provides a summary of the equity issues that Option 2 would aim to address. These issues include:

- 1A: Inconsistent availability of national programs/schemes
- 1B. Inconsistent funding models used by existing national programs and schemes
- 2A: Variability in availability of facial prostheses services between jurisdictions
- 3B: Significant financial barriers for people in lower socioeconomic groups
- 3C: Additional financial burden for young people requiring facial prostheses.

Table 22: Summary of the equity issues aimed to be addressed through Option 2

Equity issue	If Option aims to address	Description
1A	Yes	Unlike for limb prostheses and external breast prostheses, no nationally funded program or scheme currently exists for facial prostheses. Option 2 would address that gap by establishing a consistent national approach and dedicated funding for facial prostheses required as a result of cancer or cancer treatment.
1B	Yes	The EBPRP currently operates under a reimbursement model, while other schemes through which people can access prostheses use a direct provider payment model (e.g. NDIS and DVA). Option 2 would aim to remove barriers to accessing external breast prostheses by removing the requirement for an upfront payment under the EBPRP and promote consistency in the funding of prostheses.
2A	Yes	Access to publicly funded facial prostheses services currently varies significantly between states and territories. Option 2 would aim to support improved access to publicly funded prostheses services and promote consistency across jurisdictions.
2B	N/A	As Option 2 includes funding for facial prostheses and external breast prostheses only, the issues related to variability in the types of limb prostheses available under the NDIS and jurisdictional schemes would not be addressed through this option.
2C	N/A	Similarly, Option 2 would not address the issues related to variability in jurisdictional limb schemes.
3A	N/A	Service provision in rural and remote areas will depend on how the national program is implemented and delivered. Further details regarding considerations for implementation are outlined in Section 5.2.
3B	Yes	Without access to public funding, there are currently significant cost barriers for some individuals in accessing facial prostheses. Option 2 would aim to remove cost barriers by establishing dedicated funding for facial prostheses as well as removing the upfront payment barrier for breast prostheses.
3C	Yes	Younger people are often required to replace their facial prosthesis more frequently than adults, resulting in an additional financial burden for this cohort where publicly funded facial prostheses services are not available. Option 2 would aim to reduce these ongoing financial pressures currently experienced by some young people by establishing dedicated funding for both new and replacement facial prostheses that are required as a result of cancer or cancer treatment.

Source: KPMG (2025)

5.1.3 National cancer prostheses program option 3

Option 3 is to implement a national program that, in addition to the funding provided under Option 2 for facial and breast prostheses, also includes funding to ensure that individuals aged 65 years and older who require a limb prosthesis due to cancer or cancer treatment can access a prosthesis that meets their needs. This would include funding for high-grade prostheses such as microprocessor knees, if clinically indicated.

As outlined in Section 2.3, individuals aged 65 years and over currently rely on jurisdiction-based limb schemes, which vary considerably in the funding allocation, treatment approaches, and supply of prosthetic componentry and associated consumables. For example, NSW is the only state that funds high-grade limb prostheses while other states and territories typically provide lower-grade, mechanical options. Option 3 would aim to reduce jurisdictional variability in limb prostheses services as well as ensure individuals aged over 65 years can access prostheses that meet their needs, in the same way that younger individuals can through the NDIS, while maintaining the inclusion of funding for facial and breast prostheses as outlined in Option 2.

Table 23 provides a summary of the equity issues that Option 3 would aim to address. These issues include:

- 1A: Inconsistent availability of national programs/schemes
- 1B: Inconsistent funding models used by existing national programs and schemes
- 2A: Variability in availability of facial prostheses services between jurisdictions
- 2B: Variability in prostheses available under the NDIS and jurisdictional limb schemes
- 2C: Variability between jurisdictional limb schemes
- 3B: Significant financial barriers for people in lower socioeconomic groups
- 3C: Additional financial burden for young people requiring facial prostheses.

Table 23: Summary of the equity issues aimed to be addressed through Option 3

Equity issue	If Option aims to address	Description
1A	Yes	Unlike for limb prostheses and external breast prostheses, no nationally funded program or scheme currently exists for facial prostheses. Option 3 would address that gap by establishing a consistent national approach and dedicated funding for facial prostheses required as a result of cancer or cancer treatment.
1B	Yes	The EBPRP currently operates under a reimbursement model, while other schemes through which people can access prostheses use a direct provider payment model (e.g. NDIS and DVA). Option 3 would aim to remove barriers to accessing external breast prostheses by removing the requirement for an upfront payment under the EBPRP and promote consistency in the funding of prostheses.
2A	Yes	Access to publicly funded facial prostheses services currently varies significantly between states and territories. Option 3 would aim to support improved access to publicly funded prostheses services and promote consistency across jurisdictions.
2B	Yes	Access to limb prostheses currently varies significantly between jurisdictional limb schemes and the NDIS. Option 3 would aim to align limb prostheses componentry and consumables available to individuals aged over 65 years with the level of prosthetic support available to younger people under the NDIS.
2C	Yes	Access to limb prostheses also varies significantly between jurisdictional limb schemes including funding levels and prostheses options. Option 3 would aim to support improved access and consistency in service provision across jurisdictions.
3A	N/A	Service provision in rural and remote areas will depend on how the national program is implemented and delivered. Further details regarding considerations for implementation are outlined in Section 5.2.
3B	Yes	Without access to public funding, there are currently significant cost barriers for some individuals in accessing facial prostheses. Option 3 would aim to remove cost barriers by establishing dedicated funding for facial prostheses as well as removing the upfront payment barrier for breast prostheses.
3C	Yes	Younger people are often required to replace their facial prosthesis more frequently than adults, resulting in an additional financial burden for this cohort where publicly funded facial prostheses services are not available. Option 3 would aim to reduce these ongoing financial pressures currently experienced by some young people by establishing dedicated funding for both new and replacement facial prostheses that are required as a result of cancer or cancer treatment.

Source: KPMG (2025)

5.2 Considerations for the implementation of a national cancer prostheses program

A number of factors were identified through the review that would require consideration to support the implementation of a national cancer prostheses program. This includes factors that may enable or hinder the successful implementation of a potential national program, as well as the program's effectiveness in addressing the equity issues and barriers to access outlined within this report. Key considerations include:

- The program's delivery and funding model
- Workforce supply and regulation
- Care pathways, education and awareness
- Cultural safety and inclusion
- Rural and remote access
- Data collection and evaluation.

The considerations outlined within this section were identified through a variety of sources, including desktop research, consultation with stakeholders, including clinicians involved in the delivery of prostheses services and people living with or who have lived experience of cancer, and stakeholder survey responses.

5.2.1 Delivery and funding model

The delivery model and funding model chosen for a new national program would shape how prostheses services are delivered and funded. The delivery model sets out who is responsible for program administration, governance and service delivery, while the funding model defines how and to whom government funding is provided. This section outlines potential delivery and funding models for consideration.

Delivery model options for a national cancer prostheses program

In considering the implementation of a potential national cancer prostheses program, three delivery model options have been identified to manage the administration, coordination and delivery of cancer prostheses services across Australia. Each model presents distinct benefits and challenges in terms of consistency of service delivery, responsiveness to community needs and integration with existing services.

Potential delivery model options for consideration include:

- **Option A:** Centralised national administration
- **Option B:** State and territory-based coordination
- **Option C:** Third-party provider model.

The following section further details each potential delivery model, with a summary provided in Table 24 below.

Table 24: Summary of delivery model options for a national cancer prostheses program and key strengths and considerations

Delivery model	Description	Strengths	Considerations
Option A: Centralised national administration	National program managed directly by the Australian government	• National consistency • Reduced duplication • Provides single point of contact, simplifying system navigation	• May be less responsive to local needs
Option B: State and territory-based coordination	Funding implementation and management led by jurisdictional health departments	• Leverages local infrastructure • Supports tailored service delivery	• Risk of uneven implementation • Risk of variation in access
Option C: Third-party provider model	Program delivery contracted to external organisations	• Flexible, locally responsive • Potential for cultural and community-led innovation	• Risk of fragmentation • Requires strong governance and accountability

Source: KPMG (2025)

Option A: Centralised national administration

This option would involve the Australian Government directly managing and administering a national cancer prostheses program in a model similar to the NDIS or the EBPRP. The program would be governed by uniform national guidelines, with centralised eligibility assessments, funding distribution, and service coordination. Key features may include:

- Individuals across Australia would apply for prostheses through a single national portal or agency.
- All approved prostheses would be funded at consistent rates, using a nationally standardised approach.
- The national agency would contract directly with prostheses providers and be responsible for monitoring, evaluation, and data collection.

This model would aim to ensure national consistency in access and eligibility, regardless of geographic location, and provide a single point of contact for clinicians and people with lived experience, simplifying system navigation. A centralised national administration delivery model also reduces potential duplication of administrative processes across jurisdictions. However, one of the key challenges is that centralised programs may be less responsive to local needs and service delivery contexts. Regional variations in workforce, infrastructure, and cultural considerations may not be adequately addressed without strong monitoring and evaluation mechanisms.

Option B: State and territory-based coordination

Under this option, the Australian Government would provide funding to each state and territory health department, which would then manage the implementation, administration and delivery of the program within their jurisdictions, in accordance with nationally agreed standards. This approach reflects the current structure used by the jurisdictional artificial limb schemes. Key features may include:

- The Australian Government sets national access, eligibility, and performance standards.
- States and territories retain flexibility to determine service models and provider arrangements that best suit their local needs.
- Program responsibilities such as assessments, procurement, and claims processing are managed at the jurisdictional level.

A jurisdiction-based approach would allow existing regional infrastructure to be leveraged, enabling responsiveness to local needs and integration with hospital networks and health services. States and territories could tailor service models to suit the unique demographics, geography, and workforce of their areas. However, without strong national oversight, there is a risk of ongoing inequities and variability in access, service quality, and eligibility interpretation across jurisdictions. Variations in program design could result in varied outcomes for individuals, reinforcing rather than addressing some of the current equity challenges. Effective governance mechanisms would be required to ensure alignment with national goals and to maintain equity in access to cancer prostheses across Australia.

Option C: Third-party provider model

Under this model, the Australian Government could outsource the management and delivery of the program to qualified third-party providers. These could include NGOs, specialist prosthesis suppliers, comprehensive cancer centres, or community-based organisations. Key features may include:

- Third-party providers are contracted to manage claims, conduct assessments, and distribute prostheses within specific regions or for certain prosthesis types.
- Providers would be responsible for adhering to national quality and equity standards and would report outcomes to the Australian Government.

Stakeholders consulted as part of this review noted that, given the highly specialised nature of cancer prostheses and the limited size of the workforce, it may not be practical to deliver services uniformly across all locations. Instead, it was recommended to establish dedicated centres of excellence in each state and territory, supported by a travel assistance scheme to enable equitable access for individuals who need to travel for care.

A third-party provider model would enable the delivery of tailored services that reflect the specific needs of local communities and culturally diverse populations. This approach could also encourage innovative service delivery approaches and flexibility in service delivery. This approach would require robust governance and oversight to prevent fragmentation in the delivery of services across providers and locations.

Funding model options for a national cancer prostheses program

The funding model that would underpin a national cancer prostheses program is also an important consideration and defines how funding will flow between government, providers and individuals requiring prostheses due to cancer or cancer treatment. This section outlines three potential funding models for delivering a national cancer prostheses program. These include:

- **Option A:** Direct provider payments
- **Option B:** Block funding
- **Option C:** Reimbursement model.

The following section further details each potential delivery model, with a summary provided in Table 25 below.

Table 25: Summary of funding model options for a national cancer prostheses program and key strengths and considerations

Funding model	Description	Key strengths	Key considerations
Option A: Direct provider payments	Prostheses are provided to individuals at no cost, government provides reimbursement to prosthesis providers directly.	• No upfront costs to individuals • Equitable and simple access	• Requires strong oversight and robust fraud prevention
Option B: Block funding	Lump sum payments are provided to jurisdictional health departments or providers to manage prosthesis service delivery	• Funding can be used flexibly to meet local needs • No upfront costs to individuals • Supports regional tailoring	• Potential for inconsistencies in access • Funding may not meet demand • Long-term sustainability is not guaranteed
Option C: Reimbursement model	Individuals make an upfront and receive a capped reimbursement	• Lower administrative burden • Supports choice in provider	• Creates financial barriers to access • Poor suitability for high-cost prostheses

Source: KPMG (2025)

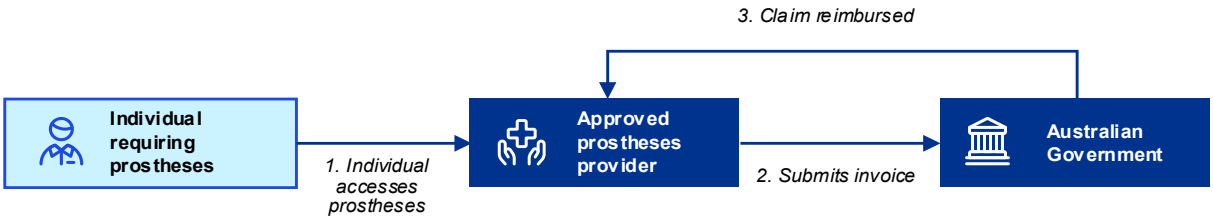
Option A: Direct provider payments

Under this model, the Australian Government would pay approved prosthesis providers directly for eligible services, similar to the funding model used by the NDIS[160]. Individuals accessing prostheses would not be required to pay upfront or manage reimbursement claims. Key features may include:

- Individuals access prostheses services provided by an approved prostheses provider, which could be a private provider or a public hospital-based service.
- Approved prostheses providers submit a payment request to the government directly for eligible prostheses
- Claims are verified and processed centrally.
- Providers are reimbursed for the prostheses provided.
- Individuals accessing services would not have any out-of-pocket costs, unless choosing a non-eligible option.

Figure 12 outlines the potential flow of funds under a direct provider payment model for a national cancer prostheses program.

Figure 12: Direct provider payment model flow of funds



Source: KPMG (2025)

This model could support equitable access to cancer prostheses by removing the requirement for individuals to pay upfront, which would particularly benefit low-income individuals. It could also simplify the user journey by removing the need for individuals to navigate billing or claims processes, with responsibility transferred to the provider.

A direct provider payment model would require robust governance, safety, and quality frameworks, as well as regulations and fraud prevention mechanisms, to prevent the misuse of funds or non-compliant providers. Stakeholders consulted as part of this review highlighted concerns about the potential emergence of providers who do not meet quality and safety standards, specifically in the facial prosthetics sector, where vulnerable individuals seeking care may be at risk of exploitation. In addition, centralised claims processing could introduce administrative complexity for the government.

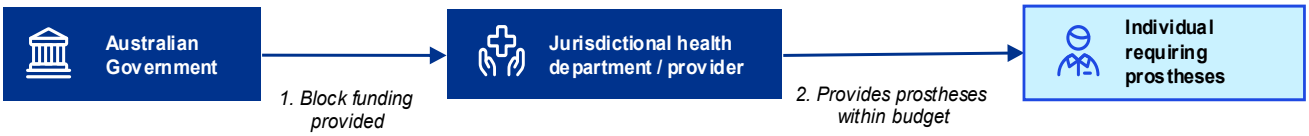
Option B: Block funding to providers or jurisdictions

Under a block funding model, the Australian Government would allocate funding to jurisdictional health departments or contracted providers, who would then manage prostheses service delivery within allocated budgets. Figure 13 below outlines the potential flow of funds under a block funding model for a national cancer prostheses program. Key features may include:

- Lump sum funding provided to providers or jurisdictional health departments based on demand.
- Providers or jurisdictional health departments manage procurement, service delivery, and budget distribution.
- Services may be embedded within existing health networks or hospitals.

[160] Currently under the NDIS, there are both registered and unregistered providers. Registered providers are individuals or organisations that have been approved by the NDIS Quality and Safeguards Commission to deliver specific NDIS supports and services. This registration process involves meeting certain quality and safety standards, undergoing audits, and demonstrating compliance with the NDIS Practice Standards and the NDIS Code of Conduct. NDIS participants who self-manage their NDIS funds have the flexibility to use both registered and unregistered providers. Unregistered providers must adhere to the NDIS Code of Conduct however have not been through the registration and audit process with the NDIS Quality and Safeguards Commission.

Figure 13: Block funding payment model flow of funds



Source: KPMG (2025)

A block-funding model could support flexibility in service delivery and local responsiveness, allowing jurisdictions and providers to tailor services to regional needs. It could also leverage existing service infrastructure and integrate with current hospital-based programs. There is a risk that funding may not meet local demand, which could result in waitlists. This approach could also lead to inconsistencies in service delivery between jurisdictions. Block funding is also often time-limited and tied to specific political commitments. As a result, it is vulnerable to changes in government priorities, budget cycles or policy shifts. Therefore, without long-term funding guarantees, the sustainability of this option cannot be guaranteed.

A hybrid model that combines both Option A and Option B could also be considered. Jurisdictional limb schemes provide an example of how this could be applied. While jurisdictional limb schemes are block-funded, the actual provision of limbs often involves direct payments to approved prosthetic service providers for the specific limbs and associated services provided to eligible individuals. Key features of this model include:

- A lump sum of funding (block funding) is allocated to the managing body of the limb scheme (e.g., EnableNSW). This funding is for the overall operation of the scheme, including administrative costs, procurement of services, and the provision of prosthetic limbs and related services to eligible residents within that jurisdiction.
- Individuals requiring a prosthesis are assessed by an approved prosthetic service provider, which could be a private provider or a public hospital-based service, and provided with a prosthesis.
- The jurisdictional limb scheme directly pays the provider for the prosthesis and associated services. These payments are generally based on a pre-determined schedule of fees.
- Individuals do not pay upfront for their prosthesis.

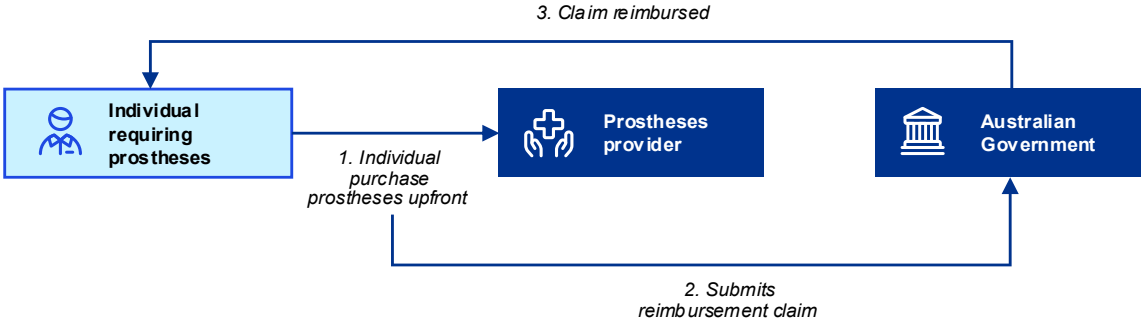
A hybrid model could support equitable access to prostheses and offer predictability in government spending. However, this model may also limit provider choice and potentially lead to long waiting lists to access services.

Option C: Reimbursement model

Similar to the current EBPRP, a reimbursement model requires individuals to pay for the cost of prostheses upfront before receiving a reimbursement up to a capped amount. Figure 14 below outlines the potential flow of funds under a reimbursement model for a national cancer prostheses program. Key features may include:

- Individuals pay for prostheses upfront and submit a receipt for reimbursement.
- The government covers a percentage or base level cap and reimburses the individual.
- Individuals who choose to purchase a higher-grade prosthesis would be required to pay the difference between the reimbursement cap and the total cost out-of-pocket.
- A central or third-party administrator processes claims.

Figure 14: Reimbursement model flow of funds



Source: KPMG (2025)

This model would be simple to administer and offers individual choice and control over their prosthesis selection and provider. However, the applicability of a reimbursement model for all prostheses types may be limited due to the costs involved and would likely lead to considerable financial barriers to access, especially among lower socioeconomic groups. As outlined previously, the current requirement for individuals to make an upfront payment under the EBPRP is a significant barrier to access for many people who require breast prostheses, with many not being able to access a prosthesis as a result. This model would likely be unsuitable for more expensive prostheses types, such as facial or limb prostheses.

5.2.2 Workforce supply and regulation

The availability and regulation of the prosthesis workforce is a key consideration for the implementation, scalability and long-term sustainability of a potential national cancer prostheses program. Timely access to safe and high-quality prostheses services depends on the capacity, geographic distribution, and regulatory oversight of the professionals delivering these services.

A key potential barrier to the successful implementation of a national program is the limited supply of specialised professionals required to deliver cancer prostheses, particularly facial prostheses. As outlined in Section 4.1.3, these prostheses are typically delivered by anaplastologists, ocularists and maxillofacial prosthetists. However, this workforce is small, highly specialised, and predominantly located in metropolitan areas. In several jurisdictions, individuals must travel interstate to access these services.

The lack of formal education or training pathways for these professions further exacerbates this challenge. Many practitioners receive qualifications overseas or through informal traineeships with existing providers. These limited entry pathways slow professional development and create disincentives for new entrants into the field. Without targeted strategies to support and grow the workforce, a national program may not improve access to cancer prostheses. The implementation of a national cancer prostheses program would require workforce planning and development, including consideration of training pathways and supervised clinical placement opportunities.

In addition to workforce supply challenges, professional regulation is another key barrier. Currently, some professions critical to the delivery of cancer prostheses, particularly anaplastologists and ocularists, are not regulated professions. This means that there are no mandatory registration requirements or competency standards in place, beyond the National Code of Conduct for Health Care Workers[161], to ensure safe and high-quality facial prosthesis care is delivered by these professionals.

Stakeholders consulted as part of this review raised concerns about the potential emergence of non-compliant or fraudulent providers, particularly if a new funding scheme were to be introduced without adequate oversight. To safeguard public funds and ensure safe and high-quality prostheses services are provided, robust governance and regulatory mechanisms would need to be embedded in the design of a national program. This could include establishing a national registration or accreditation scheme[162], setting minimum training and competency standards and requiring providers to meet defined certifications or criteria to participate in the program. The role of relevant professional bodies as well as the Australian Commission on Safety and Quality in Health Care in coordinating

[161] Department of Health, Disability and Ageing. (2025). *National Registration and Accreditation Scheme*. https://www.health.gov.au/our-work/national-registration-and-accreditation-scheme
[162] It is noted that an independent review of regulatory complexity in the National Registration and Accreditation Scheme is currently underway, with the final report anticipated to be delivered to Health Ministers in September 2025. The recommendations from this review may need to be considered with respect to establishing any new registration or accreditation schemes for providers of facial prostheses.

initiatives to ensure safe and high-quality services are provided under a potential national program would need to be considered.

5.2.3 Care pathways, education and awareness

Clearly defining and effectively communicating care pathways for accessing cancer prostheses should be considered to ensure the successful implementation of a national cancer prostheses program. A clearly defined care pathway is essential to support clinicians, individuals with lived experience, and their carers in understanding when, how, and where to access prostheses services. This clarity would help to support timely referrals, facilitate coordinated rehabilitation, and reduce uncertainty and stress during what is often an already challenging post-treatment period.

As outlined in Section 4.1.1, current access to prostheses services, programs and schemes is seen as fragmented, with variation between jurisdictions, prosthesis types and healthcare settings. This can lead to confusion among both clinicians and individuals requiring prostheses due to cancer or cancer treatment, particularly in trying to navigate different funding schemes, eligibility criteria and referral mechanisms. These challenges are reportedly further compounded when prostheses are not discussed or planned for at the time of surgery, leading to uncertainty about the availability and role of prostheses services in recovery and rehabilitation.

To address these challenges, a clearly defined care pathway would need to be considered as part of the design and implementation of a national cancer prostheses program. This could consider:

- **Eligibility criteria** for accessing each type of prosthesis
- **Referral and assessment processes**, including designated roles and responsibilities
- **Approved service providers** and locations where prostheses can be accessed
- **Timeframes and steps involved** in obtaining prostheses, including fitting, follow-up and maintenance.

As outlined in Section 4.1.1, poor awareness of existing programs, such as the EBPRP, and confusion about pathways to access were highlighted by stakeholders as key barriers to access. Therefore, the success of a potential national cancer prostheses program will likely depend not only on funding and service delivery but also on the effectiveness of communication, education, and stakeholder engagement strategies that enable individuals to navigate services confidently. Clinicians and service providers would need to be informed of their responsibilities under a new program and be equipped with educational materials to guide patients effectively through the care pathway. Likewise, individuals with lived experience of cancer and their carers would require access to accessible and culturally appropriate information regarding the program, the types of prostheses available, and how and where to access prostheses.

5.2.4 Cultural safety and inclusion

Considerations for cultural safety and inclusion would also be key to the successful implementation of a national cancer prostheses program. Without consideration of how a new program should be designed to ensure culturally safe and accessible care, there is a risk that the program may exclude priority populations such as Aboriginal and Torres Strait Islander peoples, and CALD communities. Prioritising cultural safety also aligns with the principles of equity, person-centred care, and inclusion outlined in the Australian Cancer Plan.

Stakeholders consulted as part of this review highlighted that many individuals from Aboriginal and Torres Strait Islander communities and CALD backgrounds often face additional barriers to accessing prostheses services. These include language and communication barriers, cultural stigma, and lack of culturally appropriate care. To address these barriers to accessing cancer prostheses, a potential national cancer prostheses program would need to consider embedding culturally safe practices throughout the entire care pathway.

This may include:

- **Involving Aboriginal and Torres Strait Islander Health Workers and liaison officers** in the planning, delivery and coordination of prostheses services
- **Developing and delivering education and communication materials** in culturally appropriate formats and in multiple languages, designed in partnership with community leaders
- **Ensuring prostheses are accessible in a diverse range of skin tones, forms and culturally appropriate styles**, particularly for facial and breast prostheses, where identity and dignity are closely linked
- **Training clinicians and prostheses providers** in cultural safety, trauma-informed care, and person-centred approaches to ensure respectful and inclusive interactions

- **Partnering with community-based organisations** to co-design and deliver culturally safe and trusted models of care.

Embedding cultural safety and inclusion in a new national cancer prostheses program would help to ensure equitable access, dignity in care, and empowerment of individuals from all backgrounds to make informed choices in their cancer care and rehabilitation journey.

5.2.5 Rural and remote access

Ensuring equitable access to cancer prostheses services for individuals living in rural and remote areas would be another key consideration in the design and implementation of a national cancer prostheses program. As noted throughout this report, people living outside metropolitan areas can experience significant challenges in accessing prostheses services, including the need to travel long distances and face higher out-of-pocket costs. This is especially a barrier for people requiring a facial prosthesis due to cancer or cancer treatment, with all publicly funded services currently located within hospitals located in metropolitan centres.

Due to the highly specialised nature of cancer prostheses and the workforce limitations highlighted previously, it may not be practical or feasible to establish services across all regional and rural locations. Alternative strategies to support access to prostheses services for these communities could be further considered, in collaboration with jurisdictional health departments and service providers. These strategies may include:

- **Outreach services or mobile clinics:** Providing mobile prostheses services or conducting regular outreach clinics could also be considered to ensure that prostheses assessment and fitting services are provided closer to underserved communities. These models are currently being utilised to deliver limb prostheses in rural areas of QLD, SA and the NT.
- **Telehealth or virtual care:** Virtual consultations could be utilised to facilitate initial consultations, follow-up care, patient education, and multidisciplinary coordination, thereby reducing the need for individuals requiring cancer prostheses to travel for every appointment.
- **Travel support schemes or vouchers:** Providing financial support for travel and accommodation could be considered to support individuals living in rural and remote locations to access prostheses services in metropolitan areas without additional out-of-pocket expenses. This would be particularly important for individuals who require prostheses where regular appointments for fittings or replacements are necessary. The availability and accessibility of jurisdiction-based travel schemes would need to be considered to avoid duplication of existing schemes.

5.2.6 Data collection and evaluation

The establishment of a monitoring and evaluation framework, along with mechanisms to collect robust data, would be important to support the implementation, accountability and continuous improvement of a national cancer prostheses program. Collecting comprehensive data on prosthesis needs, access, outcomes, and costs would enable the program's effectiveness to be monitored and evaluated, gaps in service delivery to be identified, and help to inform future planning and resource allocation.

Currently, there is limited national-level data collected regarding cancer-related prostheses, including the number of people who require a prosthesis following a cancer diagnosis, the cost of prostheses, wait times, and service access. This limits the ability to monitor service performance, address inequities in access and ensure workforce and funding models meet demand.

A national cancer prostheses program would likely require a dedicated data collection framework to be developed. This framework may include:

- Utilisation data, including type and frequency of prosthesis use, demographic and clinical characteristics, and geographic distribution.
- Access indicators, such as referral timeframes, travel requirements, and service availability by location.
- Cost and funding data, to assess program efficiency, cost-effectiveness, and future investment needs.
- Service delivery and provider data, including workforce capacity, wait times, and provider compliance with national standards.

Additionally, a monitoring and evaluation framework would support the monitoring of program performance over time, assessments of impact and effectiveness, and the identification of areas for improvement. The establishment and implementation of a monitoring and evaluation framework would support the delivery of targeted, equitable, and high-quality care under a national program, enabling continuous improvement and sustainability.

06

Cost implications of a potential national cancer prostheses program

6 Cost implications of a potential national cancer prostheses program

This section outlines findings related to the following review question.

- **KRQ 7:** What would be the cost and appropriate delivery model for a national cancer prostheses program?

The findings in this section are presented as follows:

- 6.1 Prostheses market implications of introducing a national program
- 6.2 Cost considerations for a national cancer prosthesis program
- 6.3 Costings for each potential option outlined in Section 0.

A summary of the key findings outlined within this section is provided below.

Summary of findings

- The potential implementation of a national prosthesis scheme may have an impact on the supply and demand in the marketplace and send price signals to manufacturers of prostheses. Currently, there is no data available to determine the number of people who may currently require a prosthesis but do not have one. The implementation of a national scheme may lead to a surge in demand for prostheses, potentially resulting in either higher prices charged by manufacturers or longer waitlists for prostheses.
- In establishing a national scheme, the price set by the Australian Government will send a price signal to the market about what a prosthesis “should” cost and the acceptable amount for manufacturers to charge. This can lead to prices clustering around the set price. Setting the price of prostheses too high could lead to increased costs to government through these clustering effects, while setting the price too low could have a detrimental impact on the delivery of services and could lead to providers exiting the market.
- There is limited data available to describe the types of cancer that may lead to a prosthesis as a result of treatment, the number of people that will require a prosthesis following treatment for cancer and the costs associated with each prosthesis type.
- Costs associated with facial prostheses were reported to vary significantly due to their highly customised nature. The average cost reported for a facial prosthesis was $6,000, although stakeholders suggested that some may cost more than $10,000. In contrast, the average cost of an ocular prosthesis was reported to be $2,500.
- The average cost of an external breast prosthesis was reported to be $400, which is in line with the reimbursement amount under the EBPRP.
- The cost of a prosthetic limb was reported to range from less than $15,000 for a basic limb through to $250,000 for a highly advanced limb. Data to describe the distribution of costs within this range was not available.

Cost modelling for a potential national cancer prostheses program indicated:

- **Option 1 would cost $51.63 million over 10 years** for facial prostheses, including ears, eyes, noses and hemi-facial prostheses.
- **Option 2 would cost $123.38 million over 10 years.** This includes $51.63 million for facial prostheses and $71.76 million for external breast prostheses, noting that the EBPRP is already funded by the Australian Government.
- **Option 3 would cost $209.75 million over 10 years.** This includes $51.63 million for facial prostheses, $71.76 million for external breast prostheses and $86.37 million for prosthetic limbs.

6.1 Prostheses market implications

In establishing a potential national program, consideration should be given to broader impacts on the on the market for prostheses. This includes potential impacts on the supply and demand for prostheses and the price signals that may be provided to prosthetic manufacturers.

6.1.1 Supply and demand

As described in Section 5, there are significant workforce challenges in the provision of prostheses, particularly for facial prostheses, including the overall workforce size, workforce distribution, and training opportunities. The prostheses workforce is small and specialised, with individuals with living or lived experience of cancer having unequal access between metropolitan areas and regional, rural and remote locations. Additionally, stakeholders reported that the existing public workforce is at capacity, with long waitlists and wait times for individuals to secure appointments, while providing services through private arrangements is often unviable and places a high-cost burden on individuals requiring cancer prostheses.

In considering the implementation of a national cancer prosthesis program, the impact on demand for prostheses services would need to be considered, noting that supply is already constrained. Increased demand for services, which may occur with the implementation of a national program, may lead to increased waitlists and potentially poorer patient outcomes if workforce challenges are not addressed.

Additionally, the likely increase in demand for services as a result of the introduction of a national program may lead to an increase in the price of prostheses more generally. The potential increase in prices caused by a mismatch between the supply and demand for prostheses is not specific to any one type of prosthesis and may affect all types.

6.1.2 Price signals

Given the individualised nature of prostheses, limited data availability, and the reliance on self-reported costs by manufacturers and people with living or lived experience of cancer, accurately determining the cost of each prosthesis type is challenging. In establishing a national scheme, the price set by the Australian Government would send price signals to the market about what a prosthesis “should” cost and the acceptable amount that prostheses manufacturers can charge.

Findings from the evaluation of the EBPRP indicated that pricing for external breast prostheses was influenced by the reimbursement amount set by the program, leading to prices charged by producers clustering around the reimbursement value of $400[163]. Setting the price of prostheses too high can lead to increased costs to government through these clustering effects. Conversely, setting the price too low can have a detrimental impact on the delivery of services. If the costs of manufacturing prostheses are not adequately covered, providers, both public and private, may exit the market, which would further reduce the accessibility of prostheses for people living with or who have lived experience of cancer.

To minimise the potential negative impacts outlined above, understanding the costs associated with different prosthesis types is crucial. Data was not available as part of this review to determine the cost of individual prosthesis types. Costs discussed throughout the review have been provided either as an average price charged by manufacturers and retailers or out-of-pocket costs to individuals requiring cancer prostheses. To ensure that a national prostheses scheme adequately funds prostheses without the impacts described above, engagement with industry, through detailed market sounding or Request for Information processes, should be considered.

6.2 Cost considerations

In considering the cost implications of a national cancer prosthesis program, a key input is the average cost associated with each type of prosthesis to be covered under the program. The cost of prostheses was reported by stakeholders to vary widely between and within the various prosthesis types and can be highly variable due to the highly individualised nature of many prostheses. There is also a range of costs that should be considered for both new and replacement prostheses, including maintenance costs and associated consumables.

Table 26 below outlines the range of values and other cost considerations associated with each prosthesis type. While costs vary by prostheses type, there were no discernible differences in cost identified based on cancer type.

[163] Department of Health, Disability and Ageing. (2024). *External Breast Prostheses Reimbursement Program Evaluation*. https://www.health.gov.au/sites/default/files/2024-09/external-breast-prostheses-reimbursement-program-evaluation-june-2024.pdf

Cost inputs were sourced through stakeholder engagement activities, with limited publicly available cost sources identified.

Survey results supported the costs reported by stakeholders during interviews. In the survey distributed to people living with or with lived experience of cancer and their carers, 50 per cent of respondents (32 out of 61 respondents) reported that they had out-of-pocket costs of more than $5,000 in accessing a prosthesis, with 16 per cent of respondents indicating their out-of-pocket expenses were greater than $10,000. This is in line with the costs reported by clinicians and manufacturers of prostheses.

Table 26: Cost considerations

Category	Cost considerations	Source
Facial prostheses (inc. ear, nose and hemi-facial)	• New - average cost: $6,000 (range: $2,000 to $10,000). Distribution of costs is unknown. Cost does not include initial consultation. An individual may have an interim prosthesis through the healing period and while their permanent prosthesis is being manufactured. • Replacement - average cost: $4,500 (up to 75% of a new prosthesis). • Facial prostheses need replacing every 3 to 5 years. Some maintenance may be required, but the cost and frequency is unknown and dependent on the individual.	• Stakeholder consultation, including with; – Retailers – Individuals with lived experience – Clinicians
Ocular prostheses	• New – average cost: $2,500. • Replacement - average cost: $2,500. • Annual maintenance: $70. • Prosthetic eyes should be replaced every 3 to 5 years.	• Stakeholder consultation, including with; – Retailers – Clinicians
External breast prostheses	• $400 for a prosthesis or up to $800 for a double mastectomy. • Eligibility also covers prophylactic mastectomy. • The reimbursement of external breast prosthesis has not changed or had indexation applied since 2008. • Individuals can claim every 2 years. • Excludes reconstructive surgery.	• Stakeholder consultation with clinicians • EBPRP documentation
Limb prostheses	• The average cost of a prosthetic limb is unknown, however the range of costs is significant. • Cost – Range: <$10,000 to $250,000+ • Componentry and labour make up the largest proportion of costs, however costs are dependent on type of limb and needs of the individual. • An individual may have an interim prosthesis through the healing period and while their permanent prosthesis is being manufactured. • Lower cost limbs are most often provided by state-based limb schemes, with high-cost limbs available through the NDIS, based on individual need. • Consumables and maintenance: $3,000 per year, noting that maintenance costs for high-cost limbs can be significantly more, however this is dependent on the limb and the needs of the individual. • Consumable costs can include gloves, stockings, donning aids, gel socks, liners, sheaths, socks, stump shrinkers and suspension sleeves. Consumable costs are individualised and based on the needs of the individual. • Limbs are expected to last 3 to 5 years before being replaced.	• Stakeholder consultation, including with; – Clinicians – NDIA

Source: KPMG (2025)

6.3 Costings for each option

This section provides an overview of the costs associated with the three options for a national cancer prosthesis program, as described in Section 5.

6.3.1 Assumptions and limitations to the cost estimates

It should be noted that the analysis presented within this section is based on a number of assumptions and is limited by a range of factors, as outlined below.

- The cost analysis was limited by significant data limitations, including a lack of publicly available data related to:
  - The range of cancer types that may lead to an individual needing a prosthesis following treatment. As a proxy, several types of cancer have been included to develop cost estimates:
    - Bone cancer
    - Breast cancer
    - Eye cancer
    - Head and neck cancer, including lip
    - Melanoma, where it occurs on the face
    - Sarcoma, all types.
  - The number of people who require a prosthesis following a cancer diagnosis
  - The cost of prostheses. As outlined in Table 26, cost inputs for different prosthesis types were derived from stakeholder engagement activities, including interviews with clinicians, retailers and manufacturers of prostheses and individuals with living or lived experience of cancer, as well as survey results.
  - The current waitlist for a prosthesis following treatment for cancer, or the number of people that may be eligible for a prosthesis under a new national program who are not currently on a waitlist.
- Given the data limitations, the cost estimates presented in this report should be considered an approximate order of magnitude. Sensitivity analysis was undertaken to understand the impact of changes to key inputs. A full list of assumptions and inputs is available in Appendix H.
- The cost model assumes a start date for the national cancer prosthesis program of 1 July 2026, and models costs on an annual basis from FY26/27 to FY35/36 (10 years).
- Publicly available data on disease incidence and population projections have been used to determine the potential number of people eligible for a prosthesis. It should be noted that that incidence data is based on calendar years and population data is based on financial years. This difference is not expected to generate material differences in the total number of people potentially eligible for a national scheme.
- Cost estimates include the cost of the prosthesis and the maintenance and replacement of prostheses when required. This considers both the time and materials required for the manufacture of each prosthesis.
- Cost estimates assume that all people eligible for a prosthesis access one. The timing of replacements is based on input from stakeholders, with prostheses typically requiring replacement every two to five years. Based on stakeholder input, the model has adopted a three-year replacement cycle for facial prostheses and limb prostheses and two years for external breast prostheses, in line with EBPRP guidelines.
- The cost model does not consider disease staging, however, in determining the number of prostheses requiring replacement, five-year survival estimates have been incorporated to estimate the number of people who require a replacement prosthesis. Additionally, there is no data available to describe the number of people who currently have a prosthesis and may be eligible for a replacement following the implementation of a national scheme.
- The cost model does not account for advances in treatment options for people with a cancer diagnosis, including potential treatment advances that result in lower demand for prostheses.
- A range of factors identified during consultations as being important in survivorship care for people with lived or living experience of a cancer diagnosis have been excluded from cost estimates, including the use of a prosthesis and a range of implementation and operational costs. If a national cancer prostheses program were to be implemented, more detailed modelling would be required to quantify these costs, which may include but are not limited to:

  - Patient prehabilitation, rehabilitation and other wrap-around supports and services
  - The development of educational material for clinicians and people with lived experience of cancer that supports the visibility of the scheme and access
  - Patient transport or travel costs. These costs are assumed to be covered by state-based patient transport schemes
  - Costs associated with the governance, administration and implementation of a national scheme. This includes any costs associated with Health Technology Assessment (HTA) processes or engagement with regulatory or advisory bodies (if required), including the Medical Services Advisory Committee (MSAC) and the Therapeutic Goods Administration (TGA)
  - Additional data collection and reporting mechanisms required for a national scheme, including data sharing agreements with state and territory health services, or changes to national datasets.
- The cost model does not consider the impacts on state-based programs or funding arrangements.
- The cost model does not consider the types of professions that may be able to provide services under a national scheme.

Detailed assumptions for each option are available in Appendix H.

6.3.2 Option 1: Facial prostheses only

Option 1 for a national cancer prostheses program considers the facial prostheses only, including prosthetic eyes, ears and noses as well as hemi-facial prostheses. As described above, limited data was available regarding the number of facial prostheses required annually as a result of cancer or cancer treatment and the types of cancer that may result the need for a prosthesis.

In determining the number of facial prostheses required, the total number of head and neck cancer (including lip), eye cancer and melanoma that occurs on the face were estimated using age-standardised incidence rates and publicly available population projections. The number of cancer cases that lead to a prosthesis was estimated from publicly available reports and adjusted for the total number of cases.

Stakeholders reported that most facial prostheses are expected to last between three and five years before needing to be replaced. The cost estimates have assumed that prostheses will be replaced every three years. Survival was accounted for by adjusting the number of replacement prostheses by the five-year survival rate for the cancer types listed above.

Table 27 below outlines the cost inputs used for facial prostheses. These costs represent the average cost and were sourced through stakeholder engagement activities. As described above, some facial prostheses can cost in excess of $10,000 and are bespoke items designed to meet the needs of the individual. Further detail on cost inputs is available in Appendix H.

Table 27: Option 1 cost inputs

Prosthesis type	New prosthesis cost	Replacement / maintenance cost
Facial prostheses	$6,000	$4,500
Eye (ocular) prostheses	$2,500	$2,500 + $70 annual polish
Proportion requiring a prosthesis	4.52%	N/A
Annual indexation	4.10% (FY25/26), 3.0% (ongoing)	N/A

Source: KPMG (2025)

The tables below illustrate the total number of cases, new prostheses, replacements and maintenance and costs for Option 1 over 10 years. The estimated cost of Option 1 ranges from $2.91 million in FY26/27 to $6.21 million on FY35/36, with a total cost over 10 years of $51.63 million.

Table 28: Option 1 total number of cancer cases diagnosed per year

Type of cancer	FY26/27	FY27/28	FY28/29	FY29/30	FY30/31	FY31/32	FY32/33	FY33/34	FY34/35	FY35/36
Head and neck cancer	5,672	5,753	5,831	5,905	5,976	6,044	6,109	6,172	6,234	6,296
Eye cancer	389	395	400	405	410	415	419	424	428	432
Facial melanoma	3,396	3,445	3,491	3,536	3,578	3,619	3,658	3,696	3,733	3,770
Total	**9,458**	**9,593**	**9,722**	**9,846**	**9,965**	**10,078**	**10,185**	**10,291**	**10,395**	**10,498**

Source: KPMG (2025)

Table 29: Option 1 total number of new prostheses required per year per cancer type

Type of cancer	FY26/27	FY27/28	FY28/29	FY29/30	FY30/31	FY31/32	FY32/33	FY33/34	FY34/35	FY35/36
Head and neck cancer	256	260	264	267	270	273	276	279	282	285
Eye cancer	136	138	140	142	144	145	147	148	150	151
Facial melanoma	154	156	158	160	162	164	165	167	169	170
Total	**546**	**554**	**561**	**569**	**575**	**582**	**588**	**594**	**600**	**606**

Source: KPMG (2025)

Table 30: Option 1 total number of replacement prostheses required per year by cancer type

Type of cancer	FY26/27	FY27/28	FY28/29	FY29/30	FY30/31	FY31/32	FY32/33	FY33/34	FY34/35	FY35/36
Head and neck cancer	0	0	0	199	202	205	143	145	147	103
Eye cancer	0	0	0	117	119	120	93	94	96	79
Facial melanoma	0	0	0	146	148	150	137	139	141	129
Total	**0**	**0**	**0**	**462**	**469**	**475**	**374**	**379**	**384**	**311**

Source: KPMG (2025)

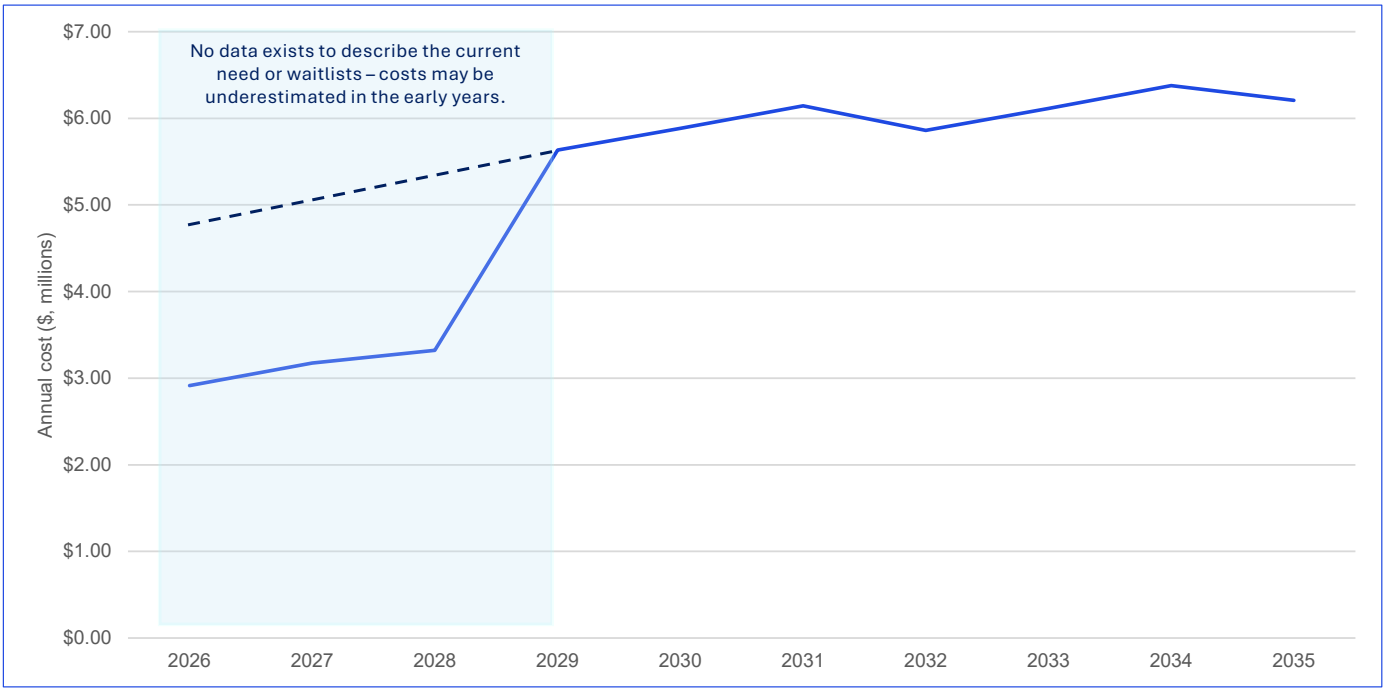
Table 31: Option 1 total cost per year

Type of cancer	FY26/27	FY27/28	FY28/29	FY29/30	FY30/31	FY31/32	FY32/33	FY33/34	FY34/35	FY35/36
New prostheses ($, millions)	$2.91	$3.14	$3.27	$3.42	$3.56	$3.71	$3.86	$4.02	$4.18	$4.35
Replacements/ maintenance ($, millions)	$0.00	$0.04	$0.05	$2.22	$2.32	$2.43	$2.00	$2.10	$2.20	$1.86
Total cost ($, millions)	**$2.91**	**$3.18**	**$3.32**	**$5.64**	**$5.88**	**$6.14**	**$5.86**	**$6.12**	**$6.38**	**$6.21**
Present value (FY24/25 $, millions)	**$2.78**	**$2.88**	**$2.87**	**$4.63**	**$4.61**	**$4.58**	**$4.16**	**$4.14**	**$4.11**	**$3.81**

Source: KPMG (2025)

Figure 15 below illustrates the change in costs over time over a ten-year period from FY26/27 to FY36/37. As described above, there is no data available to estimate the current need or size of waitlists for facial prostheses, meaning that demand for prostheses may be higher in the initial few years of programs and costs may be underestimated.

Figure 15: Option 1 annual costs



Source: KPMG (2025)

6.3.3 Option 2: Facial prostheses and external breast prostheses

Option 2 includes facial prostheses, as described in Section 6.3.2, with the addition breast prostheses through the EBPRP. It is noted that the EBPRP has been funded since 2008. The cost estimates presented here are not designed to replace the work done by the Department to determine the funding envelope for the EBPRP, and are included here to estimate future costs of the program and to estimate the total cost of the presented options.

Estimates of breast cancer incidence and publicly available population projections, combined with published rates for unilateral and bilateral mastectomy were used to determine the total number of people who would be eligible for an external breast prosthesis. The number of replacement prostheses required was adjusted to account for the number of people that would go on to have reconstructive surgery and no longer require a prosthesis, and for overall survival. It is assumed that an external breast prosthesis needs to be replaced every 2 years.
Table 32 below outlined the key cost inputs. Further detail on cost inputs is available in Appendix H.

Table 32: Option 2 cost inputs

Cost input	Value
External breast prosthesis reimbursement (new and replacement)	Unilateral - $400, Bilateral - $800
Unilateral mastectomy rate	21.0%
Bilateral mastectomy rate	12.5%
Reconstruction rate	50.0%
Annual indexation	4.10% (FY25/26), 3.0% (ongoing)

Source: KPMG (2025)

The tables below illustrate the total number of cases, new prosthetic external breast prostheses and replacements for Option 2 as well as the total costs over 10 years. The estimated cost of Option 2 ranges from $7.07 million in FY26/27 to $15.23 million in FY35/36, with a total cost over 10 years of $123.38 million. This is an incremental increase to Option 1 of $71.76 million over 10 years.

Table 33: Option 2 total number of cancer cases diagnosed per year

Type of cancer	FY26/27	FY27/28	FY28/29	FY29/30	FY30/31	FY31/32	FY32/33	FY33/34	FY34/35	FY35/36
Breast cancer	21,716	22,025	22,322	22,607	22,879	23,140	23,386	23,629	23,868	24,104
Total	**21,716**	**22,025**	**22,322**	**22,607**	**22,879**	**23,140**	**23,386**	**23,629**	**23,868**	**24,104**

Source: KPMG (2025)

Table 34: Option 2 total number of new prostheses required per year

Type of prostheses	FY26/27	FY27/28	FY28/29	FY29/30	FY30/31	FY31/32	FY32/33	FY33/34	FY34/35	FY35/36
Unilateral mastectomy	4,560	4,625	4,688	4,747	4,805	4,859	4,911	4,962	5,012	5,062
Bilateral mastectomy	2,715	2,753	2,790	2,826	2,860	2,892	2,923	2,954	2,984	3,013
Total	**9,989**	**10,132**	**10,268**	**10,399**	**10,525**	**10,644**	**10,758**	**10,869**	**10,979**	**11,088**

Source: KPMG (2025)

Table 35: Option 2 total number of replacement prostheses required per year

Type of prostheses	FY26/27	FY27/28	FY28/29	FY29/30	FY30/31	FY31/32	FY32/33	FY33/34	FY34/35	FY35/36
Replacements	0	0	4,755	4,742	4,805	4,451	4,362	4,421	4,095	4,013
Total	**0**	**0**	**4,755**	**4,742**	**4,805**	**4,451**	**4,362**	**4,421**	**4,095**	**4,013**

Source: KPMG (2025)

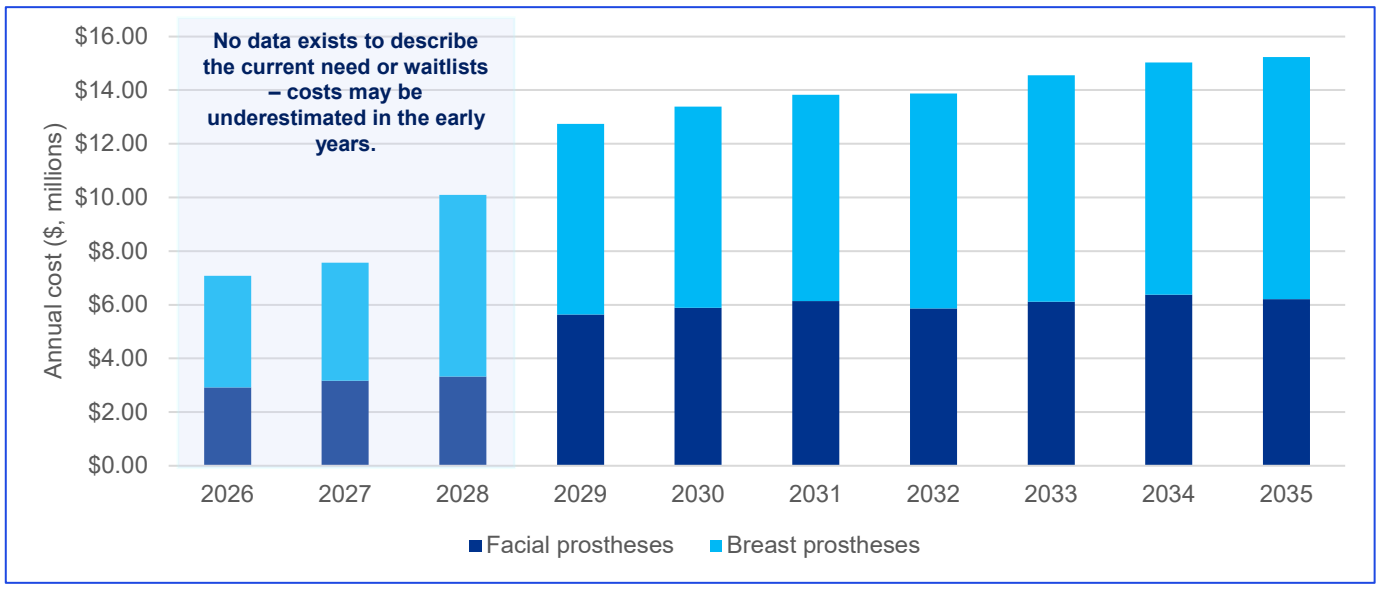
Table 36: Option 2 total cost per year

Type of prostheses	FY26/27	FY27/28	FY28/29	FY29/30	FY30/31	FY31/32	FY32/33	FY33/34	FY34/35	FY35/36
Total new prostheses ($, millions)	$4.16	$4.48	$4.67	$4.87	$5.08	$5.29	$5.51	$5.73	$5.97	$6.20
Replacements /maintenance ($, millions)	$0.00	$0.00	$2.16	$2.22	$2.32	$2.21	$2.23	$2.33	$2.22	$2.25
Total breast costs ($, millions)	$4.16	$4.48	$6.84	$7.10	$7.40	$7.51	$7.74	$8.07	$8.19	$8.45
Total option cost ($, millions)	$7.07	$7.65	$10.16	$12.73	$13.28	$13.65	$13.60	$14.18	$14.57	$14.66
Present value (FY24/25 $, millions)	**$6.74**	**$6.94**	**$8.77**	**$10.47**	**$10.41**	**$10.18**	**$9.67**	**$9.60**	**$9.39**	**$9.00**

Source: KPMG (2025)

Figure 16 below illustrates the costs associated with Option 2 over time and the contribution of facial prostheses and external breast prostheses to the total cost. Similar to Option 1, there is no data to describe the current need or size of waitlists for external breast prostheses, meaning costs in the early years may be underestimated.

Figure 16: Option 2 annual costs



Source: KPMG (2025)

It should be noted that the EBPRP current funding is $6.87 million annually or $27.50 million over the period FY21/22 to FY24/25. Total expenditure over this period was $24.25 million. These costs are similar to those modelled above, for external breast prostheses, with average annual costs being $7.18 million over the 10-year time horizon.

6.3.4 Option 3: Facial prostheses, EBPRP and prosthetic limbs for those aged 65 years and older

Option 3 includes facial prostheses and external breast prostheses as described Section 6.3.3, with the addition of prosthetic limbs for people over 65 years of age. Similarly to facial prostheses, there is limited data available to identify the types of cancer that may lead to a limb amputation. A rapid literature scan identified sarcoma and bone cancer as the leading causes of limb amputation in people with cancer. The literature scan also identified the proportion of people with soft-tissue sarcoma that required an amputation, with this figure being used as a proxy for all sarcoma types and bone cancer.[164, 165]

Stakeholders reported that limb prostheses are expected to last three to five years before needing to be replaced, with additional annual maintenance and consumable costs. For the cost estimates, it is assumed that prosthetic limbs will be replaced every three years. Survival was accounted for by adjusting the number of prosthetic limbs by the five-year survival rate for sarcoma and bone cancer. Table 37 outlines the key cost inputs for limb prostheses. Costs associated with prosthetic limbs are difficult to determine, with minimal publicly available data. State-based limb schemes are often capped at a price less than $15,000, while limbs provided by the NDIS can cost upwards of $100,000. Findings from stakeholder engagement activities also suggested that approximately three quarters of the over 65 population who require limb prostheses would benefit from more advanced limbs than what was available through most state-based limb schemes. Further detail on cost inputs is available in Appendix H.

Additionally, there is no data to describe the distribution of limb prostheses between limb types such as above or below the elbow, hands, fingers, toes and above or below the knee. This means that there is significant uncertainty around the price for prosthetic limbs used in the cost model.

Table 37: Option 3 cost inputs

Cost input	New prosthesis cost	Replacement	Annual maintenance/consumables
Prosthetic limbs (all types, average cost)	$100,000	$75,000	$3,000
Proportion requiring a prosthesis	4.20%	N/A	N/A
Annual indexation	4.10% (FY25/26), 3.0% (ongoing)	N/A	N/A

Source: KPMG (2025)

The tables below illustrate the total number of cases, new external breast prostheses, replacement and maintenance and costs for Option 3 over 10 years. The estimated cost of Option 3 ranges from $12.08 million in FY26/27 to $25.40 million in FY35/36, with a total cost over 10 years of $209.75 million. This is an incremental increase to Option 1 of $209.75 million over 10 years, and an incremental increase to Option 2 of $86.37 million over 10 years.

Table 38: Option 3 total number of cancer cases diagnosed per year (over 65 years)

Type of cancer	FY26/27	FY27/28	FY28/29	FY29/30	FY30/31	FY31/32	FY32/33	FY33/34	FY34/35	FY35/36
Sarcoma	1,018	1,048	1,076	1,102	1,126	1,149	1,173	1,198	1,223	1,248
Bone cancer	94	97	100	103	106	109	111	114	116	120
Total	**1,112**	**1,145**	**1,176**	**1,205**	**1,232**	**1,258**	**1,284**	**1,312**	**1,339**	**1,368**

Source: KPMG (2025)

[164] Huynh, T.H.N., Kuruvilla, D.R., Nester, M.D. *et al.* Limb Amputations in Cancer: Modern Perspectives, Outcomes, and Alternatives. *Curr Oncol Rep* **25**, 1457–1465 (2023). https://doi.org/10.1007/s11912-023-01475-5
[165] Evans, D.R., Lazarides, A.L., Visgauss, J.D. *et al.* Limb salvage versus amputation in patients with osteosarcoma of the extremities: an update in the modern era using the National Cancer Database. *BMC Cancer* **20**, 995 (2020). https://doi.org/10.1186/s12885-020-07502-z

Table 39: Option 3 total number of new prostheses required per year by cancer type (over 65 years)

Type of cancer	FY26/27	FY27/28	FY28/29	FY29/30	FY30/31	FY31/32	FY32/33	FY33/34	FY34/35	FY35/36
Sarcoma	43	44	45	46	47	48	49	50	51	52
Bone cancer	4	4	4	4	4	5	5	5	5	5
Total	**47**	**48**	**49**	**51**	**52**	**53**	**54**	**55**	**56**	**57**

Source: KPMG (2025)

Table 40: Option 3 total number of replacement prostheses required per year by cancer type (over 65 years)

Type of cancer	FY26/27	FY27/28	FY28/29	FY29/30	FY30/31	FY31/32	FY32/33	FY33/34	FY34/35	FY35/36
Sarcoma	0	0	0	32	33	34	23	23	24	16
Bone cancer	0	0	0	3	3	3	2	2	2	1
Total	**0**	**0**	**0**	**35**	**36**	**37**	**25**	**25**	**26**	**17**

Source: KPMG (2025)

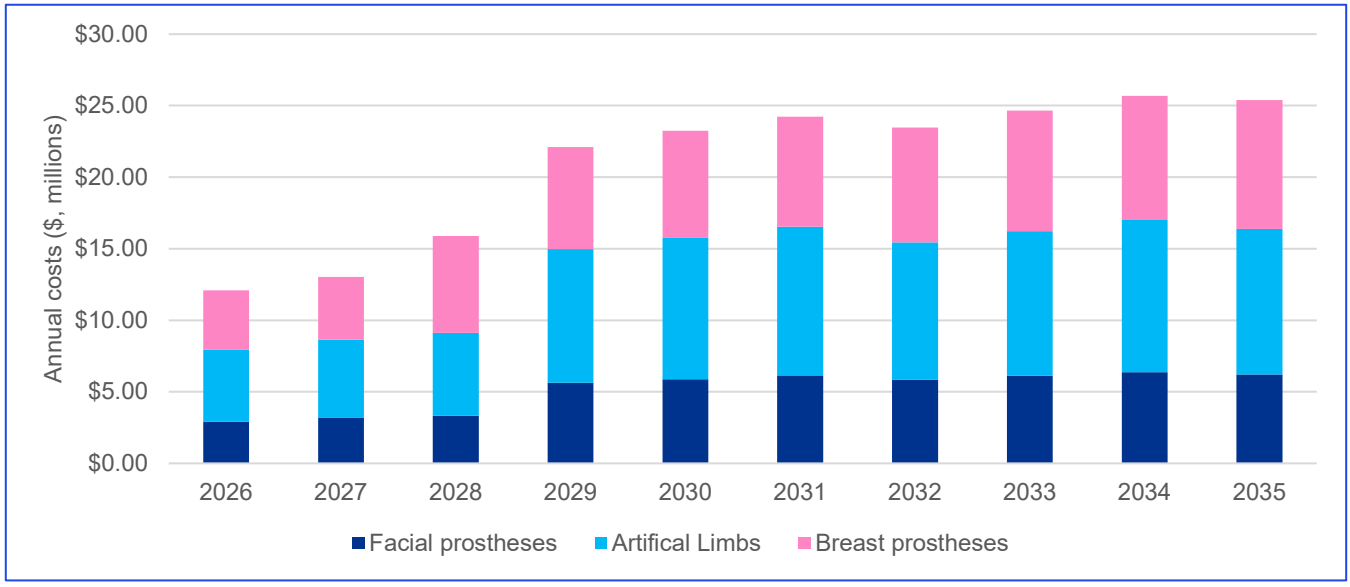
Table 41: Option 3 total cost per year

Type of cancer	FY26/27	FY27/28	FY28/29	FY29/30	FY30/31	FY31/32	FY32/33	FY33/34	FY34/35	FY35/36
Total new prostheses ($, millions)	$5.01	$5.47	$5.79	$6.11	$6.43	$6.77	$7.11	$7.48	$7.87	$8.28
Replacements/ maintenance ($, millions)	$0.00	$0.00	$0.00	$3.24	$3.43	$3.63	$2.47	$2.62	$2.77	$1.89
Total limb costs ($, millions)	$5.01	$5.47	$5.79	$9.35	$9.87	$10.40	$9.58	$10.10	$10.64	$10.16
Total option cost ($, millions)	**$12.08**	**$13.04**	**$15.89**	**$22.09**	**$23.25**	**$24.23**	**$23.46**	**$24.65**	**$25.67**	**$25.40**
Present value (FY24/25 $, millions)	**$11.51**	**$11.82**	**$13.72**	**$18.18**	**$18.21**	**$18.08**	**$16.67**	**$16.69**	**$16.55**	**$15.59**

Source: KPMG (2025)

Figure 17 below illustrates that annual cost of Option 3 and the contribution to costs of facial prostheses, prosthetic limbs and external breast prostheses. As described above the costs may be underestimated in the early years through the paucity of data to describe the waitlist or number of people who may be eligible for a prosthesis under a national scheme, but do not currently have one.

Figure 17: Option 3 annual costs



Source: KPMG (2025)

To account for the wide disparity in costs for prosthetic limbs, sensitivity analysis was conducted to understand how changes in limbs prices effect the overall cost of Option 2. Results of this analysis are described in Section 6.3.5.

6.3.5 Sensitivity analysis

As described above, there is significant uncertainty around the average cost of facial prostheses and prosthetic limbs. To address this uncertainty sensitivity analysis has been undertaken to understand how changes in the price of facial prostheses and prosthetic limbs impacts the total cost of these items. Cost inputs for new and replacement facial prostheses were varied by ±15%, and due to the potential large variation and significant uncertainty surrounding the estimated cost for prosthetic limbs, costs were varied by ±30%.

Table 42: Sensitivity analysis cost inputs

Cost inputs	Base case cost input	Scenario 1 (+15%)	Scenario 2 (-15%)	Scenario 1A (+30%)	Scenario 2A (-30%)
New facial prostheses	$6,000	$6,900	$5,100	N/A	N/A
Replacement facial prostheses	$4,500	$5,175	$3,825	N/A	N/A
New limb prostheses	$100,000	N/A	N/A	$130,000	$70,000
Replacement limbs prostheses	$75,000	N/A	N/A	$97,500	$52,500

Source: KPMG (2025)

Results of the sensitivity analysis, illustrated in Table 43 and Table 44 below, indicate that changes in the average price have, as expected, a large impact on the overall cost of facial prostheses and prosthetic limbs. For facial prostheses, a variation in average cost of ±15% would result in a $6.69 million dollar difference in the total cost of facial prostheses over the 10-year modelling period, with total costs equal to $44.94 million over 10 years at the lower estimate and $58.32 million over 10 years at the higher cost estimate. This compares to the $51.63 million costs for facial prostheses described as part of Option 1.

Table 43: Sensitivity analysis results for facial prostheses, ($, millions)

Scenario	FY26/27	FY27/28	FY28/29	FY29/30	FY30/31	FY31/32	FY32/33	FY33/34	FY34/35	FY35/36
Baseline	**$2.91**	**$3.18**	**$3.32**	**$5.63**	**$5.88**	**$6.14**	**$5.86**	**$6.11**	**$6.38**	**$6.21**
Scenario 1 (15%)	$2.53	$2.76	$2.89	$4.91	$5.13	$5.35	$5.10	$5.32	$5.55	$5.40
Scenario 2 (+15%)	$3.30	$3.59	$3.75	$6.36	$6.64	$6.93	$6.62	$6.91	$7.20	$7.01

Source: KPMG (2025)

Table 44: Sensitivity analysis results for limb prostheses, ($, millions)

Scenario	FY26/27	FY27/28	FY28/29	FY29/30	FY30/31	FY31/32	FY32/33	FY33/34	FY34/35	FY35/36
Baseline	**$5.01**	**$5.47**	**$5.79**	**$9.35**	**$9.87**	**$10.40**	**$9.58**	**$10.10**	**$10.64**	**$10.16**
Scenario 1A (-30%)	$3.55	$3.88	$4.10	$6.63	$7.00	$7.38	$6.80	$7.17	$7.55	$7.21
Scenario 2A (+30%)	$6.47	$7.06	$7.47	$12.06	$12.73	$13.42	$12.37	$13.04	$13.73	$13.12

Source: KPMG (2025)

For prosthetic limbs, a variation in average cost of ±30% would result in a $25.10 million dollar difference in the total cost of prosthetic limbs over the 10-year modelling period, with total costs equal to $61.27 million over 10 years at the lower estimate and $111.47 million over 10 years at the higher cost estimate. This compares to the $86.37 million costs for facial prostheses described as part of Option 2

A

Appendices

Appendix A: Key review questions

The Key Review Questions (KRQs) are the high-level questions that the review activities were aimed at answering. Tables below outline a set of seven KRQs, each with several sub-questions. The sections of this report that address each question are also outlined, along with the data sources that were considered to answer each question. Further detail regarding data collection is provided in Appendix B.

Key review question 1 is **What prostheses services / schemes are currently available to people living with or who have lived experience of cancer?** Table 45 below outlines the sub-questions and sections of the report where the key review question is addressed. The data sources used to answer key review question 1 include:

- Desktop review and literature scan
- Consultation with states and territories
- Consultation with Department of Health, Disability and Ageing
- Consultation with NDIA / DVA / DSS
- Consultation and survey with clinicians
- Consultation with retailers of prostheses
- Consultation with peak bodies / advocacy groups
- Consultation and survey with people who are living with or who have lived experience of cancer and their carers

Table 45: Sub-questions and sections of the report where KRQ 1 is addressed

Sub-questions	Section of this report where question is addressed
How do prostheses services / schemes differ by jurisdiction?	Section 2: Current prostheses services, programs and schemes in Australia
How do prostheses services / schemes differ by prostheses and / or cancer type?	Section 2: Current prostheses services, programs and schemes in Australia
How does this differ in rural and remote areas vs. metropolitan areas?	Section 2: Current prostheses services, programs and schemes in Australia
How does this differ for priority population groups[166]?	Section 2: Current prostheses services, programs and schemes in Australia
How are these services / schemes funded?	Section 2: Current prostheses services, programs and schemes in Australia
How do existing prostheses services / schemes address equity in terms of eligibility and out-of-pocket costs?	Section 4: Equity of access to prostheses for people living with or post a cancer diagnosis in Australia
How do prostheses services / schemes available to people living with or have lived experience of cancer in Australia compare to those available in other, comparable countries?	Section 3: Prostheses services, programs and schemes in other countries

Source: KPMG (2025)

[166] In line with the Australian Cancer Plan, priority population groups include Aboriginal and Torres Strait Islander people, people living in rural and remote areas, LGBTIQA+ people, people from Culturally and Linguistically Diverse backgrounds, people living with disability, people in lower socioeconomic groups, people living with a mental illness, older people, adolescents and young adult people, and children

Key review question 2 is **What role do state, territory and commonwealth governments currently play in providing access to cancer prostheses?** Table 46 below outlines the sub-questions and sections of the report where the key review question is addressed. The data sources used to answer key review question 2 include:

- Desktop review and literature scan
- Consultation with states and territories
- Consultation with Department of Health, Disability and Ageing
- Consultation and survey with people who are living with or who have lived experience of cancer and their carers

Table 46: Sub-questions and sections of the report where KRQ 2 is addressed

Sub-questions	Section of this report where question is addressed
How does this differ by jurisdiction?	Section 2: Current prostheses services, programs and schemes in Australia
How does this differ by prostheses and / or cancer type?	Section 2: Current prostheses services, programs and schemes in Australia
What role do other organisations including private health insurers and not-for-profit organisations play in providing access to cancer prostheses?	Section 2: Current prostheses services, programs and schemes in Australia
What role should the state, territory and commonwealth governments play to support equal access to cancer prostheses?	Section 5: Considerations and options for a national cancer prosthesis program

Source: KPMG (2025)

Key review question 3 is **In what health setting/s are people living with or have lived experience of cancer accessing cancer prostheses?** Table 47 below outlines the sub-questions and sections of the report where the key review question is addressed. The data sources used to answer KRQ 3 include:

- Desktop review and literature scan
- Consultation with states and territories
- Consultation and survey with clinicians
- Consultation with retailers of prostheses
- Consultation and survey with people who are living with or who have lived experience of cancer and their carers
- Consultation with peak bodies / advocacy groups

Table 47: Sub-questions and sections of the report where KRQ 3 is addressed

Sub-questions	Section of this report where question is addressed
How does this differ by jurisdiction?	Section 2: Current prostheses services, programs and schemes in Australia
How does this differ by prostheses and / or cancer type?	Section 2: Current prostheses services, programs and schemes in Australia
How does this differ in rural and remote areas vs. metropolitan areas?	Section 2: Current prostheses services, programs and schemes in Australia
How does this differ for priority population groups[167]?	Section 2: Current prostheses services, programs and schemes in Australia

Source: KPMG (2025)

[167] In line with the Australian Cancer Plan, priority population groups include Aboriginal and Torres Strait Islander people, people living in rural and remote areas, LGBTIQA+ people, people from Culturally and Linguistically Diverse backgrounds, people living with disability, people in lower socioeconomic groups, people living with a mental illness, older people, adolescent and young adult people and children

Key review question 4 is **What are the current barriers faced by people living with or who have lived experience of cancer in accessing prostheses?** Table 48 below outlines the sub-questions and sections of the report where the key review question is addressed. The data sources used to answer KRQ 4 include:

- Desktop review and literature scan
- Consultation with states and territories
- Consultation and survey with clinicians
- Consultation with retailers of prostheses
- Consultation and survey with people who are living with or who have lived experience of cancer and their carers
- Consultation with peak bodies / advocacy groups

Table 48: Sub-questions and sections of the report where KRQ 4 is addressed

Sub-questions	Section of this report where question is addressed
How does this differ by jurisdiction?	Section 4: Equity of access to prostheses for people living with or post a cancer diagnosis in Australia
How does this differ by prostheses and / or cancer type?	Section 4: Equity of access to prostheses for people living with or post a cancer diagnosis in Australia
How does this differ in rural and remote areas vs. metropolitan areas?	Section 4: Equity of access to prostheses for people living with or post a cancer diagnosis in Australia
How does this differ for priority population groups? Are there unique barriers faced by priority population groups176F168?	Section 4: Equity of access to prostheses for people living with or post a cancer diagnosis in Australia
Could these barriers be addressed by a national Cancer Prosthesis Program? If so, how? If not, why not?	Section 5: Considerations and options for a national cancer prosthesis program

Source: KPMG (2025)

Key review question 5 is **Are there particular prosthesis types that are more difficult than others to access? Are there particular prosthesis types that are not covered by any existing support schemes?** Table 49 below outlines the sub-questions and sections of the report where the key review question is addressed. The data sources used to answer KRQ 5 include:

- Desktop review and literature scan
- Consultation and survey with people who are living with or have lived experience and carers
- Consultation and survey with clinicians
- Consultation with retailers of prostheses
- Consultation with peak bodies / advocacy groups
- Consultation and survey with people who are living with or who have lived experience of cancer and their carers

[168] In line with the Australian Cancer Plan, priority population groups include Aboriginal and Torres Strait Islander people, people living in rural and remote areas, LGBTIQA+ people, people from Culturally and Linguistically Diverse backgrounds, people living with disability, people in lower socioeconomic groups, people living with a mental illness, older people, adolescent and young adult people and children

Table 49: Sub-questions and sections of the report where KRQ 5 is addressed

Sub-questions	Section of this report where question is addressed
If so, what are the key drivers that make these prosthesis types more difficult to access?	Section 4: Equity of access to prostheses for people living with or post a cancer diagnosis in Australia
How does this differ by jurisdiction?	Section 4: Equity of access to prostheses for people living with or post a cancer diagnosis in Australia
How does this differ in rural and remote areas vs. metropolitan areas?	Section 4: Equity of access to prostheses for people living with or post a cancer diagnosis in Australia
How does this differ for priority population groups177F169?	Section 4: Equity of access to prostheses for people living with or post a cancer diagnosis in Australia

Source: KPMG (2025)

Key review question 6 is **Is there a gap in equity and access to prosthetics for individuals living with or post a cancer diagnosis?** Table 50 below outlines the sub-questions and sections of the report where the key review question is addressed. The data sources used to answer KRQ 6 include:

- Desktop review and literature scan
- Consultation with states and territories
- Consultation and survey with clinicians
- Consultation with retailers of prostheses
- Consultation with NDIA / DVA / DSS
- Consultation with peak bodies / advocacy groups
- Consultation and survey with people who are living with or who have lived experience of cancer and their carers

Table 50: Sub-questions and sections of the report where KRQ 6 is addressed

Sub-questions	Section of this report where question is addressed
How does this differ by jurisdiction?	Section 4: Equity of access to prostheses for people living with or post a cancer diagnosis in Australia
How does this differ in rural and remote areas vs. metropolitan areas?	Section 4: Equity of access to prostheses for people living with or post a cancer diagnosis in Australia
How does this differ by socio-economic status?	Section 4: Equity of access to prostheses for people living with or post a cancer diagnosis in Australia
How does this differ by prostheses and / or cancer type?	Section 4: Equity of access to prostheses for people living with or post a cancer diagnosis in Australia
How does this differ by priority population groups178F170?	Section 4: Equity of access to prostheses for people living with or post a cancer diagnosis in Australia
Could this gap be addressed by a national Cancer Prosthesis Program? If so, how?	Section 5: Considerations and options for a national cancer prosthesis program

Source: KPMG (2025)

[169] In line with the Australian Cancer Plan, priority population groups include Aboriginal and Torres Strait Islander people, people living in rural and remote areas, LGBTIQA+ people, people from Culturally and Linguistically Diverse backgrounds, people living with disability, people in lower socioeconomic groups, people living with a mental illness, older people, adolescent and young adult people and children
[170] Ibid.

Key review question 7 **What would be the cost of a national cancer prosthesis program?** Table 51 below outlines the sub-questions and sections of the report where the key review question is addressed. The data sources used to answer KRQ 7 include:

- Desktop review and literature scan
- AIHW cancer data
- Consultation and survey with people who are living with or who have lived experience of cancer and their carers
- Consultation with the Department of Health, Disability and Ageing
- Consultation with states and territories
- Consultation with NDIA
- Consultation with peak bodies / advocacy groups
- Consultation and survey with clinicians
- Consultation with retailers of prostheses

Table 51: Sub-questions and sections of the report where KRQ 7 is addressed

Sub-questions	Section of this report where question is addressed
How many people living with or who have lived experience of cancer require new and replacement prostheses each year in Australia? How does this differ by prostheses and / or cancer type?	Section 6: Cost implications of a national cancer prosthesis program
What are the key cost components that should be considered for new and replacement prostheses? How does this differ by prostheses and / or cancer type?	Section 6: Cost implications of a national cancer prosthesis program
What is the average cost of new and replacement prostheses? How does this differ by prostheses and / or cancer type?	Section 6: Cost implications of a national cancer prosthesis program
What impact might a national program have on the market price for prostheses?	Section 6: Cost implications of a national cancer prosthesis program
What are the key enablers for successful implementation of a new Cancer Prosthesis Program?	Section 5: Considerations and options for a national cancer prosthesis program
What eligibility criteria should be considered for the program to ensure existing gaps are addressed?	Section 5: Considerations and options for a national cancer prosthesis program
What funding model would be most appropriate (e.g. Commonwealth led and funded, state / jurisdiction co-contribution, patient co-contribution, private health insurance)? How do similar programs in other jurisdictions work?	Section 6: Cost implications of a national cancer prosthesis program

Source: KPMG (2025)

Appendix B: Data collection

Appendix B includes materials related to the various data collection activities undertaken as part of this review, including:

- **B.1 List of stakeholders consulted**
- **B.2 Survey of people living with or with lived experience of cancer and their carers questions and results**
- **B.3 Survey of clinicians involved in the delivery of prostheses services questions and results**
- **B.4 Literature scan search protocol**
- **B.5 List of documents reviewed**

B.1 List of stakeholders consulted

This section details the stakeholders who attended the review design workshop and participated in consultation interviews as part of this review. The list of review design workshop attendees include:

- **Advocacy group / peak body**
  - Cancer Council Australia: Workshop attended
  - NACCHO: Workshop attended
  - Rare Cancer Australia: Workshop attended
  - Head and Neck Cancer: Workshop attended
- **Commonwealth agency**
  - Cancer Australia: Workshop attended
- **State/territory representatives**
  - NSW Health: Workshop attended
  - WA Health Workshop attended

Table 52 below outlines the list of stakeholders that were consulted as part of the review and their consultation status.

Table 52: List of stakeholders for consultation and consultation status

Stakeholder group	Organisation	Comments
Advocacy group / peak body	Cancer Council Australia	Interview conducted
Advocacy group / peak body	National Aboriginal Community Controlled Health Organisation	Interview conducted
Advocacy group / peak body	Rare Cancer Australia	Interview conducted
Advocacy group / peak body	Head and Neck Australia	Interview conducted
Advocacy group / peak body	Limbs 4 Life	Interview conducted
Advocacy group / peak body	The Australian Orthotic Prosthetic Association	Interview conducted
Advocacy group / peak body	The Australian and New Zealand Association of Oral and Maxillofacial Surgeons	Interview conducted
Advocacy group / peak body	Canteen	Interview conducted
Advocacy group / peak body	Prostate Cancer Foundation Australia	Interview conducted
Advocacy group / peak body	Federation of Ethnic Communities Council of Australia	Interview conducted
Advocacy group / peak body	Social Policy Group	Interview conducted

Stakeholder group	Organisation	Comments
Advocacy group / peak body	Ethnic Communities Council Queensland	Written response received
Advocacy group / peak body	Breast Cancer Network Australia	Invitation declined
Advocacy group / peak body	Older Persons Advocacy Network	Invitation declined
Advocacy group / peak body	People with Disability Australia	No response received
Advocacy group / peak body	Australasian Academy of Facial Plastic Surgeons	No response received
Advocacy group / peak body	Australian & New Zealand Head and Neck Society	No response received
Advocacy group / peak body	Ethnic Communities Council Western Australia	No response received
Advocacy group / peak body	Australian & New Zealand Head and Neck Society	No response received
Clinicians	Fiona Stanley Hospital	Interview conducted
Clinicians	Cancer Network WA	Interview conducted
Clinicians	Royal Melbourne Hospital	Interview conducted
Clinicians	Royal Brisbane Hospital	Interview conducted
Clinicians	Prosthetic Art Technology	Interview conducted
Clinicians	Wollongong Public Hospital	Interview conducted
Clinicians	Chris O'Brien Life house	Interview conducted
Clinicians	Peter Mac Cancer Centre	Interview conducted
Clinicians	Adelaide Dental Hospital	Interview conducted
Clinicians	Flinders Medical Centre	Interview conducted
Clinicians	The University of Sydney	Interview conducted
Clinicians	McGrath Foundation	Interview conducted
Clinicians	Alfred Health	Interview declined
People with lived experience	Not applicable	Interview conducted
People with lived experience	Not applicable	Interview conducted
People with lived experience	Not applicable	Interview conducted
People with lived experience	Not applicable	Interview conducted
People with lived experience	Not applicable	Interview conducted
People with lived experience	Not applicable	No response received
People with lived experience	Not applicable	No response received
Department of Health, Disability and Ageing	Technology Assessment and Access Division	Interview conducted
Department of Health, Disability and Ageing	Medicare Benefits and Digital Health Division	Interview conducted
Department of Health, Disability and Ageing	Cancer Policy Section	Interview conducted
Department of Health, Disability and Ageing	Primary Care Branch	Interview declined
Department of Health, Disability and Ageing	Private Health Strategy Branch	Interview declined
Commonwealth agencies	National Disability Insurance Agency	Interview conducted
Commonwealth agencies	Department of Social Services	Interview conducted

Stakeholder group	Organisation	Comments
Commonwealth agencies	Department of Veterans' Affairs	Interview conducted
Commonwealth agencies	Cancer Australia	Interview conducted
Retailers	Artificial Eyes	Interview conducted
Retailers	Morphett Eyes	Interview conducted
Retailers	Ossur	No response received
Retailers	Ottobock	No response received
Retailers	OPC Health	No response received
Retailers	Massons Healthcare	No response received
Retailers	Taska Prosthetics	No response received
State / territory representatives	ACT Health Directorate	Interview conducted
State / territory representatives	Cancer Institute NSW	Interview conducted
State / territory representatives	Department of Health NT	Interview conducted
State / territory representatives	Department of Health QLD	Interview conducted
State / territory representatives	Department of Health SA	Interview conducted
State / territory representatives	Department of Health TAS	Interview conducted
State / territory representatives	Department of Health WA	Interview conducted
State / territory representatives	Royal Melbourne Hospital	Interview conducted

Source: KPMG (2025)

B.2 Survey of people living with or with lived experience of cancer and their carers

Not all respondents provided a response to every question, therefore the number of respondents for each question fluctuates. The total number of respondents are noted in each question.

A total of 61 respondents provided a response for every mandatory question in the survey. On the other hand, 57 other respondents started the survey but did not complete it. The most common drop-off question was question 6.

1. How old are you, or the age of the person you care for?

Response	Number of respondents	Proportion of total respondents (%)
Under 25 years old	1	0.9
25 to 34 years old	3	2.6
35 to 44 years old	2	1.7
45 to 54 years old	20	17.1
55+ years old	91	77.8
Total	117	100

Source: KPMG (2025)

2. What is your gender, or the gender of the person you care for? [single answer, mandatory]

Response	Number of respondents	Proportion of total respondents (%)
Male	63	53.4
Female	53	44.9
Other	1	0.9
Prefer not to say	1	0.9
Total	**118**	**100**

Source: KPMG (2025)

3. In what state / territory do you, or the person you care for, live? [single answer, mandatory]

Response	Number of respondents	Proportion of total respondents (%)
New South Wales	58	49.6
Victoria	19	16.2
Queensland	25	21.4
Western Australia	4	3.4
South Australia	10	8.6
Australian Capital Territory	0	0
Tasmania	1	0.9
Northern Territory	0	0
Total	**117**	**100**

Source: KPMG (2025)

4. How would you describe the area where you, or the person you care for, live? [single answer, mandatory]

Response	Number of respondents	Proportion of total respondents (%)
Metropolitan area	53	52.5
Regional centre	27	26.7
Rural area	20	19.8
Remote community	1	0.9
Total	**101**	**100**

Source: KPMG (2025)

5. What type of prosthesis do you, or the person you care for, require? [multi answer, mandatory]

Response	Number of respondents	Proportion of total respondents (%)
Limb prosthesis **Including: arm prostheses fitted at, above or below the elbow, including hand and finger prostheses and leg prostheses fitted at, above or below the knee, including foot and toe prostheses**	1	1.2
Facial prosthesis **Including: Prosthetic ears, noses, eyeballs, orbital prosthetics, hemi-facial prosthetics, and artificial soft or hard palates**	56	66.7
An artificial breast worn in the bra	3	3.6
Voice prostheses	13	15.5
Dental prostheses	10	11.9
Fat grafting*	1	1.2
Total	**84**	**100**

Source: KPMG (2025)

*Note: This respondent did not report another prosthesis.

Most of the respondents responded with having only one prosthesis, or reported a secondary prosthesis related to their main prosthesis (e.g., a nose prosthesis and a magnetic attachment for the nose prosthesis). The latter type of response has been grouped under the respondent's main prosthesis and counted as a single response.

Six respondents described having two distinct prostheses. Their responses have been counted as two responses each in the table above. They are:

- Two respondents have a prosthetic nose and a prosthetic eyeball,
- One respondent has a prosthetic nose and an artificial palate,
- One respondent has a prosthetic nose and an artificial breast,
- One respondent has an artificial palate and a dental prosthesis, and
- One respondent has an artificial palate and a hemi-facial prosthesis.

6. To what extent do you agree with the following statements about your prosthesis (or the prosthesis used by the person you care for)? [grid, mandatory]

A total of eight statements were provided to the survey respondents, who were asked if they agreed or disagreed with each statement, on a 5-point Likert scale.

The responses to each statement are organised by three distinct categories – jurisdiction, remoteness, and prosthesis type – to outline the distribution of each response. Each column outlines the number of respondents, and the proportion of respondents for each row indicated in an accompanying bracket.

Statement 1: Clear information about prostheses options, funding available and the process for obtaining a prosthesis was provided

Table 53: Responses by jurisdiction to Statement 1

Response	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
New South Wales	11 (30.6%)	4 (11.1%)	3 (8.3%)	8 (22.2%)	10 (27.8%)
Victoria	0 (0.0%)	1 (16.7%)	1 (16.7%)	2 (33.3%)	2 (33.3%)
Queensland	4 (28.6%)	5 (35.7%)	2 (14.3%)	0 (0.0%)	3 (21.4%)
South Australia	1 (25.0%)	1 (25.0%)	0 (0.0%)	2 (50.0%)	0 (0.0%)
Tasmania	1 (100.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total	**17 (27.9%)**	**11 (18.0%)**	**6 (9.8%)**	**12 (19.7%)**	**15 (24.6%)**

Source: KPMG (2025)

Table 54: Responses by remoteness to Statement 1

Response	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
Metropolitan area	9 (28.1%)	5 (15.6%)	3 (9.4%)	7 (21.9%)	8 (25.0%)
Regional centre	5 (26.3%)	3 (15.8%)	3 (15.8%)	3 (15.8%)	5 (26.3%)
Rural area	2 (22.2%)	3 (33.3%)	0 (0.0%)	2 (22.2%)	2 (22.2%)
Remote community	1 (100.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total: 61 respondents	**17 (27.9%)**	**11 (18.0%)**	**6 (9.8%)**	**12 (19.7%)**	**15 (24.6%)**

Source: KPMG (2025)

Table 55: Responses by prosthesis type to Statement 1

Response	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
Facial prosthesis	12 (30.8%)	7 (17.9%)	3 (7.7%)	7 (17.9%)	10 (25.6%)
An artificial breast worn in the bra	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	3 (100.0%)
Voice prostheses	3 (23.1%)	2 (15.4%)	1 (7.7%%)	4 (30.8%)	3 (23.1%)
Dental prostheses	3 (33.3%)	2 (22.2%)	2 (22.2%)	2 (22.2%)	0 (0.0%)
Fat grafting	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (100.0%)	0 (0.0%)
Total: 65* respondents	**18 (27.7%)**	**11 (16.9%)**	**6 (9.2%)**	**14 (21.5%)**	**16 (24.6%)**

Source: KPMG (2025)

*Note: While there are only 61 actual respondents, there is a total of 65 distinct responses due to four respondents having more than one type of prosthesis.

Statement 2: There were minimal barriers to accessing a prosthesis that met my needs.

Table 56: Responses by jurisdiction to Statement 2

Response	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
New South Wales	15 (41.7%)	5 (13.9%)	4 (11.1%)	7 (19.4%)	5 (13.9%)
Victoria	0 (0.0%)	4 (66.7%)	1 (16.7%)	0 (0.0%)	1 (16.7%)
Queensland	5 (35.7%)	4 (28.6%)	1 (7.1%)	2 (14.3%)	2 (14.3%)
South Australia	1 (25.0%)	2 (50.0%)	0 (0.0%)	1 (25.0%)	0 (0.0%)
Tasmania	1 (100.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total: 61 respondents	**22 (36.1%)**	**15 (24.6%)**	**6 (9.8%)**	**10 (16.4%)**	**8 (13.1%)**

Source: KPMG (2025)

Table 57: Responses by remoteness to Statement 2

Response	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
Metropolitan area	12 (37.5%)	9 (28.1%)	3 (9.4%)	5 (15.6%)	3 (9.4%)
Regional centre	6 (31.6%)	3 (15.8%)	3 (15.8%)	3 (15.8%)	4 (21.0%)
Rural area	3 (33.3%)	3 (33.3%)	0 (0.0%)	2 (22.2%)	1 (11.1%)
Remote community	1 (100.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total: 61 respondents	**22 (36.1%)**	**15 (24.6%)**	**6 (9.8%)**	**10 (16.4%)**	**8 (13.1%)**

Source: KPMG (2025)

Table 58: Responses by prosthesis type to Statement 2

Response	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
Facial prosthesis	16 (41.0%)	8 (20.5%)	4 (10.3%)	5 (12.8%)	6 (15.4%)
An artificial breast worn in the bra	0 (0.0%)	1 (33.3%)	0 (0.0%)	2 (66.7%)	0 (0.0%)
Voice prostheses	1 (7.7%)	4 (30.8%)	3 (23.1%)	3 (23.1%)	2 (15.4%)
Dental prostheses	6 (66.7%)	2 (22.2%)	0 (0.0%)	1 (11.1%)	0 (0.0%)
Fat grafting	0 (0.0%)	1 (1.5%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total: 65 respondents	**23 (35.4%)**	**16 (24.6%)**	**7 (10.8%)**	**11 (16.9%)**	**8 (12.3%)**

Source: KPMG (2025)

Statement 3: The cost of the prosthesis impacted my decision making or ability to obtain a prosthesis .

Table 59: Responses by jurisdiction to Statement 3

Response	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
New South Wales	5 (13.9%)	1 (2.8%)	7 (19.4%)	5 (13.9%)	18 (50.0%)
Victoria	2 (33.3%)	0 (0.0%)	2 (33.3%)	1 (16.7%)	1 (16.7%)
Queensland	2 (14.3%)	0 (0.0%)	0 (0.0%)	5 (35.7%)	7 (50.0%)
South Australia	1 (25.0%)	0 (0.0%)	0 (0.0%)	1 (25.0%)	2 (50.0%)
Tasmania	1 (100.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total: 61 respondents	**11 (18.0%)**	**1 (1.6%)**	**9 (14.8%)**	**12 (19.7%)**	**28 (45.9%)**

Source: KPMG (2025)

Table 60: Responses by remoteness to Statement 3

Response	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
Metropolitan area	3 (9.4%)	1 (3.1%)	5 (15.6%)	8 (25.0%)	15 (46.9%)
Regional centre	6 (31.6%)	0 (0.0%)	3 (15.8%)	1 (5.3%)	9 (47.4%)
Rural area	2 (22.2%)	0 (0.0%)	1 (11.1%)	3 (33.3%)	3 (33.3%)
Remote community	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (100.0%)
Total: 61 respondents	**11 (18.0%)**	**1 (1.6%)**	**9 (14.8%)**	**12 (19.7%)**	**28 (45.9%)**

Source: KPMG (2025)

Table 61: Responses by prosthesis type to Statement 3

Response	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
Facial prosthesis	5 (12.8%)	1 (2.3%)	4 (10.3%)	7 (17.9%)	22 (56.4%)
An artificial breast worn in the bra	0 (0.0%)	0 (0.0%)	1 (33.3%)	2 (66.7%)	0 (0.0%)
Voice prostheses	5 (38.5%)	0 (0.0%)	5 (38.5%)	3 (23.1%)	0 (0.0%)
Dental prostheses	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (11.1%)	8 (88.9%)
Fat grafting	1 (100.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total: 65 respondents	**11 (16.9%)**	**1 (1.5%)**	**10 (15.4%)**	**13 (200%)**	**30 (46.2%)**

Source: KPMG (2025)

Statement 4: There was a long wait time to receive access to a prosthesis

Table 62: Responses by jurisdictions to Statement 4

Response	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
New South Wales	5 (13.9%)	5 (13.9%)	6 (16.7%)	9 (25.0%)	11 (30.6%)
Victoria	3 (50.0%)	1 (16.7%)	0 (0.0%)	2 (33.3%)	0 (0.0%)
Queensland	2 (14.3%)	3 (21.4%)	2 (14.3%)	1 (7.1%)	6 (42.9%)
South Australia	0 (0.0%)	0 (0.0%)	1 (25.0%)	2 (50.0%)	1 (25.0%)
Tasmania	0 (0.0%)	0 (0.0%)	1 (100.0%)	0 (0.0%)	0 (0.0%)
Total: 61 respondents	**10 (16.4%)**	**9 (14.8%)**	**10 (16.4%)**	**14 (23.0%)**	**18 (29.5%)**

Source: KPMG (2025)

Table 63: Responses by remoteness to Statement 4

Response	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
Metropolitan area	6 (18.8%)	5 (15.6%)	5 (15.6%)	7 (21.9%)	9 (28.1%)
Regional centre	3 (15.8%)	2 (10.5%)	5 (26.3%)	5 (26.3%)	4 (21.1%)
Rural area	1 (11.1%)	2 (22.2%)	0 (0.0%)	2 (22.2%)	4 (44.4%)
Remote community	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (100.0%)
Total: 61 respondents	**10 (16.4%)**	**9 (14.8%)**	**10 (16.4%)**	**14 (23.0%)**	**18 (29.5%)**

Source: KPMG (2025)

Table 64: Responses by prosthesis type to Statement 4

Response	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
Facial prosthesis	4 (10.3%)	4 (10.3%)	4 (10.3%)	10 (25.6%)	17 (43.6%)
An artificial breast worn in the bra	1 (33.3%)	0 (0.0%)	1 (33.3%)	1 (33.3%)	0 (0.0%)
Voice prostheses	5 (38.5%)	3 (23.1%)	3 (23.1%)	2 (15.4%)	0 (0.0%)
Dental prostheses	0 (0.0%)	3 (33.3%)	2 (22.2%)	1 (11.1%)	3 (33.3%)
Fat grafting	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (100.0%)	0 (0.0%)
Total: 65 respondents	**10 (15.4%)**	**10 (15.4%)**	**10 (15.4%)**	**15 (23.1%)**	**20 (30.8%)**

Source: KPMG (2025)

Statement 5: I had to travel a significant distance (e.g. to another city or town) to access a prosthesis

Table 65: Responses by jurisdiction to Statement 5

Response	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
New South Wales	10 (27.8%)	0 (0.0%)	8 (22.2%)	6 (16.7%)	12 (33.3%)
Victoria	3 (50.0%)	0 (0.0%)	2 (33.3%)	0 (0.0%)	1 (16.7%)
Queensland	4 (28.6%)	0 (0.0%)	3 (21.4%)	1 (7.1%)	6 (42.9%)
South Australia	2 (50.0%)	0 (0.0%)	1 (25.0%)	1 (25.0%)	0 (0.0%)
Tasmania	0 (0.0%)	0 (0.0%)	0 (0.00%)	0 (0.0%)	1 (100.0%)
Total: 61 respondents	**19 (31.2%)**	**0 (0.0%)**	**14 (23.0%)**	**8 (13.1%)**	**20 (32.8%)**

Source: KPMG (2025)

Table 66: Responses by remoteness to Statement 5

Response	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
Metropolitan area	14 (43.8%)	0 (0.0%)	12 (37.5%)	3 (9.4%)	3 (9.4%)
Regional centre	3 (15.8%)	0 (0.0%)	0 (0.0%)	4 (21.1%)	12 (63.2%)
Rural area	2 (22.2%)	0 (0.0%)	2 (22.2%)	1 (11.1%)	4 (44.4%)
Remote community	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (100.0%)
Total: 61 respondents	**19 (31.2%)**	**0 (0.0%)**	**14 (23.0%)**	**8 (13.1%)**	**20 (32.8%)**

Source: KPMG (2025)

Table 67: Responses by prosthesis type to Statement 5

Response	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
Facial prosthesis	9 (23.1%)	0 (0.0%)	8 (20.5%)	6 (15.4%)	16 (41.0%)
An artificial breast worn in the bra	2 (66.7%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (33.3%)
Voice prostheses	7 (53.9%)	0 (0.0%)	3 (23.1%)	1 (7.7%)	2 (15.4%)
Dental prostheses	4 (44.4%)	0 (0.0%)	3 (33.3%)	1 (11.1%)	1 (11.1%)
Fat grafting	0 (0.0%)	0 (0.0%)	1 (100.0%)	0 (0.0%)	0 (0.0%)
Total: 65 respondents	**22 (33.9%)**	**0 (0.0%)**	**15 (23.1%)**	**8 (12.%)**	**20 (30.8%)**

Source: KPMG (2025)

Statement 6: My prosthesis has improved my quality of life

Table 68:Responses by jurisdiction to Statement 6

Response	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
New South Wales	2 (5.6%)	1 (2.8%)	3 (8.3%)	5 (13.9%)	25 (69.4%)
Victoria	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	6 (100.0%)
Queensland	0 (0.0%)	0 (0.0%)	1 (7.1%)	2 (14.3%)	11 (78.6%)
South Australia	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	4 (100.0%)
Tasmania	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (100.0%)
Total: 61 respondents	**2 (3.3%)**	**1 (1.6%)**	**4 (6.6%)**	**7 (11.5%)**	**47 (77.0%)**

Source: KPMG (2025)

Table 69:Responses by remoteness to Statement 6

Response	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
Metropolitan area	1 (3.1%)	0 (0.0%)	2 (6.3%)	2 (6.3%)	27 (84.4%)
Regional centre	1 (5.3%)	0 (0.0%)	0 (0.0%)	4 (21.0%)	14 (73.7%)
Rural area	0 (0.0%)	1 (11.1%)	1 (11.1%)	1 (11.1%)	6 (66.7%)
Remote community	0 (0.0%)	0 (0.0%)	1 (100.0%)	0 (0.0%)	0 (0.0%)
Total: 61 respondents	**2 (3.3%)**	**1 (1.6%)**	**4 (6.6%)**	**7 (11.5%)**	**47 (77.0%)**

Source: KPMG (2025)

Table 70: Responses by prosthesis type to Statement 6

Response	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
Facial prosthesis	2 (5.1%)	0 (0.0%)	1 (2.6%)	4 (10.3%)	32 (82.1%)
An artificial breast worn in the bra	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	3 (100.0%)
Voice prostheses	1 (7.7%)	0 (0.0%)	0 (0.0%)	2 (15.4%)	5 (76.9%)
Dental prostheses	0 (0.0%)	1 (11.1%)	3 (33.3%)	2 (22.2%)	3 (33.3%)
Fat grafting	0 (0.0%)	0 (0.0%)	0 (0.00%)	0 (0.0%)	1 (100.0%)
Total: 65 respondents	**3 (4.6%)**	**1 (1.5%)**	**4 (6.2%)**	**8 (12.3%)**	**49 (75.4%)**

Source: KPMG (2025)

Statement 7: My prosthesis has improved my daily functioning

Table 71: Responses by jurisdiction to Statement 7

Response	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
New South Wales	2 (5.6%)	1 (2.8%)	5 (13.89%)	5 (13.9%)	23 (63.9%)
Victoria	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	6 (100.0%)
Queensland	0 (0.0%)	1 (7.1%)	2 (14.3%)	2 (14.3%)	9 (64.3%)
South Australia	0 (0.0%)	1 (25.0%)	0 (0.0%)	0 (0.0%)	3 (75.0%)
Tasmania	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (100.0%)
Total: 61 respondents	**2 (3.3%)**	**3 (4.%)**	**7 (11.%)**	**7 (11.5%)**	**42 (68.9%)**

Source: KPMG (2025)

Table 72: Responses by remoteness to Statement 7

Response	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
Metropolitan area	1 (3.1%)	2 (6.3%)	4 (12.5%)	2 (6.3%)	23 (71.9%)
Regional centre	1 (5.3%)	0 (0.0%)	0 (0.0%)	4 (21.1%)	14 (73.7%)
Rural area	0 (0.0%)	1 (11.1%)	2 (22.2%)	1 (11.1%)	5 (55.6%)
Remote community	0 (0.0%)	0 (0.0%)	1 (100.0%)	0 (0.0%)	0 (0.0%)
Total: 61 respondents	**2 (3.3%)**	**3 (4.9%)**	**7 (11.5%)**	**7 (11.5%)**	**42 (68.9%)**

Source: KPMG (2025)

Table 73: Responses by prosthesis type to Statement 7

Response	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
Facial prosthesis	2 (5.1%)	1 (2.6%)	5 (12.8%)	3 (7.7%)	28 (71.8%)
An artificial breast worn in the bra	0 (0.0%)	1 (33.3%)	1 (33.3%)	0 (0.0%)	1 (33.3%)
Voice prostheses	1 (7.7%)	0 (0.0%)	0 (0.0%)	2 (15.4%)	10 (76.9%)
Dental prostheses	0 (0.0%)	2 (22.2%)	3 (33.3%)	2 (22.2%)	2 (22.2%)
Fat grafting	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (100.0%)
Total: 65 respondents	**3 (4.6%)**	**4 (6.2%)**	**9 (13.9%)**	**7 (10.8%)**	**42 (64.6%)**

Source: KPMG (2025)

Statement 8: My prosthesis has supported my emotional wellbeing

Table 74: Responses by jurisdiction to Statement 8

Response	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
New South Wales	1 (2.8%)	2 (5.6%)	3 (8.3%)	5 (13.9%)	25 (69.4%)
Victoria	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (16.7%)	5 (83.3%)
Queensland	0 (0.0%)	1 (7.1%)	1 (7.1%)	1 (7.1%)	11 (78.6%)
South Australia	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (25.0%)	3 (75.0%)
Tasmania	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (100.0%)
Total: 61 respondents	**1 (1.6%)**	**3 (4.9%)**	**4 (6.6%)**	**8 (13.1%)**	**45 (73.8%)**

Source: KPMG (2025)

Table 75: Responses by remoteness to Statement 8

Response	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
Metropolitan area	1 (3.1%)	0 (0.0%)	2 (6.3%)	4 (12.5%)	25 (78.1%)
Regional centre	0 (0.0%)	2 (10.5%)	0 (0.0%)	3 (15.8%)	14 (73.7%)
Rural area	0 (0.0%)	1 (11.1%)	1 (11.1%)	1 (11.1%)	6 (66.7%)
Remote community	0 (0.0%)	0 (0.0%)	1 (100.0%)	0 (0.0%)	0 (0.0%)
Total: 61 respondents	**1 (1.6%)**	**3 (4.9%)**	**4 (6.6%)**	**8 (13.1%)**	**45 (73.8%)**

Source: KPMG (2025)

Table 76: Responses by prosthesis type to Statement 8

Response	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
Facial prosthesis	2 (5.1%)	0 (0.0%)	1 (2.6%)	3 (7.7%)	33 (84.%)
An artificial breast worn in the bra	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	3 (100.0%)
Voice prostheses	0 (0.0%)	2 (15.4%)	0 (0.0%)	4 (30.8%)	7 (53.9%)
Dental prostheses	0 (0.0%)	1 (11.1%)	3 (33.3%)	2 (22.2%)	3 (33.3%)
Fat grafting	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (100.0%)
Total: 65 respondents	**2 (3.1%)**	**3 (4.6%)**	**4 (6.2%)**	**9 (13.9%)**	**47 (72.3%)**

Source: KPMG (2025)

7. Did you have to pay an out-of-pocket fee for your prosthesis (or the prosthesis used by the person you care for)? [single answer, mandatory]

- Yes
- No

If 'Yes' is selected for Q7, Q8 will appear. If 'No' is selected for Q7, proceed directly to Q9.

Table 77:Responses to Question 7 by jurisdiction

Response	Number of "yes" respondents t	Proportion of "yes" respondents	Number of "No" respondents	Proportion of "No" respondents
New South Wales	19	52.8%	17	47.2%
Victoria	2	33.3%	4	66.7%
Queensland	9	64.3%	5	35.7%
South Australia	2	50.0%	2	50.0%
Tasmania	1	100.0%	0	0.0%
Total: 61 respondents	**33**	**54.1%**	**28**	**45.9%**

Source: KPMG (2025)

Table 78: Responses to Question 7 by remoteness

Response	Number of "Yes" respondents	Proportion of "Yes" respondents	Number of "No" respondents	Proportion of "No" respondents
Metropolitan area	14	43.8%	18	56.3%
Regional centre	11	57.9%	8	42.1%
Rural area	8	88.9%	1	11.1%
Remote community	0	0.0%	1	100.0%
Total: 61 respondents	**33**	**54.1%**	**28**	**45.9%**

Source: KPMG (2025)

Table 79: Responses to Question 7 by prosthesis type

Response	Number of "Yes" respondents	Proportion of "Yes" respondents	Number of "No" respondents	Proportion of "No" respondents
Facial prosthesis	19	52.8%	17	47.2%
An artificial breast worn in the bra	2	66.7%	1	33.3%
Voice prostheses	5	38.5%	8	61.5%
Dental prostheses	6	75.0%	2	25.0%
Fat grafting	1	100.0%	0	0.0%
Total: 65 respondents	**33**	**54.1%**	**28**	**45.9%**

Source: KPMG (2025)

8. How much was the out-of-pocket cost for your prosthesis (or the prosthesis used by the person you care for)? [free text, required]

29 respondents responded with a figure. These costs are assumed to only cover one prosthesis/ one operation. Two respondents who have multiple prostheses each only provided one figure, and it is unclear which prostheses they are referring to. Two respondents who provided a percentage (e.g., I pay 80% of the cost) have not been included.

The average out-of-pocket cost reported is $6,300, ranging from $100 to $39,000.

Each column outlines the number of respondents, and the proportion of respondents within each row indicated in an accompanying bracket.

Table 80: Responses to Question 8 by jurisdiction

Response	$100 - $999	$1,000 - $4,999	$5,000 - $9,999	$10,000 or more
New South Wales	5 (29.4%)	5 (29.4%)	6 (35.3%)	1 (5.9%)
Victoria	0 (0.0%)	1 (50.0%)	0 (0.0%)	1 (50.0%)
Queensland	1 (12.5%)	1 (12.5%)	4 (50.0%)	2 (25.0%)
South Australia	2 (66.7%)	1 (33.3%)	0 (0.0%)	0 (0.0%)
Tasmania	0 (0.0%)	0 (0.0%)	1 (100.0%)	0 (0.0%)
Total: 31* responses	**8 (25.8%)**	**8 (25.8%)**	**11** (35.5%)	**4 (12.9%)**

Source: KPMG (2025)

*Note: While there are only 29 respondents, there is a total of 31 distinct responses due to two respondents having more than one type of prosthesis.

Table 81: Responses to Question 8 by remoteness

Response	$100 - $999	$1,000 - $4,999	$5,000 - $9,999	$10,000 or more
Metropolitan area	5 (41.67%)	2 (16.67%)	3 (25.00%)	2 (16.67%)
Regional centre	2 (18.18%)	3 (27.27%)	5 (45.45%)	2 (9.09%)
Rural area	1 (12.50%)	3 (37.50%)	3 (37.50%)	1 (12.50%)
Remote community	0 (0.00%)	0 (0.00%)	0 (0.00%)	0 (0.00%)
Total: 31 responses	**8 (25.81%)**	**8 (25.81%)**	**11 (35.48%)**	**5 (12.90%)**

Source: KPMG (2025)

Table 82: Responses to Question 8 by prosthesis type

Response	$100 - $999	$1,000 - $4,999	$5,000 - $9,999	$10,000 or more
Facial prosthesis	2 (10.5%)	4 (21.1%)	10 (52.6%)	3 (15.8%)
An artificial breast worn in the bra	2 (66.7%)	1 (33.3%)	0 (0.0%)	0 (0.0%)
Voice prostheses	3 (75.0%)	1 (25.0%)	0.0%	0.0%
Dental prostheses	3 (20.0%)	1 (40.0%)	1 (20.0%)	1 (20.0%)
Fat grafting	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (100.0%)
Total: 31 responses	**8 (25.0%)**	**8 (25.0%)**	**11 (34.4%)**	**5 (15.6%)**

Source: KPMG (2025)

9. Did you have access to any of the following funding sources for your prosthesis (or the prosthesis used by the person you care for)? [multi answer, mandatory]

- NDIS
- Department of Veterans Affairs (DVA)
- State/territory health department program/scheme
- Private health insurance
- Charity
- Philanthropic source
- Family / friends / other relatives
- Other, please specify [free text, not required]

Six respondents identified another funding source that was not included in the survey options. These funding sources are:

- Two respondents identified Medicare as their funding source – they both had an external breast prosthesis,
- Two respondents identified their hospital as their funding source – they both had a prosthetic nose and one respondent had an additional soft or hard palate prosthesis,
- One respondent identified part of their superannuation pension as their funding source, and
- One respondent did not specify their funding source.

Each column outlines the number of respondents, and the proportion of respondents within each row indicated in an accompanying bracket.

Table 83: Responses to Question 9 by jurisdiction

Jurisdiction	NDIS	DVA	State / territory health depart-ment	Private health insuran ce	Charity	Philant-hropic source	Family / friends/ other relatives	Other	No funding access-ed
New South Wales	2 (5.1%)	1 (2.5%)	11 (28.2%)	2 (5.1%)	1 (2.6%)	0 (0.0%)	0 (0.0%)	6 (15.4%)	16 (41.0%)
Victoria	0 (0.0%)	0 (0.0%)	2 (3.3%)	2 (3.3%)	2 (3.3%)	0 (0.0%)	1 (16.7%)	0 (0.0%)	1 (16.7%)
Queensland	0 (0.0%)	0 (0.0%)	0 (0.0%)	2 (13.3%)	2 (13.3%)	0 (0.0%)	3 (20.0%)	1 (6.7%)	7 (46.7%)
South Australia	0 (0.0%)	0 (0.0%)	2 (40.00%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	3 (60.0%)
Tasmania	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (100.0%)
Total: 66* responses	**2 (3.0%)**	**1 (1.5%)**	**15 (22.7%)**	**6 (9.1%)**	**3 (4.6%)**	**0 (0.0%)**	**4 (6.06%)**	**7 (10.6%)**	**28 (42.4%)**

Source: KPMG (2025)

*Note: While there are 61 respondents, a few respondents had their responses recorded twice in these tables, outlined below:

- One respondent identified two different funding sources for their single prosthesis – private health insurance and family / friends / other.
- Four respondents identified the same funding source for both their prostheses. Two of these four respondents said they did not access funding. One respondent identified their hospital as their funding source. One respondent identified a state / territory health department program / scheme as their funding source – they have an artificial soft or hard palate and a dental prosthesis.

Table 84: Responses to Question 9 by remoteness

Response	NDIS	DVA	State / territory health depart-ment	Private health insura-nce	Charity	Philant-hropic source	Family / friends/ other relatives	Other	No funding access-ed
Metropolitan area	0 (0.0%)	0 (0.0%)	12 (33.3%)	4 (11.1%)	2 (5.6%)	0 (0.0%)	2 (5.6%)	5 (13.9%)	11 (30.6%)
Regional centre	2 (10.5%)	1 (5.3%)	2 (10.5%)	0 (0.0%)	1 (5.3%)	0 (0.0%)	2 (10.5%)	2 (10.5%)	9 (47.4%)
Rural area	0 (0.0%)	0 (0.0%)	1 (10.0%)	2 (20.00%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	7 (70.0%)
Remote community	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (100.0%)
Total: 66* responses	**2 (3.0%)**	**1 (1.5%)**	**15 (22.7%)**	**6 (9.09%)**	**3 (4.6%)**	**0 (0.0%)**	**4 (6.1%)**	**7 (10.6%)**	**28 (42.4%)**

Source: KPMG (2025)

Table 85: Responses to Question 9 by prosthesis type

Response	NDIS	DVA	State / territory health depart-ment	Private health insura-nce	Charity	Philant-hropic source	Family / friends/ other relatives	Other	No funding access-ed
Facial prosthesis	2 (5%)	1 (2.5%)	9 (22.5%)	2 (5.0%)	3 (7.5%)	0 (0.0%)	4 (10.0%)	5 (12.5%)	14 (35.0%)
An artificial breast worn in the bra	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	2 (66.7%)	1 (33.3%)
Voice prostheses	0 (0.0%)	0 (0.0%)	5 (38.5%)	1 (7.7%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	7 (53.9%)
Dental prostheses	0 (0.0%)	0 (0.0%)	1 (11.1%)	3 (33.3%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	5 (55.6%)
Fat grafting	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (100.0%)
Total: 66* responses	**2 (3.0%)**	**1 (1.5%)**	**15 (22.7%)**	**6 (9.1%)**	**3 (4.6%)**	**0 (0.0%)**	**4 (6.0%)**	**7 (10.6%)**	**28 (42.4%)**

Source: KPMG (2025)

10. If you could recommend one immediate change to improve access to prostheses for people living with or have lived experience of cancer, what would it be? [free text, not required]

Table 86: Responses to Question 10 by theme

Theme	Details
Timely and available access	Not having access to prostheses/ not knowing if their prostheses will be approved for provision have significant psychological and social impacts on individuals More prosthetic specialists to meet demand and reduce waitlists
Funding support	Public funding to cover prostheses Amendment of private health funds to allow for prosthetic cover Being able to claim the rebate for external breast prostheses immediately, which can help individuals who do not have cash up front for purchase
Access to information	More straightforward processes for accessing prostheses Having access to prostheses as an option in treatment plans – as individuals may not know about prostheses
Access to wraparound services	Having access to support items to maintain and support the prosthesis (e.g., bras holding breast prostheses) Having access to wraparound rehabilitation services such as speech pathologists Greater flexibility on the Medicare rebate for breast prostheses – being able to use this money instead to replace support items that can wear out before the prostheses

Source: KPMG (2025)

11. Is there anything else you would like to share? [free text, not required]

Table 87: Responses to Question 11 by theme

Theme	Details
Impact of prostheses on function, self-esteem, and recovery	Dental prostheses allow individuals with lived experience of cancer to regain their function for speech and eating. Not having a prosthesis due to its financial cost affects their quality of life significantly A lack of facial prostheses mean that individuals with lived experience of cancer are missing a part of their face, resulting in them not wanting to leave their house, giving up their job, and giving up their social life. The psychological impact of this is debilitating People with lived experience of cancer have had to cut back on food, medicine, and entertainment to save up for their prostheses
Funding support	Facial prostheses should be funded by the government as they are a critical part of recovery Amending the Prescribed List to include prostheses allow those with private health insurance to have more options for funding support
Location of services	Many individuals have to travel great distances to access services, as there are few services in regional, rural, or remote areas
Workforce availability	The wait times to receive a prosthesis is substantial. There should be more people who can manufacture prosthesis in Australia This can be through incentives such as funding for training pathways for these professionals
Importance of support items	Support items such as medical compression products and mastectomy bras are used with the prostheses but are not funded.

Source: KPMG (2025)

B.3 Survey of clinicians involved in the delivery of prostheses services

Similar to the survey of people living with or with lived experience of cancer and their carers, not all respondents provided a response to every question, therefore the number of respondents for each question fluctuates. The total number of respondents are noted in each question.

A total of 57 respondents provided a response for every mandatory question in the survey. On the other hand, 40 other respondents started the survey but did not complete it. The most common drop-off question was question 5.

1. In what state/territory do you practice? [single answer, mandatory]

Table 88: Response to question 1

Response	Number of respondents	Proportion of total respondents (%)
New South Wales	26	31.3
Victoria	27	32.5
Queensland	14	16.9
Western Australia	5	6.0
South Australia	6	7.2
Australian Capital Territory	2	2.4
Tasmania	1	1.2
Northern Territory	2	2.4
Total	**83**	**100**

Source: KPMG (2025)

2. How would you describe the area where you practice? [single answer, mandatory]

Table 89: Response to question 2

Response	Number of respondents	Proportion of total respondents (%)
Metropolitan area	62	74.7
Regional centre	18	21.7
Rural area	3	3.6
Remote community	0	0
Total	**83**	**100**

Source: KPMG (2025)

3. What is your speciality or area of practice? [single answer, mandatory]

- Anaplastology
- Dentistry
- Oncology
- Oral and maxillofacial surgery
- Orthopaedic surgery
- Orthotics and prosthetics
- Otolaryngology head and neck surgery
- Plastic and reconstructive surgery
- Prosthodontics
- Psychology or social work
- Research / academia
- Other, please specify [free text, not required]

Table 90: Response to question 3

Response	Number of respondents	Proportion of total respondents (%)
Anaesthesia	1	1.8
Anaplastology	5	8.8
Dentistry / dental oncology **Includes the following practitioners: oral health specialists, oral medicine specialists**	8	14.0
Lymphatic system **Includes the following practitioners: lymphologists, lymphoedema physiotherapists or therapists**	6	10.5
Oncology **Includes surgical oncology, radiation oncology, and medical oncology**	10	17.5
Oral and maxillofacial **Includes oral and maxillofacial surgery and maxillofacial prosthetics**	7	12.3
Orthopaedic surgery	0	0.0
Orthotics and prosthetics	0	0.0
Otolaryngology head and neck surgery	9	15.8
Plastic and reconstructive surgery	2	3.5
Prosthodontics **Includes maxillofacial prosthodontics**	2	3.5
Psychology or social work	2	3.5
Research / academia	1	1.8
Speech pathology	3	5.3
Multiple areas of practice*	1	1.8
Total	**57**	**100**

Source: KPMG (2025)

*Note: One respondent described themselves as a nurse in oral and maxillofacial surgery, otolaryngology head and neck surgery, and plastic and reconstructive surgery.

4. From your perspective, what are the most significant barriers for people living with or who have a lived experience of cancer to access prostheses? [multi answer, mandatory]

- Cost / access to funding
- Availability of prostheses services / skilled professions
- Availability of prostheses
- Wait times
- Other, please specify [free text, not required]

As this question allowed for respondents to select multiple options (and respondents often did), the total number of responses in the tables exceed the number of respondents.

The following dot points outlines the five “Other” responses for this question. All five responses were different from one another. These responses have an accompanying bracket that describes the respondent.

- Awareness around the available services. (Victoria; metropolitan; oncology)
- Availability of surgery to get initial implants (Victoria; metropolitan; multiple areas of practice)
- Public funding as part of an overall treatment plan (Victoria; metropolitan; dentistry)
- Clinician subjectivity in identifying needs of people with lived experience of cancer (Western Australia; metropolitan; lymphatic system)
- Availability of services to people from remote areas (Northern Territory; regional; dentistry)

Table 91: Response to question 4 by jurisdiction

Response	Cost / access to funding	Availability of prostheses services / skilled professions	Availability of prostheses	Wait times	Other
New South Wales	15 (39.7%)	12 (31.6%)	5 (13.2%)	6 (15.8%)	0 (0.0%)
Victoria	18 (35.3%)	15 (29.4%)	6 (11.8%)	9 (17.7%)	3 (5.9%)
Queensland	9 (37.5%)	7 (29.2%)	4 (16.7%)	4 (16.7%)	0 (0.0%)
South Australia	5 (33.3%)	5 (33.3%)	3 (20.0%)	2 (13.3%)	0 (0.0%)
Western Australia	2 (33.3%)	2 (33.3%)	0 (0.0%)	1 (16.7%)	1 (16.7%)
Northern Territory	1 (16.7%)	1 (16.7%)	1 (16.7%)	2 (33.3%)	1 (16.7%)
Total: 57 respondents / 138 responses	**50 (35.7%)**	**49 (30.0%)**	**19 (13.6%)**	**24 (17.1%)**	**5 (3.6%)**

Source: KPMG (2025)

Table 92: Response to question 4 by remoteness

Response	Cost / access to funding	Availability of prostheses services / skilled professions	Availability of prostheses	Wait times	Other
Metropolitan	38 (35.9%)	34 (32.1%)	14 (13.2%)	16 (15.1%)	4 (3.8%)
Regional centre	10 (40.0%)	6 (24.0%)	3 (12.0%)	5 (20.0%)	1 (4.0%)
Rural area	2 (28.6%)	2 (28.6%)	2 (28.6%)	1 (14.3%)	0 (0.0%)
Total: 57 respondents / 138 responses	**50 (36.2%)**	**42 (30.4%)**	**19 (13.8%)**	**22 (15.9%)**	**5 (3.6%)**

Source: KPMG (2025)

Table 93: Response to question 4 by area of practice

Response	Cost / access to funding	Availability of prostheses services / skilled professions	Availability of prostheses	Wait times	Other
Anaesthesia	1 (100.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Anaplastology	5 (41.7%)	4 (33.3%)	1 (8.3%)	2 (16.7%)	0 (0.0%)
Dentistry / dental oncology	7 (30.4%)	8 (34.8%)	2 (8.7%)	4 (17.4%)	2 (8.7%)
Lymphatic system	5 (33.3%)	4 (26.7%)	1 (6.7%)	4 (26.7%)	1 (6.7%)
Oncology	10 (41.7%)	8 (33.3%)	4 (16.7%)	1 (4.2%)	1 (4.2%)
Oral and maxillofacial	6 (33.3%)	6 (33.3%)	3 (16.7%)	3 (16.7%)	0 (0.0%)
Otolaryngology head and neck surgery	7 (36.8%)	6 (31.6%)	3 (15.8%)	3 (15.8%)	0 (0.0%)
Plastic and reconstructive surgery	1 (25.0%)	1 (25.0%)	1 (25.0%)	1 (25.0%)	0 (0.0%)
Prosthodontics	2 (50.0%)	1 (25.0%)	0 (0.0%)	1 (25.0%)	0 (0.0%)
Psychology or social work	2 (40.0%)	1 (20.0%)	1 (20.0%)	1 (20.0%)	0 (0.0%)
Research / academia	1 (33.3%)	1 (33.3%)	1 (33.3%)	0 (0.0%)	0 (0.0%)
Speech pathology	2 (33.3%)	2 (33.3%)	1 (16.7%)	1 (16.7%)	0 (0.0%)
Multiple areas of practice	1 (25.0%)	0 (0.0%)	1 (25.0%)	1 (25.0%)	1 (25.0%)
Total: 57 respondents / 138 responses	**50 (36.2%)**	**42 (30.4%)**	**19 (13.8%)**	**22 (15.9%)**	**5 (3.6%)**

Source: KPMG (2025)

5. In your experience, what are the most common funding schemes / mechanisms accessed by people requiring a prosthesis? [multi answer, mandatory]

- NDIS
- Department of Veterans Affairs (DVA)
- State / territory health department program / scheme
- Private health insurance
- Charity
- Philanthropic sources
- Family / friends / other relatives
- Other, please specify [free text, not required]

The following dot points outlines the five “Other” responses for this question. These responses have an accompanying bracket that describes the respondent.

- Not available in South Australia (South Australia; metropolitan; otolaryngology head and neck surgery)
- Medicare (Queensland; metropolitan; lymphatic system)

- Public funding as part of an overall treatment plan (Western Australia; metropolitan; oral and maxillofacial)
- Self-funding (South Australia; metropolitan; lymphatic system)
- Self-funding (Victoria; metropolitan; speech pathology)

Responses by jurisdictions

Table 94: Response to question 5 by jurisdiction

Jurisdiction	NDIS	DVA	State / territory health depart-ment	Private health insurance	Charity	Philanth-ropic source	Family / friends/ other relatives	Other
New South Wales	1 (2.6%)	4 (10.3%)	5 (12.8%)	6 (15.38%)	7 (17.9%)	7 (18.0%)	9 (23.1%)	0 (0.0%)
Victoria	1 (2.9%)	4 (11.8%)	15 (44.1%)	4 (11.76%)	4 (11.8%)	0 (0.0%)	5 (14.7%)	1 (2.9%)
Queensland	3 (14.3%)	5 (23.8%)	5 (23.8%)	3 (14.29%)	2 (9.5%)	0 (0.0%)	2 (9.5%)	1 (4.8%)
South Australia	1 (11.1%)	0 (0.0%)	2 (22.2%)	2 (22.22%)	0 (0.0%)	0 (0.0%)	2 (22.2%)	2 (22.2%)
Western Australia	0 (0.0%)	1 (16.7%)	2 (33.3%)	1 (20.00%)	0 (0.0%)	0 (0.0%)	1 (20.0%)	1 (20.0%)
Northern Territory	0 (0.0%)	0 (0.0%)	1 (33.3%)	1 (33.33%)	0 (0.0%)	0 (0.0%)	1 (33.3%)	0 (0.0%)
Total: 57 respondents / 112 responses	**6 (5.4%)**	**14 (12.5%)**	**30 (26.8%)**	**17 (15.18%)**	**13 (11.%)**	**7 (6.25%)**	**20 (17.9%)**	**5 (4.5%)**

Source: KPMG (2025)

Table 95: Response to question 5 by remoteness

Response	NDIS	DVA	State / territory health depart-ment	Private health insurance	Charity	Philanth-ropic source	Family / friends/ other relatives	Other
Metropolitan	4 (4.6%)	11 (12.6%)	25 (28.7%)	13 (14.9%)	9 (10.3%)	6 (6.9%)	14 (16.1%)	5 (5.8%)
Regional centre	2 (9.5%)	3 (14.3%)	5 (23.8%)	2 (9.5%)	3 (14.3%)	1 (4.8%)	5 (23.8%)	0 (0.0%)
Rural area	0 (0.0%)	0 (0.0%)	0 (0.0%)	2 (50.0%)	1 (25.0%)	0 (0.0%)	1 (25.0%)	0 (0.0%)
Total: 57 respondents / 112 responses	**6 (5.4%)**	**14 (12.5%)**	**30 (26.8%)**	**17 (15.2%)**	**13 (11.6%)**	**7 (6.3%)**	**20 (17.9%)**	**5 (4.5%)**

Source: KPMG (2025)

Table 96: Response to question 5 by area of practice

Response	NDIS	DVA	State / territory health depart-ment	Private health insurance	Charity	Philanth-ropic source	Family / friends/ other relatives	Other
Anaesthesia	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (100.0%)	0 (0.0%)
Anaplastology	2 (16.7%)	2 (16.7%)	3 (25.0%)	1 (8.3%)	1 (8.3%)	1 (8.3%)	0 (0.0%)	0 (0.0%)
Dentistry / dental oncology	0 (0.0%)	0 (0.0%)	6 (40.0%)	3 (20.0%)	4 (26.7%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Lymphatic system	1 (9.1%)	0 (0.0%)	2 (18.2%)	3 (27.3%)	2 (18.2%)	0 (0.0%)	2 (18.2%)	1 (9.1%)
Oncology	2 (10.5%)	3 (15.8%)	5 (26.3%)	4 (21.1%)	2 (10.5%)	1 (5.3%)	0 (0.0%)	0 (0.0%)
Oral and maxillofacial	0 (0.0%)	3 (18.8%)	4 (25.%)	3 (18.8%)	1 (6.3%)	1 (6.3%)	1 (6.3%)	1 (6.3%)
Otolaryngology head and neck surgery	0 (0.0%)	3 (18.8%)	3 (18.8%)	1 (6.3%)	1 (6.3%)	3 (18.8%)	1 (6.3%)	1 (6.3%)
Plastic and reconstructive surgery	0 (0.0%)	0 (0.0%)	2 (66.7%)	0 (0.0%)	0 (00%)	0 (0.0%)	0 (0.0%)	1 (33.3%)
Prosthodontics	0 (0.0%)	1 (25.0%)	2 (50.0%)	1 (25.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Psychology or social work	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (25.0%)	1 (25.0%)	1 (25.0%)	1 (25.0%)	0 (0.0%)
Research / academia	1 (25.0%)	1 (25.0%)	0 (0.0%)	0 (0.0%)	1 (25.0%)	0 (0.0%)	1 (25.0%)	0 (0.0%)
Speech pathology	0 (0.0%)	0 (0.0%)	2 (50.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (25.0%)	1 (25.0%)
Multiple areas of practice	0 (0.0%)	1 (50.0%)	1 (50.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total: 57 respondents / 112 responses	**6 (5.4%)**	**14 (12.5%)**	**30 (26.8%)**	**17 (15.2%)**	**13 (11.6%)**	**7 (6.3%)**	**20 (17.9%)**	**5 (4.5%)**

Source: KPMG (2025)

6. In your experience, what is the average cost of a prosthesis? When thinking about the cost, please consider the total cost, including parts, labour and fitting of the prosthesis. [free text, not required]

7. In your experience, are there particular prostheses that are more difficult to access than others through existing schemes? [multi answer, mandatory]

- Limb prostheses including: Arm prostheses fitted at, above or below the elbow, including hand and finger prostheses and leg prostheses fitted at, above or below the knee, including foot and toe prostheses
- Facial prostheses including: Prosthetic ears, noses, eyeballs, orbital prosthetics, hemi-facial prosthetics, artificial soft or hard palates
- An artificial breast worn in the bra
- Other, please specify [free text, not required]

Of the facial prostheses, the most common prosthesis named as being difficult to access is a prosthetic nose. 28 out of 57 (49.1%) respondents selected this option for this question. Of the "other" responses, the most common prosthesis named are dental prostheses, with eight out of 17 respondents listing that as a response.

Table 97: Response to question 7 by jurisdiction

Response	Limb prostheses	Facial prostheses	Artificial breast worn in the bra	Other
New South Wales	0 (0.0%)	43 (93.5%)	0 (0.0%)	3 (6.5%)
Victoria	0 (0.0%)	42 (80.8%)	0 (0.0%)	10 (19.2%)
Queensland	0 (0.0%)	13 (81.3%)	0 (0.0%)	3 (18.8%)
South Australia	0 (0.0%)	19 (95.0%)	0 (0.0%)	1 (5.0%)
Western Australia	0 (0.0%)	6 (100.0%)	0 (0.0%)	0 (0.0%)
Northern Territory	0 (0.0%)	2 (100.0%)	0 (0.0%)	0 (0.0%)
Total: 57 respondents / 142 responses	**0 (0.0%)**	**125 (88.0%)**	**0 (0.0%)**	**17 (12.0%)**

Source: KPMG (2025)

Table 98: Response to question 7 by remoteness

Response	Limb prostheses	Facial prostheses	Artificial breast worn in the bra	Other
Metropolitan	0 (0.0%)	97 (86.6%)	0 (0.00%)	15 (13.4%)
Regional centre	0 (0.0%)	19 (90.5%)	0 (0.00%)	2 (9.5%)
Rural area	0 (0.0%)	9 (100.%)	0 (0.00%)	0 (0.0%)
Total: 57 respondents / 142 responses	**0 (0.0%)**	**125 (88.0%)**	**0 (0.0%)**	**17 (12.0%)**

Source: KPMG (2025)

Table 99: Response to question 7 by area of practice

Response	Limb prostheses	Facial prostheses	Artificial breast worn in the bra	Other
Anaesthesia	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Anaplastology	0 (0.0%)	18 (94.7%)	0 (0.0%)	1 (5.3%)
Dentistry / dental oncology	0 (0.0%)	11 (78.6%)	0 (0.0%)	3 (21.4%)
Lymphatic system	0 (0.0%)	6 (75.0%)	0 (0.0%)	2 (25.0%)
Oncology	0 (0.0%)	22 (95.7%)	0 (0.0%)	1 (4.3%)
Oral and maxillofacial	0 (0.0%)	21 (87.5%)	0 (0.0%)	3 (12.5%)
Otolaryngology head and neck surgery	0 (0.0%)	20 (83.3%)	0 (0.0%)	4 (16.7%)
Plastic and reconstructive surgery	0 (0.0%)	4 (100.0%)	0 (0.0%)	0 (0.0%)
Prosthodontics	0 (0.0%)	1 (50.0%)	0 (0.0%)	1 (50.0%)
Psychology or social work	0 (0.0%)	6 (100.0%)	0 (0.0%)	0 (0.0%)
Research / academia	0 (0.0%)	3 (100.0%)	0 (0.0%)	0 (0.0%)
Speech pathology	0 (0.0%)	8 (88.9%)	0 (0.0%)	1 (1.1%)
Multiple areas of practice	0 (0.0%)	5 (83.3%)	0 (0.0%)	1 (16.7%)
Total: 57 respondents / 111 responses	**0 (0.0%)**	**125 (88.0%)**	**0 (0.0%)**	**17 (12.0%)**

Source: KPMG (2025)

8. If a national Cancer Prosthesis Program were to be implemented, what factors would you consider to be most important for the successful implementation of the program? [multi answer (max 3), mandatory]

- Appropriate funding
- Availability of a workforce of the requisite skills / education / training to deliver prostheses services included in the Program
- Clearly defined referral pathways
- Patient education / information
- Clearly defined eligibility guidelines and delineation from other schemes or programs (e.g. NDIS, DVA)
- Breadth / scope of prostheses included in the Program
- Other, please specify [free text, not required]

Table 100: Response to question 8 by jurisdiction

Response	Appropriate funding	Availability of a workforce	Clearly defined referral pathways	Patient education / information	Clearly defined delineation from other schemes	Breadth / scope of prostheses	Other
New South Wales	16 (35.6%)	11 (24.4%)	9 (20.0%)	1 (2.2%)	4 (8.9%)	3 (6.7%)	1 (2.2%)
Victoria	18 (34.0%)	13 (24.5%)	7 (13.2%)	3 (5.7%)	8 (15.1%)	4 (7.5%)	0 (0.0%)
Queensland	6 (21.4%)	7 (25.0%)	5 (17.9%)	4 (14.3%)	3 (10.7%)	3 (10.7%)	0 (0.0%)
South Australia	4 (26.7%)	4 (26.7%)	4 (26.7%)	1 (6.7%)	1 (6.7%)	1 (6.7%)	0 (0.0%)
Western Australia	2 (22.2%)	3 (33.3%)	1 (11.1%)	0 (0.0%)	2 (22.2%)	1 (11.1%)	0 (0.0%)
Northern Territory	2 (33.3%)	1 (16.7%)	2 (33.3%)	0 (0.0%)	1 (16.7%)	0 (0.0%)	0 (0.0%)
Total: 57 respondents / 156 responses	**48 (30.8%)**	**39 (25.0%)**	**28 (17.9%)**	**9 (5.8%)**	**19 (12.2%)**	**12 (7.7%)**	**1 (0.6%)**

Source: KPMG (2025)

Table 101: Response to question 8 by remoteness

Response	Appropriate funding	Availability of a workforce	Clearly defined referral pathways	Patient education / information	Clearly defined delineation from other schemes	Breadth / scope of prostheses	Other
Metropolitan	36 (29.0%)	32 (25.8%)	19 (15.3%)	8 (6.5%)	18 (14.5%)	10 (8.1%)	1 (0.8%)
Regional centre	10 (38.5%)	5 (19.2%)	7 (26.9%)	1 (3.8%)	1 (3.8%)	2 (7.7%)	0 (0.0%)
Rural area	2 (33.3%)	2 (33.3%)	2 (33.3%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total: 57 respondents / 156 responses	**48 (30.8%)**	**39 (25.0%)**	**28 (17.9%)**	**9 (5.8%)**	**19 (12.2%)**	**12 (7.7%)**	**1 (0.6%)**

Source: KPMG (2025)

Table 102: Response to question 8 by area of practice

Response	Appropriate funding	Availability of a workforce	Clearly defined referral pathways	Patient education / information	Clearly defined delineation from other schemes	Breadth / scope of prostheses	Other
Anaesthesia	1 (100.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Anaplastology	5 (38.5%)	3 (23.1%)	2 (15.4%)	0 (0.0%)	2 (15.4%)	1 (7.7%)	0 (0.0%)
Dentistry / dental oncology	7 (29.2%)	7 (29.2%)	5 (20.8%)	1 (4.2%)	3 (12.5%)	1 (4.2%)	0 (0.0%)
Lymphatic system	4 (22.2%)	4 (22.2%)	2 (11.1%)	1 (5.6%)	3 (16.7%)	4 (22.2%)	0 (0.0%)
Oncology	9 (32.1%)	8 (28.6%)	7 (25.0%)	2 (7.1%)	2 (7.1%)	0 (0.0%)	0 (0.0%)
Oral and maxillofacial	7 (36.8%)	5 (26.3%)	3 (15.8%)	0 (0.0%)	4 (21.1%)	0 (0.0%)	0 (0.0%)
Otolaryngology head and neck surgery	8 (36.4%)	5 (22.7%)	4 (18.2%)	1 (4.5%)	2 (9.1%)	2 (9.1%)	0 (0.0%)
Plastic and reconstructive surgery	1 (20.0%)	1 (20.0%)	1 (20.0%)	1 (20.0%)	0 (0.0%)	1 (20.0%)	0 (0.0%)
Prosthodontics	1 (16.7%)	1 (16.7%)	1 (16.7%)	1 (16.7%)	0 (0.0%)	1 (16.7%)	1 (16.7%)
Psychology or social work	2 (33.3%)	1 (16.7%)	2 (33.3%)	1 (16.7%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Research / academia	0 (0.0%)	1 (33.3%)	0 (0.0%)	0 (0.0%)	1 (33.3%)	1 (33.3%)	0 (0.0%)
Speech pathology	2 (25.0%)	2 (25.0%)	0 (0.0%)	1 (12.5%)	2 (25.0%)	1 (12.5%)	0 (0.0%)
Multiple areas of practice	1 (33.3%)	1 (33.3%)	1 (33.3%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total: 57 respondents / 156 responses	**48 (30.8%)**	**39 (25.0%)**	**28 (17.9%)**	**9 (5.8%)**	**19 (12.2%)**	13 (7.7%)	**1 (0.6%)**

Source: KPMG (2025)

9. If you could recommend one immediate change to improve access to prostheses for people living with or have lived experience of cancer, what would it be? [free text, not required]

Table 103: Response to question 9 by theme

Theme	Details
Funding support	Increased funding for facial prostheses, dental prostheses, voice prostheses Increased funding for support items (e.g., medical compression garments)
Workforce availability and qualifications	Increased number of technicians and anaplastologists to deliver services More education and training pathways for support staff A national training program to ensure nationally consistent skilled workforce A national body / regulation agency to ensure a skilled workforce More community awareness of the importance of facial prostheses, to attract more people into the workforce
Centralised database of information	To ensure consistency of information and awareness Having a single point of manufacture and fabrication in each state that each person with lived experience of cancer can be aware of. This also assists with consistency of service delivery, as there is significant variability depending on site and local services

Source: KPMG (2025)

10.Is there anything else you would like to share? [free text, not required]

Table 104: Response to question 10 by theme

Theme	Details
Scope of the review	Oral prostheses and voice prostheses should be included in the review as they are something many people with lived experience of head and neck cancer require
Availability of funding	Facial prostheses being classified as “cosmetic” by funding sources mean that individuals do not receive these prostheses in a timely manner and as part of their treatment plan Increased funding addresses the barrier of individuals not being able to access prostheses due to financial limits. The impact of individuals being able to access prostheses is an improvement in quality of life, good recovery outcomes. Prostheses also restore dignity, enable social reintegration and allow them to return to work and contribute to the economy Increased funding to allow public sector clinicians to collaborate with private laboratories and expand capacity to deliver prostheses services Increased funding for support items (e.g., lymphoedema garments) for body parts other than limbs Increased funding for training of specialists to support the care of their patients
Workforce availability and qualifications	There are not enough trained anaplastologists or technicians in Australia, lengthening treatment wait times and placing pressure on the existing clinicians There should be a board or policy that regulates the profession. This prohibits non-qualified individuals from providing services Due to the complexity of cancer, a multidisciplinary team providing care and rehabilitation is important. This may include the addition of a maxillofacial prosthodontist into the team

Source: KPMG (2025)

B.4 Literature scan search protocol

A literature scan, encompassing academic and grey literature, was conducted to ensure the review was grounded in the best available evidence for what is effective in supporting the needs of people who require a prostheses following diagnosis and treatment for cancer. The aim of the literature scan was to draw on both national and international evidence to:

- Identify national and international programs / services to support access to prostheses for people living with or who have lived experience of cancer
- Identify barriers and enablers to access
- Identify learnings that could be applied to the future development and implementation of a national program or scheme in Australia.
- Insight into the cost of similar programs
- Any other additional relevant information.

Table 105 and Table 106 below outlines the search protocol used for undertaking the literature scan, including the inclusion and exclusion criteria, sources, as well as the search concepts and terms.

Table 105: Literature scan search protocol

Element	Detail
Inclusion criteria	• Peer reviewed studies using all types of methodologies including reviews and primary research • Grey literature sources including government reports, evaluations and reviews, professional association publications, frameworks and policies • Studies or reports published in the last 5 years (2020-2025) • Literature specific to Australia or including Australian case studies and comparable jurisdictions including the UK, New Zealand, Canada, and the USA. • English language sources.
Exclusion criteria	• Studies older than 2020 unless highly relevant • Studies focused on prostheses for non-cancer related conditions • Studies that focus on surgically implanted prostheses • Studies that are not relevant to Australia or comparable international contexts • Studies published in languages other than English
Sources	• Databases including Embase, Medline, PubMed (National Library of Medicine/National Institute of Health), Pan American Health Organization (PAHO) Virtual Health Library (VHL). • Grey literature will be sought from the Department of Health, Disability and Ageing, Australian Institute of Health and Welfare, as well as key healthcare and policy organisation websites such as the Cancer Australia.

Source: KPMG (2025)

Table 106: Literature scan search concepts and terms

Search concepts	Search terms
Cancer prostheses programs	“Cancer patients”, “lived experience of cancer” “prostheses”, “policy”, “programs”
Cancer prostheses access	“Australia”, “prostheses access”, “barriers”, “enablers”, “equity”, “service provision”, “patient pathways”, “wait times”, “disparity”, “Aboriginal and Torres Strait Islander”, “Culturally and Linguistically Diverse”, “rural and remote”
Cancer prostheses reimbursement	“NDIS”, “Government”, “block-funding”, “grants”, “funding”, “Medicare”, “subsidies”, “reimbursement”, “health insurance”
Cost	“Cost”, “pricing”, “prices”, “value”, “cost-effectiveness”, “cost-benefit”, ‘cost-utility”, “health costs’

Source: KPMG (2025)

B.5 List of documents reviewed

This section outlines the documents reviewed during the development of this report, including materials provided by the Department and other key stakeholders.

Table 107: List of documents reviewed

Document name	Provided by
Community Affairs Legislation Committee	The Department
EBPRP Final report	The Department
Head and Neck Cancer Funding Proposal 2024	The Department
Rare and Less Common Cancer Inquiry	The Department
AIHW Health System Expenditure on Prostate cancer	Representative from peak body

Source: KPMG (2025)

Appendix C: Facial prostheses services, programs and schemes

This appendix includes details regarding the publicly funded facial prostheses services, programs and schemes available via the DVA and in the ACT, QLD, VIC and WA.

C.1 Department of Veterans' Affairs

Table 108: DVA facial prostheses details

Category	Description
Eligibility criteria	• Holds either a Veteran Gold Card or Veteran White Card that covers cancer • Have a formal diagnosis of the relevant condition
Products and services included	• Ear prostheses • Eye prostheses • Nose prostheses
Cost coverage	• Covers the full cost with no out of pocket for the individual
Repairs and warranty	• DVA accepts the financial responsibility for items not covered under the warranty period.
Referral pathway	• Requires prescription or recommendation from a GP, or specialist who submits a RAP form
Settings in which prostheses may be accessed	• Facial prostheses do not have a contracted supplier and is therefore up to the discretion of the health care professional to choose a relevant supplier.
Clinicians involved	• GP or specialist provides a prescription and submits a RAP form to DVA
Funded by	• Australian Government
Role of Australian government	• Funds and administers the DVA Rehabilitation Appliances Program
Role of state/territory governments	• None

Source: DVA (2023)[171]

[171] The Department of Veterans Affairs. (2023). *RAP National Schedule of Equipment*. https://www.dva.gov.au/sites/default/files/2023-06/RAPSchedule-June2023.pdf

C.2 Australian Capital Territory

Table 109: Canberra Health Service prosthetic eye scheme details

Category	Description
Eligibility criteria	• Resident of the ACT • Recommendation received by an ophthalmologist • Remaining biologic eye (if present) has been examined within the last two year by an ophthalmologist or optometrist
Products and services included	• Prosthetic eye or eyes (if bilaterial prosthetics are required)
Cost coverage	• The full cost of the prosthesis and componentry, with no out of pocket for the individual
Repairs and warranty	• Replacement of the prosthetic eye every five years or if clinically unsatisfactory
Referral pathway	• Application form is completed by requesting ophthalmologist which includes clinical information about the assessment of remaining biological eye (if present) • Ophthalmology administrative staff from the Canberra Health Services will notify the individual via phone of the approval and mail a letter of approval to the Ocularist
Settings in which prostheses may be accessed	• Ocularist of the individual's choice (there is only one ocularist in Canberra)
Clinicians involved	• Ophthalmologist: recommendation for the provision of prosthetic eyes, assessment of remaining biological eye (if present), and completion of application • Optometrist: assessment of remaining biological eye (if present) • Ocularist: creation of the prosthetic eye
Funded by	• ACT Government
Role of Australian Government	• None
Role of state/territory government	• Provide funding and administers the prosthetic eye scheme through CHS

Source: Canberra Health Services (2023).[172]

[172] Canberra Health Services. (2023). *Provision of Prosthetic Eyes (Adults and Children).* https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.canberrahealthservices.act.gov.au%2F__data%2Fassets%2Fword_doc%2F0005%2F1981607%2FProvision-of-Prosthetic-Eyes.docx&wdOrigin=BROWSELINK

C.3 Queensland

Table 110: Queensland Health facial prosthesis service

Category	Description
Eligibility criteria	• Must have a Medicare card
Products and services included	• Ocular prosthesis • Orbital prostheses • Ear prosthesis • Hemifacial prostheses • Nasal prostheses
Cost coverage	• The full cost of the prosthesis and componentry, with no out of pocket for the person
Repairs and warranty	• Full replacement cost covered; however, limited information is publicly available regarding duration or frequency limits
Referral pathway	• Referral letter from a GP, or specialist sent to the Royal Brisbane and Women's Hospital
Settings in which prostheses may be accessed	• Royal Brisbane and Women's Hospital
Clinicians involved	• Maxillofacial prosthetist: creation of the facial prostheses • Ocularist: creation of the prosthetic eye
Funded by	• Queensland Government
Role of Australian Government	• None
Role of state/territory government	• Provide funding to public hospital

Source: Royal Brisbane and Women's Hospital (2022). [173]

[173] Royal Brisbane and Women's Hospital. (2022). *Oral and Maxillofacial Surgery*. https://metronorth.health.qld.gov.au/rbwh/healthcare-services/oral-maxillofacial#professional

C.4 Victoria

Table 111: Facial prosthesis service in Victoria

Category	Description
Eligibility criteria	• Must have a Medicare card
Products and services included	• Ocular prosthesis • Orbital prostheses • Ear prosthesis • Hemifacial prostheses • Nasal prostheses
Cost coverage	• The full cost of the prosthesis and componentry, with no out of pocket for the person
Repairs and warranty	• Full replacement cost covered; however, limited information is publicly available regarding duration or frequency limits
Referral pathway	• Referral letter from a GP, or specialist sent to the Royal Melbourne Hospital
Settings in which prostheses may be accessed	• Royal Melbourne Hospital
Clinicians involved	• Maxillofacial prosthetist: creation of the facial prostheses • Ocularist: creation of the prosthetic eye
Funded by	• Victorian Government
Role of Australian Government	• None
Role of state/territory government	• Provide funding to public hospitals

Source: The Royal Melbourne Hospital (2023).[174]

[174] The Royal Melbourne Hospital. (2023). *Maxillofacial Prosthetics.* https://www.thermh.org.au/services/maxillofacial-prosthetics

C.5 Western Australia

Table 112: WA facial prosthesis service

Category	Description
Eligibility criteria	• Must have a Medicare card • Must require a custom-made maxillofacial extraoral prosthesis as an external substitute for a partially or totally absent facial part
Products and services included	• Ocular prosthesis • Orbital prostheses • Ear prosthesis • Hemifacial prostheses • Nasal prostheses
Cost coverage	• The full cost of the prosthesis and componentry, with no out of pocket for the individual
Repairs and warranty	• One prosthesis will be provided per facial part. • Replacement of a prosthesis may be considered due to anatomical changes from physiological growth or atrophy of the face where the prosthesis is attached and / or changes in the medical condition of the patient's face where the prosthesis is attached. • Replacement prostheses are not generally provided due to change of aesthetic preference, loss or damage.
Referral pathway	• Referral letter from a GP, or specialist sent to Fiona Stanley Hospital
Settings in which prostheses may be accessed	• Fiona Stanley Hospital
Clinicians involved	• Maxillofacial prosthetist: creation of the facial prostheses • Ocularist: creation of the prosthetic eye
Funded by	• Department of Health WA
Role of Australian Government	• None
Role of state/territory government	• Provide funding to public hospitals

Source: KPMG (2025) gathered from stakeholder consultation

Appendix D: Breast prostheses services, programs and schemes

This appendix includes details regarding external breast prostheses services, programs and schemes available in Australia.

D.1 External Breast Prosthesis Reimbursement Program

Table 113: EBPRP program details

Category	Description
Eligibility criteria	• Be enrolled in Medicare, • Be a permanent resident of Australia, • Have undergone breast surgery as a result of breast cancer. Eligible procedures include double mastectomies, prophylactic (preventative) mastectomies, partial mastectomies, and lumpectomies; and • Not have received a reimbursement under the program within the past two years.
Products and services included	• External breast prostheses • Swimming prostheses
Cost coverage	• Up to $400 for each new or replacement breast prosthesis following a unilateral mastectomy • Up to $800 for new or replacement breast prostheses following a bilateral mastectomy
Repairs and warranty	• Warranty policies and coverage for repairs vary by retailer
Referral pathway	• No prescription or referral from a health professional is necessary to claim a reimbursement. • The person can purchase prostheses from their preferred retailer • The person then submits a form to Services Australia with a copy of the purchase receipt with a description of what was purchased, the date and supplier information • Services Australia then process the claim (typically within 10 business days) and deposits the reimbursement directly into the persons nominated bank account
Settings in which prostheses may be accessed	• Specialist mastectomy stores • Mobile fitting services • Home fitting services • Major department stores • Undergarment stores
Clinicians involved	• Breast care and McGrath nurses: provide support and education to people with breast cancer about prostheses services available
Funded by	• Australian Government
Role of Australian Government	• Funds and administers the EBPRP
Role of state/territory governments	• None

Source: Adapted from Services Australia, 2024 [175]

[175] Services Australia. (2024). *External Breast Prostheses Reimbursement Program*. https://www.servicesaustralia.gov.au/how-to-claim-external-breast-prosthesis-reimbursement-program?context=21976

D.2 Availability of external breast prostheses retailers across Australia

Table 114: Availability of external breast prostheses retailers and in-person fittings

Jurisdiction	Location of accredited limb prostheses service providers	MM1	MM2	MM3 to 4	MM5 to 7
Australian Capital Territory	Canberra	Yes	N/A	N/A	N/A
New South Wales	Sydney	Yes	N/A	N/A	N/A
New South Wales	Lake Macquarie	Yes	N/A	N/A	N/A
New South Wales	Kiama	N/A	Yes	N/A	N/A
New South Wales	Wagga Wagga	N/A	N/A	Yes	N/A
New South Wales	Newcastle	Yes	N/A	N/A	N/A
Queensland	Brisbane	Yes	N/A	N/A	N/A
Queensland	Gold Coast	Yes	N/A	N/A	N/A
Queensland	Cairns	N/A	Yes	N/A	N/A
Queensland	Mackay	N/A	Yes	N/A	N/A
Queensland	Townsville	N/A	Yes	N/A	N/A
Queensland	Toowoomba	N/A	Yes	N/A	N/A
Victoria	Melbourne	Yes	N/A	N/A	N/A
Victoria	Mornington	Yes	N/A	N/A	N/A
Victoria	Geelong	N/A	Yes	N/A	N/A
Victoria	Bendigo	N/A	Yes	N/A	N/A
Victoria	Warrnambool	N/A	N/A	Yes	N/A
Victoria	Sale	N/A	N/A	Yes	N/A
Victoria	Gippsland	N/A	N/A	Yes	N/A
South Australia	Adelaide	Yes	N/A	N/A	N/A
South Australia	Broken Hill	N/A	N/A	Yes	N/A
South Australia	Port Pirie	N/A	N/A	Yes	N/A
South Australia	Murray Bridge	N/A	N/A	Yes	N/A
Western Australia	Perth	Yes	N/A	N/A	N/A
Western Australia	Southwest region including Busselton	N/A	N/A	Yes	N/A
Northern Territory	Darwin	N/A	Yes	N/A	N/A
Tasmania	Hobart	N/A	Yes	N/A	N/A
Tasmania	Launceston	N/A	Yes	N/A	N/A

Source: KPMG *using information from BCNA, 2025*

D.3 My Care Kit

Table 115: My Care Kit program details

Category	Description
Eligibility criteria	• People who have recently had breast surgery • People undergoing radiation therapy
Products and services included	• A post-surgery bra or $70 online voucher for a bra • Temporary breast prosthesis, also known as a soft form (maximum of two)
Cost coverage	• The full cost of the prosthesis and post-surgery bra are covered, with no out of pocket costs for the individual
Repairs and warranty	• Not applicable
Referral pathway	• The prosthesis is ordered online via the BCNA website by a healthcare professional on behalf of their patient • The healthcare professional will measure and fit the person for the bra
Settings in which the prostheses may be accessed	• The prosthesis is ordered online and can be sent either directly to the persons home or to the healthcare professional for distribution
Clinicians involved	• Breast care and McGrath nurses: provide support and education to people with breast cancer about prostheses services available
Funded by	• Australian government
Role of the Australian Government	• Funds BCNA to deliver the kits
Role of state/territory governments	• None

Source: Adapted from BNCA (2025) [176]

[176] Breast Cancer Network Australia. (2025). *My Care Kit*. https://www.bcna.org.au/my-care-kit/

D.4 Knitted Knockers Australia

Table 116: Knitted Knockers Australia program details

Category	Description
Eligibility criteria	• People who have recently had breast surgery
Products and services included	• Knitted breast prosthesis
Cost coverage	• Covers the full cost of prostheses • Out of pocket cost for postage of the prostheses if pick up is unavailable ($10 single mastectomy, $16 double mastectomy)
Repairs and warranty	• No information
Referral pathway	• Person requiring the prostheses can complete the order form online
Settings in which prostheses may be accessed	• The prosthesis can be sent either directly to the persons home or picked up at a local Knitted Knockers Australia Branch
Funded by	• Donations
Role of Australian Government	• None
Role of state/territory governments	• None

Source: Adapted from Knitted Knockers Australia (n.d.) [177]

[177] Knitted Knockers Australia. (n.d.). *Prosthesis*. https://knittedknockersaustralia.com/prosthesis/

D.5 Department of Veterans' Affairs

Table 117: DVA breast prostheses details

Category	Description
Eligibility criteria	• Holds either a Veteran Gold Card or Veteran White Card that covers cancer • Have a formal diagnosis of the relevant condition
Products and services included	• External breast prostheses • Mastectomy bras, compression garments, sports bras • Compression sleeves, gloves and gauntlets
Cost coverage	• Covers the full cost with no out of pocket for the individual
Repairs and warranty	• DVA accepts the financial responsibility for items not covered under the warranty period. Prior approval is not required unless it exceed $650.
Referral pathway	• Requires prescription or recommendation from a General Practitioner (GP), medical specialist or registered nurse who submits an RAP form.
Settings in which prostheses may be accessed	• Breast prostheses do not have a contracted supplier and is therefore up to the discretion of the health care professional to choose a relevant supplier.
Clinicians involved	• GP, medical specialist or registered nurse: provides a prescription and submits a RAP form to DVA
Funded by	• Australian Government
Role of Australian government	• Funds and administers the DVA RAP
Role of state/territory governments	• None

Source: DVA (2021)[178]

[178] The Department of Veterans Affairs. (2021). *Breast Prosthesis – Non-implanted*. https://www.dva.gov.au/providers/rehabilitation-appliances-program-rap/rap-schedule/rap-aw02

Appendix E: Limb prostheses services, programs and schemes

This appendix includes details regarding limb prostheses services, programs and schemes available in Australia.

E.1 National Disability Insurance Scheme

Table 118: Commonly used prostheses listed on the NDIS Assistive Technology Guide

Support Item	Description
Prosthesis - For use in Wet Environment (i.e. waterproofing)	Prosthesis that incorporates specialised components or treatments to enable use in wet environments
Prosthesis - Osseo-Integration Mounting - Upper or Lower - Additional Cost	Extra cost to facilitate connection through titanium or similar bone implants to upper or lower residual limb, outside the standard prosthetic cost
Prosthesis - Transfemoral or Higher	Devices that replace part of the lower limb between the knee and hip joints after limb loss/absence
Prosthesis - Transtibial or Lower	Devices that replace part of the lower limb between the knee and the ankle joint after limb loss/absence
Prosthesis - Upper Limb - Including Powered	Devices that replace part or all of the upper limb (not including finger replacement only
Prosthesis - Lower Limb for Sports	Lower limb prosthetics customised, or custom made for use in sport.
Arm and/or Hand for Sport and leisure	A hardware device or adaptions for arm and/or hand prosthetics, to enable participation in sport.

Source: NDIS (2024)[179]

Table 119: NDIS details

Category	Description
Eligibility criteria	• Be under 65 years old • Be an Australian citizen, permanent resident, or Protected Special Category Visa holder • Live in Australia • Have a disability caused by a permanent impairment that substantially reduces functional capacity to undertake one or more of the following activities: moving around, communicating, socialising, learning, or undertaking self-care or self-management tasks.
Products and services included	• Entry level or standard prostheses (up to K2 classification) • Higher grad prostheses (microprocessor joints and computerised components) • Myoelectric prostheses for upper limb amputees • Componentry such as limb socks and sheaths
Cost coverage	• The full cost of the prosthesis and componentry, with no out of pocket for the person
Repairs and warranty	• The NDIS will fund repairs, maintenance, minor and major adjustments to prosthetic limbs (or prosthetic limbs funded by other systems prior to the participant joining the NDIS) • Limbs will be replaced at typical replacement intervals - 3 years for most adults and, as needed, due to growth for children under 18 years of age (typically no more than bi-annually)
Referral pathway	• Confirm eligibility for the NDIS • Submit an access request form to the NDIA

[179] NDIS. (2024). Assistive Technology, Home modifications and consumables code guide 2024-2025

Category	Description
	• Attend a planning meeting with a local area coordinator to discuss goals and required supports • Meet with an accredited prosthetist for a functional assessment and to obtain a prescription and quotation for the required prosthesis • Develop a NDIS plan that includes the recommended prosthetic device and associated supports • Once the plan is approved, funding is allocated, and the participant can proceed with obtaining the prescribed prostheses through registered providers.
Settings in which prostheses may be accessed	• Public artificial limb services • Private prosthetic providers registered with the NDIS
Clinicians involved	• Prosthetists: assesses the persons functional needs, design, prescribe, manufacture and fit prosthetic limb • Physiotherapist: supports rehabilitation and strength training • Occupational therapist: assesses the person's ability to complete daily living tasks, help develops functional goals to inform NDIS planning
Funded by	• Australian Government
Role of Australian Government	• Funds and administers the NDIS
Role of state/territory governments	• None

Source: Adapted from NDIS (2024) [180]

E.2 Availability of accredited limb prostheses service providers

Table 120: Availability of accredited limb prostheses service providers

Jurisdiction	Location of accredited limb prostheses service providers	MM1	MM2	MM3 to 4	MM5 to 7
Australian Capital Territory	Canberra	Yes	N/A	N/A	N/A
New South Wales	Sydney	Yes	N/A	N/A	N/A
New South Wales	Gosford	N/A	Yes	N/A	N/A
New South Wales	Wyong	N/A	Yes	N/A	N/A
New South Wales	Woy Woy	N/A	Yes	N/A	N/A
New South Wales	Newcastle	N/A	Yes	N/A	N/A
New South Wales	Tamworth	N/A	N/A	Yes	N/A
New South Wales	Dubbo	N/A	N/A	Yes	N/A
New South Wales	Orange	N/A	N/A	Yes	N/A
New South Wales	Bathurst	N/A	N/A	Yes	N/A
New South Wales	Wagga Wagga	N/A	N/A	Yes	N/A
New South Wales	Port Macquarie	N/A	N/A	Yes	N/A
New South Wales	Coffs Harbour	N/A	N/A	Yes	N/A

[180] National Disability Insurance Scheme. (2024). *Including Specific Types of Supports in Plans Operational Guideline - Prosthetic limbs.* https://www.ndis.gov.au/operational-guidelines/including-specific-types-supports-plans-operational-guideline/including-specific-types-supports-plans-operational-guideline-prosthetic-limbs

Jurisdiction	Location of accredited limb prostheses service providers	MM1	MM2	MM3 to 4	MM5 to 7
New South Wales	Lismore	N/A	N/A	Yes	N/A
New South Wales	Nowra	N/A	N/A	Yes	N/A
New South Wales	Albury	N/A	N/A	Yes	N/A
New South Wales	Wingham	N/A	N/A	Yes	N/A
Queensland	Brisbane	Yes	N/A	N/A	N/A
Queensland	Gold Coast	Yes	N/A	N/A	N/A
Queensland	Sunshine Coast	Yes	N/A	N/A	N/A
Queensland	Rockhampton	N/A	Yes	N/A	N/A
Queensland	Townsville	N/A	Yes	N/A	N/A
Queensland	Toowoomba	N/A	Yes	N/A	N/A
Queensland	Bundaberg	N/A	Yes	N/A	N/A
Queensland	Mackay	N/A	Yes	N/A	N/A
Queensland	Cairns	N/A	Yes	N/A	N/A
Queensland	Maryborough	N/A	N/A	Yes	N/A
Victoria	Melbourne	Yes	N/A	N/A	N/A
Victoria	Geelong	N/A	Yes	N/A	N/A
Victoria	Ballarat	N/A	Yes	N/A	N/A
Victoria	Bendigo	N/A	Yes	N/A	N/A
Victoria	Traralgon	N/A	N/A	Yes	N/A
Victoria	Mildura	N/A	N/A	Yes	N/A
South Australia	Adelaide	Yes	N/A	N/A	N/A
South Australia	Whyalla	N/A	N/A	Yes	N/A
South Australia	Port Augusta	N/A	N/A	Yes	N/A
South Australia	Mount Gambier	N/A	N/A	Yes	N/A
South Australia	Port Lincoln	N/A	N/A	Yes	N/A
South Australia	Port Pirie	N/A	N/A	Yes	N/A
South Australia	Cenduna	N/A	N/A	N/A	Yes
South Australia	Coober Pedy	N/A	N/A	N/A	Yes
Western Australia	Perth	Yes	N/A	N/A	N/A
Northern Territory	Darwin	N/A	Yes	N/A	N/A
Northern Territory	Alice Springs	N/A	N/A	Yes	N/A

Jurisdiction	Location of accredited limb prostheses service providers	MM1	MM2	MM3 to 4	MM5 to 7
Northern Territory	Katherine	N/A	N/A	N/A	Yes
Northern Territory	Nhulunbuy	N/A	N/A	N/A	Yes
Tasmania	Hobart	N/A	Yes	N/A	N/A
Tasmania	Launceston	N/A	Yes	N/A	N/A
Tasmania	Burnie	N/A	Yes	N/A	N/A

Source: KPMG (2025) using information from State and Territory Artificial Limb Schemes

E.3 Department of Veterans' Affairs

Table 121: DVA limb prostheses details

Category	Description
Eligibility criteria	• Holds either a Veteran Gold Card or Veteran White Card that covers cancer • Have a formal diagnosis of the relevant condition
Products and services included	• Everyday prostheses • Stump socks, silicon liners and knee sleeves • A secondary prosthesis for sports or recreation purposes • Footwear for prosthetic limb
Cost coverage	• Covers the full cost with no out of pocket costs for the individual
Repairs and warranty	• DVA accepts the financial responsibility for items not covered under the warranty period.
Referral pathway	• Requires an assessment by a multidisciplinary prosthetic team including a prosthetist and a physiotherapist
Settings in which prostheses may be accessed	• Limb prostheses do not have a contracted supplier and is therefore up to the discretion of the health care professional to choose a relevant supplier.
Clinicians involved	• An amputee clinic multidisciplinary teams involves a: • Rehabilitation physicians: assess, diagnoses and treats a person's mobility and function. • Prosthetists: assesses the persons functional needs, and design, manufacture and fit prosthetic limb • Physiotherapist: supports rehabilitation and strength training
Funded by	• Australian Government
Role of Australian government	• Funds and administers the DVA
Role of state/territory governments	• None

Source: DVA (2023)[181]

[181] The Department of Veterans Affairs. (2023). *RAP National Schedule of Equipment*. https://www.dva.gov.au/sites/default/files/2023-06/RAPSchedule-June2023.pdf

E.4 Australian Capital Territory

Table 122: ACTALS details

Category	Description
Eligibility criteria	• Have a limb deficiency for which a prosthesis is prescribed by a Prescribing Consultant in Rehabilitation Medicine employed within CHS, and • Be a permanent Australian resident and be listed on a Medicare Card, and • For regular and ongoing services, be a permanent resident of the ACT or surrounding NSW region, and • Not be eligible for funding of prosthetics from alternative funds or bodies.
Products and services included	Upper and lower limb prostheses, including: • Arm and leg prostheses • Partial hand prostheses • Partial foot prostheses (proximal to the metatarsophalangeal joint) Annual consumable items per limb • 14 socks/gel • 6 Sheaths • 4 Cosmetic stockings • 2 AK suspension belts • 3 Knee suspension sleeves • 3 Stump Shrinkers • 2 Liners
Cost coverage	• Covers the full cost with no out of pocket for the individual
Repairs and warranty	• All prostheses provided through ACTALs funding include a 12 months warranty against manufacturing defects • One minor repair or maintenance service per year is included at no cost • Prostheses are expected to last a minimum of 3 years
Referral pathway	• Referrals made by a Rehabilitation Medicine Consultant employed by CHS
Settings in which prostheses may be accessed	Prosthetics and Orthotics Service at Canberra Health Services, including • Village Creek Centre • Canberra Hospital • University of Canberra Hospital
Clinicians involved	• Rehabilitation Medicine Consultant: provides referral for limb prostheses • Prosthetists: assesses the persons functional needs, and designs, manufacture and fit prosthetic limb
Funded by	• Commonwealth funding provided to Canberra Health Services
Role of Australian Government	• Funds the ACTALS
Role of state/territory government	• Manages and distributes funding

Source: ACT *Government (2021)* [182]

[182] ACT Government. (2021). ACT Artificial Limb Scheme. https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.canberrahealthservices.act.gov.au%2F__data%2Fassets%2Fword_doc%2F0004%2F1981057%2FACT-Artificial-Limb-Scheme-ACTALS-Adults-and-Children.docx&wdOrigin=BROWSELINK

E.5 New South Wales

Table 123: EnableNSW Prosthetic Limb Service details

Category	Description
Eligibility criteria	• Acquired amputation as a result of disease or injury and the level of amputation is complete trans-metatarsal/trans-metacarpal or higher, and • Be living in NSW or Lord Howe Island, and • Be eligible for Medicare, and • Not be eligible for assistance through another government program
Products and services included	• A standard limb prosthesis • Annual consumable items per limb • 12 stump socks or sheaths (including gel socks) per residual limb; and • 2 stump shrinkers per residual limb; and • 1 roll-on liner per residual limb; and • 2 pairs of cosmetic stockings per prosthetic limb. • High-cost components such as microprocessor knees or advanced prosthetic feet (funded under exceptional circumstances)
Cost coverage	• If the individual holds a pensioner concession card, healthcare card or seniors' health card they are not required to pay anything. • People on higher incomes are required to pay 15% of the cost of services provided. This contribution is capped at $200 per year. • If the individual prefers a prosthesis that is more expensive than the one prescribed, they may choose to fund this out-of-pocket.
Repairs and warranty	• Prostheses are expected to last 2-3 years • EnableNSW will cover the costs of repairs and maintenance • EnableNSW will fund repairs/adjustments/supply up to a max of $700 for minor repairs and $2000 for major repair
Referral pathway	• The amputee clinic prescribes an interim prosthesis. • The clinic submits the prescription to EnableNSW for approval. • EnableNSW notifies the Prosthetic Service Provider to commence manufacturing. • The provider contacts the patient for fitting. • Once the patient confirms receipt and fit, EnableNSW pays the provider directly.
Settings in which prostheses may be accessed	• Accredited amputee clinics across NSW (See Table 131 in Appendix F.1 for a list of accredited amputee clinics in NSW and their associated PSPs.)
Clinicians involved	An amputee clinic multidisciplinary teams involves a: • Rehabilitation physicians: assess, diagnoses and treats a person's mobility and function. • Prosthetists: assesses the persons functional needs, and design, manufacture and fit prosthetic limb • Physiotherapist: supports rehabilitation and strength training
Funded by	• Commonwealth funding distributed by EnableNSW PLS
Role of Australian Government	• Funds EnableNSW PLS
Role of state/territory government	• Manages and distributes funding

Source: Adapted from EnableNSW (n.d) [183]

[183] EnableNSW. (n.d.). *Prosthetic Limb Service.* https://www.enable.health.nsw.gov.au/about/publications/fact-sheets/pls#:~:text=The%20Prosthetic%20Limb%20Service%20(PLS,provides%20funding%20for%20prosthetic%20limbs.

E.6 Northern Territory

Table 124: Prosthetic limb services in NT

Category	Description
Eligibility criteria	• Have a below knee, above knee, partial foot, above elbow or below elbow amputation. • Not currently receiving prosthetic services from a private provider or NDIS.
Products and services included	• Upper and lower limb prosthesis
Cost coverage	• No information available
Repairs and warranty	• No information available
Referral pathway	• Referral from health professional
Settings in which prostheses may be accessed	Public Hospital Prosthetic and Orthotic Department • Royal Darwin and Palmerston Hospital Prosthetics and Orthotics Department • Alice Springs Prosthetics Department
Clinicians involved	An amputee clinic multidisciplinary teams involves a: • Rehabilitation physicians: assess, diagnoses and treats a person's mobility and function. • Prosthetists: assesses the persons functional needs, and design, manufacture and fit prosthetic limb • Physiotherapist: supports rehabilitation and strength training
Funded by	• Commonwealth funding provided to Prosthetic and Orthotic services in public hospitals
Role of Australian Government	• Funds Prosthetic and Orthotic services in public hospitals
Role of state/territory governments	• N/A – funding provided by the Australian Government is managed directly by public hospitals in the NT

Source: NT Government (n.d.)[184]

[184] NT Government. (n.d.). *Prosthetics and orthotics.* https://nt.gov.au/wellbeing/allied-health/prosthetics-and-orthotics

E.7 Queensland

Table 125: Queensland Artificial Limb Service details

Category	Description
Eligibility criteria	• Over the age of 65 years, and • Have undergone an amputation as a result of disease or injury and the level of amputation is complete trans-metatarsal/trans-metacarpal or higher, and • Be an Australian Citizen, or have Australian residency • Have a Medicare Card, and • Be a permanent resident of Queensland • Have completed an 'interim rehabilitation program' at an amputee clinic, been assessed and deemed competent and suitable to use a prosthetic limb, and • Not be obtaining prosthetic funding support or services through another Government agency or state service.
Products and services included	Upper and lower limb prostheses, including: • One standard prosthetic limb for each amputated limb for standard day to day activities • Partial foot prostheses may be supplied for partial foot amputations, proximal to the metatarsal phalange joint • Partial hand prostheses may be supplies excluding digits only • Socket replacements Annual consumable items per limb • 2 cosmetic gloves • 6-12 stockings • 1 Donning Aid • 1 Foam Cover • 2 Liners • 8 sprays/lotions/creams • 4-6 Sheaths/gaiters • 1 shower cover • 13-16 socks • 2 stump shrinkers • 2 suspension sleeves • One cosmetic cover or artistic feature per 12-month period (not per limb/socket replacement)
Cost coverage	An applicant may be required to privately fund a co-payment for prosthetics where: • The prosthetic components requested exceed the maximum QALS funding levels and have not been approved for full funding by QALS, or • The prosthetist/applicant has chosen upgraded components which are outside the scope of QALS funding levels e.g. microprocessor joints or components specific to recreational use. Maximum funding level: • Feet and Terminal Devices - K1 - $900, K2 or above: $1,500 • Elbow and Knee units - K1 - $1,500, K2 or above: $3,000 • External components - $11,500
Repairs and warranty	• Prostheses expected to last up to 36 months • QALS will fund up to $550 for a minor repair without prior approval • Socket replacements and the replacement of major components will require an inspection of the prosthesis by the PSP, and prior funding approval from QALS, before any repairs can commence. • Socket warranty has minimum 3 months on fit and minimum 12 months on socket integrity.
Referral pathway	• Person applies to QALS via form • Applicant contacts chosen PSP to arrange appointment to be reviewed and assessed for prosthetic need • PSP submits form on behalf of client with a quote for the service required • QALS process application and advice PSP of the status • QALS issues a purchase order for the approved QALS amount • PSP complete from to QALS with their invoice for services.
Settings in which prostheses may be accessed	• Public hospital interim clinics and PSPs (See Table 134 in Appendix F.2 for a list of accredited amputee clinics in QLD and their associated PSPs.)
Clinicians involved	An amputee clinic multidisciplinary teams involves a: • Rehabilitation physicians: assess, diagnoses and treats a person's mobility and function.

Category	Description
	• Prosthetists: assesses the persons functional needs, and design, manufacture and fit prosthetic limb • Physiotherapist: supports rehabilitation and strength training
Funded by	• Commonwealth funding provided to QALS
Role of Australian Government	• Funds the QALS
Role of state/territory governments	• Manages and distributes funding

Source: Queensland Health. (2023). [185]

E.8 South Australia

Table 126: SAALS details

Category	Description
Eligibility criteria	• Limb deficiency either as the result of an amputation, and • Be a permanent resident of Australia and hold a Medicare card, and • Have not received and are not entitled to receive compensation or damages for the incident that led to your limb deficiency
Products and services included	• Upper and lower limb prostheses • A prosthesis may be provided if the individual has a significant partial foot or hand amputation that hinders normal activity • Annual consumable items per limbs is provided • High-cost components such as myo-electric expertise with individualised contemporary solutions (funded under exceptional circumstances)
Cost coverage	• No information available
Repairs and warranty	• The expected life of an adult prosthesis is three years. • Any replacements within this time limit require a letter of explanation from prescribing doctor. There must be sound reasons for a replacement to be authorised within this time period.
Process of referral	• Attend prescribing amputee clinic for assessment and prescription • SAALS reviews and approves funding, which is then directed to the individual's chosen PSP
Settings in which prostheses may be accessed	• Public Hospitals and outreach community health services (See Table 135 in Appendix F.3 for a list of accredited amputee clinics in SA)
Clinicians involved	An amputee clinic multidisciplinary teams involves a: • Rehabilitation physicians: assess, diagnoses and treats a person's mobility and function. • Prosthetists: assesses the persons functional needs, and design, manufacture and fit prosthetic limb • Physiotherapist: supports rehabilitation and strength training
Funded by	• Commonwealth funding provided to SAALS
Role of Australian Government	• Funds the SAALS
Role of state/territory governments	• Manages and distributes funding

Source: Amputees in Touch South Australia. (n.d.). [186]

[185] Queensland Health. (2023). Guidelines for Queensland Artificial limb Service. https://www.health.qld.gov.au/__data/assets/pdf_file/0026/1161773/guidelines-QALS.pdf
[186] Amputees in Touch South Australia. (n.d.) *Artificial Limb Scheme (SAALS)*. https://amputeesintouch.org.au/amputee-support/artificial-limb-scheme/#:~:text=The%20Artificial%20Limb%20Scheme%20is,Amputee%20Limb%20Service%20(SAALS).

E.9 Tasmania

Table 127: Tasmanian Artificial Limb Scheme details

Category	Description
Eligibility criteria	• No information available
Products and services included	• Upper and lower limb prosthesis
Cost coverage	• No information available
Repairs and warranty	• No information available
Referral pathway	• Outpatient individuals require a referral from health professional • In patient individuals is directly managed by the treating medical team
Settings in which prosthesis may be accessed	Public hospitals: • The Royal Hobart Hospital • Launceston General Hospital • Northwest Regional Hospital
Clinicians involved	An amputee clinic multidisciplinary teams involves a: • Rehabilitation physicians: assess, diagnoses and treats a person's mobility and function. • Prosthetists: assesses the persons functional needs, and design, manufacture and fit prosthetic limb • Physiotherapist: supports rehabilitation and strength training
Funded by	• Commonwealth funding provided to TALS
Role of Australian Government	• Funds the Tasmanian Artificial Limb Scheme
Role of state/territory governments	• Manages and distributes funding

Source: Department of Health Tasmania (2025)[187]

[187] Department of Health Tasmania. (2025). Orthotic and Prosthetic Services. https://www.health.tas.gov.au/health-topics/orthotics-and-prosthetics/orthotic-and-prosthetic-services

E.10 Victoria

Table 128: Prosthetic limb services in Victoria

Category	Description
Eligibility criteria	• Over the age of 65 years, and • Have undergone an amputation as a result of disease or injury, and • Be an Australian Citizen, or have Australian residency • Have a Medicare Card, and • Not be obtaining prosthetic funding support or services through another Government agency or state service.
Products and services included	• No information available
Cost coverage	• No information available
Repairs and warranty	• No information available
Referral processes	• Public hospital in-patient and out-patient referrals
Settings in which prostheses may be accessed	• Public hospital Prosthetic and Orthotic Department
Clinicians involved	An amputee clinic multidisciplinary teams involves a: • Rehabilitation physicians: assess, diagnoses and treats a person's mobility and function. • Prosthetists: assesses the persons functional needs, and design, manufacture and fit prosthetic limb • Physiotherapist: supports rehabilitation and strength training
Funded by	• Commonwealth funding provided to Prosthetic and Orthotic services in public hospitals
Role of Australian Government	• Funds Prosthetic and Orthotic services in public hospitals
Role of state/territory governments	• N/A – funding provided by the Australian Government is managed directly by public hospitals in Victoria

Source: The Royal Melbourne Hospital (2024).[188]

E.11 Western Australia

Table 129: WALSA funding based on mobility class

Mobility class	Foot Component Funding	Knee Component Funding
Class 1	Standard SACH foot	Standard or safety knee
Class 2	Up to $884.49 per foot	Knee selected by PSP, not exceeding Class 3 knee funding
Class 3	Up to $884.49 per foot	Up to $3,007.66 per knee
Class 4	Up to $1,353.75 per foot	Up to $3,329.85 per knee

Source: Healthy WA (2022)[189]

[188] The Royal Melbourne Hospital. (2024). *Prosthetics and Orthotics.* https://www.thermh.org.au/services/prosthetics-orthotics
[189] HealthyWA. (2022). *Prostheses for amputees*. https://www.healthywa.wa.gov.au/Articles/N_R/Prostheses-for-amputees

Table 130: WALSA details

Category	Description
Eligibility criteria	Interim prosthesis: • All age groups requiring an interim prosthesis for the completion of a rehabilitation program • Holds a current green Medicare card Definitive prosthesis: • A permanent WA resident, and • Holds a current green Medicare card or protected special category visa, and • Has completed a 'rehabilitation program' using an interim prosthesis, been assessed by the rehabilitation consultant and deemed competent and suitable to use a prosthetic limb, and • are not obtaining prosthetic funding support or services through another government agency or state service.
Products and services included	Upper and lower limb prostheses including: • Interim Prostheses • One standard permanent prosthesis per limb which could include Standard SACH foot, standard knee or safety knee Annual consumable items per limb, including: • 2 cosmetic gloves • 12 stockings • 1 donning aid • 6 gel socks • 4 liners • Lotions/creams/sprays as required • 6 sheaths • 24 socks • 2 stump shrinkers • 4 suspension sleeves
Cost coverage	• WALSA will contribute up to the maximum funding levels for registered WALSA individuals by the relevant mobility class for the purchase of non-standard componentry. • Individuals may provide additional funding themselves to purchase an alternative prosthesis
Repairs and warranty	• Prostheses are expected to last 3 years • Replacement of a prosthesis during the 3-year period may require clinical justification and/or clarification by the PSP maintaining the prosthetic limb and components.
Referral pathway	• Attend prescribing amputee clinic for assessment and prescription • WAALS reviews and approves funding, which is then directed to the individual's chosen PSP
Setting in which prostheses may be accessed	• Fiona Stanley Hospital Rehabilitation Unit
Clinicians involved	An amputee clinic multidisciplinary teams involves a: • Rehabilitation physicians: assess, diagnoses and treats a person's mobility and function. • Prosthetists: assesses the persons functional needs, and design, manufacture and fit prosthetic limb • Physiotherapist: supports rehabilitation and strength training
Funded by	• Commonwealth funding provided to WALSA
Role of Australian Government	• Funds the WALSA
Role of state/territory governments	• Manages and distributes funding

Source: Healthy WA (2022) [190]

[190] HealthyWA. (2022). *Prostheses for amputees*. https://www.healthywa.wa.gov.au/Articles/N_R/Prostheses-for-amputees

Appendix F: State and territory accredited amputee clinics and PSPs

F.1 NSW accredited amputee clinics and PSPs

Table 131: EnableNSW accredited amputee clinics and PSPs in Metropolitan NSW

EnableNSW accredited amputee clinic	Prosthetic service provider
Royal Prince Alfred Hospital	APC Prosthetics
Lidcombe Hospital Amputee Clinic and Rehabilitation Service	APC Prosthetics
Bathurst Base Hospital Rehabilitation Unit	Southern Prosthetics and Orthotics
Camden Hospital Amputee Clinic	Southern Prosthetics and Orthotics
Concord Hospital	Artificial Limbs and Appliances (OAPL)
Hornsby Ku-Ring-Gai Hospital	APC Prosthetic
St Vincent's Hospital	OAPL
Nepean Hospital	OAPL, Southern Prosthetics and Orthotics
Liverpool Hospital	APC Prosthetics
St George Hospital	OAPL
Prince of Wales Hospital	OAPL
Sutherland Hospital Amputee Clinic	OAPL
Royal North Shore Hospital	APC Prosthetics
Port Kembla Hospital Prosthetics and Orthotics	Southern Prosthetics and Orthotics
Westmead Hospital	APC Prosthetics

Source: EnableNSW (n.d)

Table 132: EnableNSW accredited amputee clinics and PSPs in Regional NSW

EnableNSW accredited amputee clinic	Prosthetic service provider
Gosford Private Hospital	No information
Wyong Hospital	APC Prosthetics
Woy Woy Hospital	APC Prosthetics
Tamworth Base Hospital	APC Prosthetics
Dubbo Lourdes Hospital	Hunter Prosthetics and Orthotics Service
Hunter Valley Private Hospital	No information
Rankin Park Hospital	Hunter Prosthetics and Orthotics Service
Orange Health Service	Southern Prosthetics and Orthotics
Bathurst Base Hospital	APC Prosthetics
Wagga Wagga Rural Referral Hospital	Albury Prosthetics and Orthotics Service

Source: EnableNSW (n.d)

Table 133: EnableNSW accredited amputee clinics and PSPs in Remote NSW

EnableNSW accredited amputee clinic	Prosthetic service provider
Coffs Harbour Health Campus	Northern Prosthetics
Lismore Carroll Centre	Northern Prosthetics
Port Macquarie Base Hospital	Hunter Prosthetics and Orthotics Service
Nowra Shoalhaven Hospital	Southern Prosthetics and Orthotics
Wingham Hospital	APC Prosthetics
Albury Wodonga Prosthetics and Orthotics Service	Albury Prosthetics and Orthotics Service

Source: EnableNSW (n.d)[191]

[191] EnableNSW. (n.d.) EnableNSW accredited amputee clinics. https://www.enable.health.nsw.gov.au/services/pls/enablensw-accredited-amputee-clinics

F.2 QLD accredited amputee clinics and PSPs

Table 134: QALS accredited amputee clinics and PSPs

Location	QALS accredited amputee clinic	Prosthetic service provider
Metropolitan	• Royal Brisbane and Women's Hospital • Princess Alexandra Hospital • Queensland Children's Hospital • Redcliffe Community Health Centre • Sunshine Coast University Hospital • Gold Coast University Hospital	• Brisbane: Ability Prosthetics and Orthotics (APO), OAPL, Leading Edge Prosthetics, Prosthetic Solutions Queensland • Logan: OAPL, Queensland Prosthetics (QP) • Gold Coast: Custom Prosthetics, Southern Prosthetics and Orthotics • Ipswich: OAPL • Sunshine Coast: OAPL, Dynamic Prosthetics and Orthotics, Prosthetics Solutions Queensland
Regional	• Toowoomba Health Service • Rockhampton Hospital • Maryborough General Hospital • Bundaberg Hospital • Mackay base Hospital • Cairns Base Hospital • Townsville General Hospital	• Toowoomba: Multiple PSPs including APO, OAPL, and Dynamic Prosthetics and Orthotics (DPO) • Bundaberg, Maryborough, Rockhampton, Mackay, Cairns, Townsville: OAPL, SSS Prosthetics and Orthotics, APO, and DPO

Source: Queensland Health (2025) [192]

F.3 SA accredited amputee clinics

Table 135: SA amputee clinics

Location	Amputee clinic
Metropolitan	• Central Adelaide: Queen Elizabeth Hospital (with outreach to the Royal Adelaide Hospital and Hampstead Rehabilitation Centre) • Northern Adelaide Rehabilitation Service (Orthotics and Prosthetics Clinic) • Southern Adelaide: Flinders Medical Centre
Regional	• Ceduna – Visiting service every two months (Whyalla Orthotic & Prosthetic Team) • Coober Pedy – Visiting service every three months • Mount Gambier – Fortnightly visits • Port Augusta – Weekly service (servicing Far North SA) • Port Lincoln – Visiting service every third Thursday • Port Pirie – Visiting service every third Wednesday • Whyalla [193]

Source: Queensland Health. (2025). [194]

[192] Queensland Health. 2025. *QALS Resources – Groups and Contact Lists. https*://www.health.qld.gov.au/mass/prescribe/artificial-limbs/qals-groups#AmputeeClinics
[193] SA Health. (2025). Orthotics and prosthetic services. https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/services/hospitals/rehabilitation+services/orthotics+and+prosthetics+services/orthotics+and+prosthetics+services#_Ceduna
[194] Queensland Health. 2025. *QALS Resources – Groups and Contact Lists. https*://www.health.qld.gov.au/mass/prescribe/artificial-limbs/qals-groups#AmputeeClinics

Appendix G: Equity issues and case studies

As described in Section 4.2, a number of issues related to equitable access of prostheses have been identified and grouped into the following three categories:

12. Differences in equitable access between different types of prostheses
13. Differences in equitable access within the same type of prosthesis
14. Additional access issues experienced by priority population groups.

This appendix provides additional details regarding each equity issue, as well as case studies to further illustrate the differences in equitable access.

The equity issues were identified via a variety of sources including desktop research and mapping of the available schemes and programs for prostheses, consultation with stakeholders including clinicians involved in the delivery of prostheses services and people living with or who have lived experience of cancer, and stakeholder survey responses. The case studies were developed based on the experiences and insights shared by stakeholders during consultation, however, are not based on specific individuals.

G.1 Differences in equitable access between different types of prostheses

When considering differences in equitable access between different types of prostheses, two key issues were identified:

- 1A: Inconsistent availability of national prostheses programs and schemes
- 1B: Inconsistent funding models used by existing national programs and schemes.

Equity Issue 1A: Inconsistent availability of national programs and schemes

As described in Section 2, there is a national program and funding scheme available for people who require external breast prostheses (EBPRP) and limb prostheses (NDIS). In contrast, there is no national program or funding scheme available for people requiring a facial prosthesis. Instead, the individuals who have had a part of their face removed due to head and neck cancer are reliant on the availability of jurisdictional prostheses services, which are highly fragmented, varied and limited, or are required to fund the cost of their prostheses out of their own pocket.

The differences in equitable access to prostheses due to inconsistencies in the availability of national programs and schemes is illustrated by Case Study 1A outlined over page. This case study has been developed based on stakeholder experiences shared during consultation activities conducted as part of this review.

Case Study 1A: Steve and Sylvia

Steve

Steve is a 70-year-old man living in Sydney who was recently diagnosed with head and neck cancer. Steve is retired and an active member of his community – he plays lawn bowls once a week and enjoys spending the remainder of his spare time helping to look after his three young grandchildren.

As part of his cancer treatment, Steve underwent surgery to remove his nose. Following his recovery from surgery, Steve asked his surgeon about options for a prosthesis.

With no publicly funded facial prostheses services available in Sydney, Steve was referred to a private anaplastologist. Steve was quoted $5,000 for a custom-made prosthesis, which would need to be replaced every two to three years, and was shocked to learn that there is no government funding or rebate available. He enquired with both the NDIS and his private health insurance, however, was told that facial prostheses are not covered by either scheme. With cost of living pressures and being a retiree, Steve couldn't afford to pay for an initial prosthesis and couldn't imagine how he could possibly afford ongoing replacements for the rest of his life.

Two years on from his surgery, Steve is still living without a prosthesis and is experiencing significant mental health challenges. He no longer plays lawn bowls as his feels uncomfortable in public, he has withdrawn from family and friends due to embarrassment about his appearance and even no longer sees his grandchildren.

Sylvia

Sylvia is a 70-year-old woman living in Sydney who was recently diagnosed with breast cancer. Sylvia is retired and enjoys socialising with her friends and family.

As part of her cancer treatment, Sylvia underwent a unilateral mastectomy. Following her surgery, Sylvia received a My Care Kit from BCNA, which included a temporary breast prosthesis and post-surgery bra.

Once she had fully recovered from surgery, Sylvia's breast care nurse referred her to an external breast retailer 10 minutes-drive from her house where she was measured and fitted for an external breast prosthesis. Sylvia was required to pay $400 upfront for her prosthesis, however, was fully re-imbursed for this through the EBPRP two weeks later.

Two years on from her surgery, Sylvia is in remission, has returned to her everyday activities and feels comfortable and confident to socialise with her friends and family thanks to her breast prosthesis. Soon, Sylvia will return to the same retailer to replace her current prosthesis. Her replacement prosthesis will be reimbursed under the EBPRP in the same way that her first prosthesis was.

Source: KPMG (2025) using information provided by stakeholders during consultation

Equity Issue 1B: Inconsistent funding models used by existing national programs and schemes

As outlined in Section 2, different funding models underpin existing national programs and schemes for prostheses. The EBPRP operates under a reimbursement model which requires participants to make an upfront payment of at least $400 per prosthesis in order to access breast prostheses. As outlined in Section 4.1.4, the requirement to make an upfront payment is a significant barrier to access for many people who require breast prostheses, with many not being able to access a prosthesis as a result.

In contrast, people who meet the eligibility criteria for either the NDIS or DVA, are able to access fully funded limb prostheses without being required to make an upfront or gap payment.

The differences in equitable access to prostheses due to inconsistent funding models used by these existing national programs and schemes is illustrated by Case Study 1B outlined over page. This case study has been developed based on stakeholder experiences shared during consultation activities conducted as part of this review.

Case Study 1B: Ben and Bianca

Ben

Ben is a 32-year-old man living in Brisbane who was recently diagnosed with osteosarcoma in his left femur. Ben lives an active lifestyle and works as an accountant in the Brisbane CBD. As part of his cancer treatment, Ben underwent an above knee amputation on his left side. Following his recovery from surgery, Ben received an interim prosthesis through his local hospital's artificial limb scheme.

After an assessment, Ben's orthotist recommended that Ben would be an ideal candidate for a K3 level prosthetic with a microprocessor knee and energy restoring foot. This prosthetic limb would support Ben's active lifestyle and enable him to still walk to and from the train station each day on his commute to work. Ben's orthotist and physiotherapist supported his application to the NDIS for his prosthetic limb, which was approved and fully funded. Despite Ben's limb being expensive (approximately $200,000), Ben was not required to make any upfront or out-of-pocket payments.

Two years on from his surgery, Ben is thrilled with his prosthetic limb. He has been able to restore his function following his amputation and now maintains an active lifestyle.

Bianca

Bianca is a 34-year-old woman living in Brisbane who was recently diagnosed with breast cancer. Bianca is married and a full-time mum to a two-year-old daughter. As part of her cancer treatment, Bianca underwent a unilateral mastectomy. Following her surgery, Bianca received a My Care Kit from BCNA, which included a temporary breast prosthesis and post-surgery bra.

Once she had fully recovered from surgery, Bianca's breast care nurse referred her to an external breast retailer to be fitted for an external breast prosthesis for long-term use. When Bianca called the retailer to make an appointment she was informed that she would need to make a $400 upfront payment for her prosthesis, which would later be reimbursed under the EBPRP. With increasing cost of living pressures and Bianca not currently working while raising her young daughter, the upfront payment required would put significant pressure on her family's financial situation. Bianca decided to not proceed with purchasing the prosthesis and instead, continued to use her temporary prosthesis.

Two years on from her surgery, Bianca is still using her temporary prosthesis. As the temporary prosthesis is not weighted nor intended for long-term use, Bianca has developed chronic neck and back pain and frequently develops skin irritations from the prosthesis. While the option to obtain a more suitable prosthesis for long-term use under the EBPRP is still available, the upfront payment required remains a significant barrier for Bianca.

Source: KPMG (2025) using information provided by stakeholders during consultation

G.2 Differences in equitable access for the same type of prostheses

When considering differences in equitable access for the same type of prostheses, three key issues were identified:

- 2A: Variability in availability of facial prostheses services between jurisdictions
- 2B: Variability in prostheses available under the NDIS and jurisdictional limb schemes
- 2C: Variability between jurisdictional limb schemes.

Equity Issue 2A: Variability in availability of facial prostheses services between jurisdictions

As outlined in Section 2, there is significant variation across jurisdictions in the availability of publicly funded facial prostheses services, schemes and programs. In Victoria, Queensland and Western Australia, some major public hospitals provide access and funding to facial prostheses including orbital, ears, nasal, and hemifacial prostheses. In the ACT, only ocular prostheses are publicly funded, while ear, hemifacial and nasal prostheses are not covered. In New South Wales, South Australia, Tasmania and the Northern Territory, there are no publicly funded facial prostheses services, meaning individuals must travel interstate to access prostheses where they may facing long wait times as non-residents. Stakeholders described this as being a "postcode lottery" where the ability to access prostheses is entirely dependent on where you live.

The differences in equitable access to facial prostheses due to the variable availability of publicly funded facial prostheses services across Australia is illustrated by Case Study 2A outlined below. This case study has been developed based on stakeholder experiences shared during consultation activities conducted as part of this review.

Case Study 2A: Raj and Robert

Raj

Raj is 54 years old, lives in Adelaide and works as a school teacher. He recently completed treatment for head and neck cancer, which resulted in the removal of one of his ears.

Following his recovery from surgery, Raj asked his surgeon about options for a prosthesis. With no publicly funded facial prostheses services available in South Australia, Raj was informed that there were no options available to him in South Australia and that he would need to travel interstate if he wanted to access a prosthesis.

Raj enquired with an interstate anaplastologist and received a quote of approximately $4,000 for a prosthetic ear, which would need to be replaced every three years. Along with the cost of travel and accommodation for consultations, fittings, and future replacements Raj could not afford this and made the difficult decision to forego a prosthesis.

Two years on from his surgery, Raj continues to live without a prosthesis. He decided not to return to his job as a teacher due to discomfort and embarrassment regarding his appearance. He also now avoids social outings and feels increasingly isolated from his family and friends.

Robert

Robert is 56 years old, lives in Brisbane and owns a cafe. Like Raj, Robert also recently underwent surgery for head and neck cancer that resulted in the removal of one of his ears.

Following his surgery, Robert was referred to a publicly funded facial prosthesis service at the Royal Brisbane and Women's Hospital. Robert was placed on a wait list, however after a six-month wait, received a custom-made prosthetic ear at no personal cost.

After receiving his prosthesis, Robert soon returned to serving his regular customers at his cafe with a renewed sense of confidence. His prosthesis will require replacing in approximately three years, at which time he will return to the Royal Brisbane and Women's Hospital where he will receive a replacement prosthesis at no cost.

Source: KPMG (2025) using information provided by stakeholders during consultation

Equity Issue 2B: Variability in prostheses available under the NDIS and jurisdictional limb schemes

As detailed in Section 2, people who have lost their limbs due to cancer or cancer treatment typically receive their definitive prosthetic limb through the NDIS. Stakeholders reported that under the NDIS, subject to an application and approval process, advanced limbs are able to be accessed, including microprocessor knees and energy restoring feet.

Individuals who do not meet the eligibility criteria for the NDIS, which includes all people aged 65 years and older, are reliant on jurisdiction-based limb schemes. With the exception of New South Wales, jurisdictional limb schemes do not fund high grade prostheses, such as microprocessor knees and computerised components, which are funded under the NDIS for those who are eligible. This means that those reliant on jurisdictional limb schemes can typically only access basic prostheses and components such as mechanical knees.

> "Without access to higher-grade prostheses, many people aged 65 and older are left with no option but to use a wheelchair. Lower-grade prostheses can be so physically and mentally exhausting to use that walking becomes impossible."
>
> **- Clinician**

The differences in equitable access due to variability in the types of prostheses available under the NDIS and jurisdictional limb schemes is illustrated by Case Study 2B outlined below. This case study has been developed based on stakeholder experiences shared during consultation activities conducted as part of this review.

Case Study 2B: John and Jenny

John

John is 66 years old, lives in Perth and recently underwent an above knee amputation as a result of cancer. Prior to his cancer diagnosis, John lived an active lifestyle and while he was starting to consider his future retirement plans, he was still working four days per week in real estate.

As John does not meet the age-based eligibility requirements of the NDIS, he is provided with a prosthetic limb with a mechanical knee unit through the Western Australia limb service. Following his cancer treatment, John has lost muscle mass and tone and due to the weight of the mechanical knee unit, John finds walking with his prosthesis extremely difficult. He finds himself needing to concentrate with every step he takes as his prosthetic often feels unstable, leaving him mentally and physically exhausted at the end of each day.

John has also experienced several falls with the use of the mechanical knee unit, particularly in the initial stages while he was getting used to the new prosthesis, with two falls resulting in a short hospital stay. As a result of the falls, John has lost confidence in walking and now uses a wheelchair.

Due to his mobility challenges, he decided to bring forward his retirement and not return to work. John reflects that his quality of life has deteriorated significantly since his amputation and he has found it incredibly difficult to adjust to his new life and circumstances.

Jenny

In contrast, Jenny is 63 years old. Like John, Jenny recently underwent an above-knee amputation due to cancer. Being under 65 years of age, Jenny is eligible to receive a limb prosthesis through the NDIS.

Jenny tried a few prostheses and found that the microprocessor knee suits her and her lifestyle best. With the support of her orthotist and physiotherapist, the NDIS approved funding for her prosthesis as well as physiotherapy sessions that helped Jenny to rebuild her strength and adjust to mobilising with her new prosthetic.

Jenny has been able to adjust to her new life with a prosthesis and has not experienced any adverse events such as falls due to the stability offered by her prosthesis.

Source: KPMG (2025) using information provided by stakeholders during consultation

Equity Issue 2C: Variability between jurisdictional limb schemes

As mentioned in Section 2, there are significant differences between jurisdictional limb schemes. These differences include funding provided per person, treatment approaches, prosthetic componentry and consumables provided.

As highlighted under Equity Issue 2B, stakeholders reported that New South Wales are the only jurisdiction that currently offer access to advanced componentry, including microprocessor knees. This means that if John, from Case Study 2B, lived in New South Wales rather than Western Australia, he would have likely been able to access a limb with more advanced componentry, such as a microprocessor knee or energy restoring foot. The impact of being able to access a more advanced limb for John would likely be significant. According to stakeholders consulted as part of this review, microprocessor knees offer significant benefits for older individuals in particular due to the enhanced safety and stability offered. Stakeholders described this inequity as a further example of "postcode lottery".

G.3 Additional access issues experienced by priority population groups

As identified in the Australian Cancer Plan, significant disparities in cancer outcomes exist between specific population groups in Australia. This section explores the additional equity issues identified for priority population groups, as defined by the Australian Cancer Plan, in relation to access to cancer prostheses. These issues include:

- 3A: Limited services available in rural and remote areas
- 3B: Financial barriers for people in lower socioeconomic groups
- 3C: Additional financial burden for young people requiring facial prostheses

Equity Issue 3A: Limited services available in rural and remote areas

It was consistently identified by stakeholders that people living in rural and remote areas experience additional barriers to accessing prostheses services compared to those who live in metropolitan or regional areas. As outlined in Section 2, most prostheses services are located in metropolitan areas, with some availability, depending on prosthesis type, in regional areas. This is reportedly driven by a combination of factors, including the relatively small size of the prosthesis workforce, the highly specialised nature of prostheses services and the relatively small number of people who require prostheses services.

While it was highlighted by stakeholders that establishing dedicated prostheses services in rural and remote areas would be impractical and cost prohibitive, there is currently limited evidence of the use of alternate models such as virtual care, outreach/mobile services or hub and spoke models to deliver prostheses care to people in rural and remote areas. For people living in rural and remote areas, the need to travel long distances to access prostheses services presents a significant financial and logistical barrier to access that is not experienced by people living in metropolitan or regional areas. While some jurisdictions offer partial reimbursement for travel costs related to medical care, these schemes often do not cover full travel costs.

The differences in equitable access due to the limited service availability in rural and remote areas is illustrated by Case Study 3A outlined over page. This case study has been developed based on stakeholder experiences shared during consultation activities conducted as part of this review.

Case Study 3A: Robert and Rebecca

Robert

Robert is 56 years old, lives in Brisbane and owns a cafe. As outlined in Case Study 2A, Robert recently underwent surgery for head and neck cancer that resulted in the removal of one of his ears.

Following his surgery, Robert was referred to a publicly funded facial prosthesis service at the Royal Brisbane and Women's Hospital. Robert was placed on a wait list, however after a 6 month wait, received a custom-made prosthetic ear at no personal cost.

After receiving his prosthesis, Robert soon returned to serving his regular customers at the cafe with a renewed sense of confidence. His prosthesis will require replacing in approximately three years, at which time he will return to the Royal Brisbane and Women's Hospital where he will receive a replacement prosthesis at no cost.

Rebecca

Rebecca is 46 years old and lives in Mount Isa in Queensland. Like Robert, Rebecca recently underwent surgery for head and neck cancer that resulted in the removal of one of her ears.

Following surgery, Rebecca was informed that the only publicly funded facial prosthesis service in Queensland was located in Brisbane. While concerned about her appearance following surgery, Rebecca had already spent long periods of time away from home as part of her cancer care. The prospect, and potential costs involved, of having to make additional trips to Brisbane to access prosthetic care leads Rebecca to decide against accessing a prosthesis.

Two years on from her surgery, Rebecca is still living without a prosthesis. She has withdrawn from her community due to embarrassment about her appearance and is experiencing significant mental health challenges as a result.

Source: KPMG (2025) using information provided by stakeholders during consultation

Equity Issue 3B: Significant financial barriers exist for people in lower socioeconomic groups

In jurisdictions where there are no publicly funded facial prostheses services available, people in lower socioeconomic groups face significant financial barriers to access. The costs involved in accessing private prostheses services can be substantial, with the cost of an ear, nose or hemi-facial prosthetic reported to range from $2,000 to $10,000. In addition to this initial cost, facial prostheses are typically made of silicone and do not last more than two to three years, leading to recurring expenses to continually replace the prosthesis every few years for the remainder of the person's life.

These barriers are not unique to facial prostheses. People from lower socioeconomic groups were also identified to experience barriers in accessing external breast prostheses under the EBPRP. Due to the program's reimbursement model, an upfront payment of at least $400 must be made to access a prosthesis. While this payment will be reimbursed approximately two weeks later, it was reported by stakeholders that the upfront payment can present a significant barrier to access for those in lower socioeconomic groups.

These financial barriers to accessing prostheses are illustrated by Steve's experience outlined Case Study 1A and Bianca's experience described in Case Study 1B.

Equity Issue 3C: Additional financial burden for young people requiring facial prostheses

Further to the financial barriers outlined under Equity Issue 3B, there is an additional financial burden for young people who require facial prostheses where there are no publicly funded services available. Stakeholders highlighted that children up to the age of six may require a new prosthesis every couple of months as they grow. After the age of six and until fully grown, a new prosthesis is typically required every year. The increased need for replacement prostheses presents an additional financial burden and barrier to access than what would be experienced by adults living in the same jurisdiction.

Additionally, in some jurisdictions it was reported by stakeholders that facial prostheses services may be provided at no cost under publicly funded paediatric services. However, once a person ages out of paediatric services, these services are no longer available.

> "I lost half my face at 8 years of age – my prosthetics were covered as I was a child. I became an adult and whoosh all services disappeared. My private health told me it was cosmetic and I was told I wasn't deformed enough to get NDIS. I had the same prosthesis that I paid for when I was 24 until I turned 50 – the same pair of glasses for 26 years because nobody could detach and reapply the prosthetic to spectacles.
>
> **- Person with lived experience of cancer**

Appendix H: Cost model inputs

Table 136: Cost model CPI and discount rate inputs

Item	Value	Source
Healthcare CPI	4.1%	Consumer Price Index, Australian Bureau of Statistics
Discount Rate	5.0%	Pharmaceutical Benefits Advisory Committee (PBAC) Guidelines

Source: KPMG (2025)

Table 137: Cost model inputs for head and neck cancer

Item	Value	Source
Cases (2024 estimate)	5,531	AIHW Australian Cancer Database
Age-standardised Incidence (per 100,000 people)	20.4	AIHW Australian Cancer Database
5-year survival	72.0%	Cancer Australia
Proportion requiring a prosthesis	4.52%	KPMG assumption based on Head and Neck Cancer Australia Budget Submission

Source: KPMG (2025)

Table 138: Cost model inputs for melanoma

Item	Value	Source
Cases (2024 estimate)	18,964	AIHW Australian Cancer Database
Age-standardised Incidence (per 100,000 people)	69.8	AIHW Australian Cancer Database
5-year survival	94.0%	Cancer Australia
Proportion occurring on the face/head/neck	17.5%	Zito PM, Scharf R. (2023) Melanoma of the Head and Neck. Retrieved from: https://www.ncbi.nlm.nih.gov/books/NBK513248/ Note: Estimate is 10% to 25%, the mid-point was adopted.
Proportion requiring a prosthesis	4.52%	KPMG assumption based on Head and Neck Cancer Australia Budget Submission

Source: KPMG (2025)

Table 139: Cost model inputs for eye cancer

Item	Value	Source
Cases (2024 estimate)	368	AIHW Australian Cancer Database
Age-standardised Incidence (per 100,000 people)	1.4	AIHW Australian Cancer Database
5-year survival	85.0%	Cancer Australia
Proportion requiring a prosthesis	35.0%	Huang, Y., & Guo, Y. (2024). Quality of life among people with eye cancer: a systematic review from 2012 to 2022. *Health and quality of life outcomes*, *22*(1), 3. https://doi.org/10.1186/s12955-023-02219-6.

Source: KPMG (2025)

Table 140: Cost model inputs for sarcoma of all types

Item	Value	Source
Cases (2024 estimate)	1,782	AIHW Australian Cancer Database
Age-standardised Incidence (per 100,000 people)	9.9	AIHW Australian Cancer Database
5-year survival	70.0%	Cancer Australia
Proportion requiring an amputation	4.20%	Dilday, J.C., Nelson, D.W., Fischer, T.D. et al. Disparities in Amputation Rates for Non-metastatic Extremity Soft Tissue Sarcomas and the Impact on Survival. Ann Surg Oncol 28, 576–584 (2021). https://doi.org/10.1245/s10434-020-08586-4

Source: KPMG (2025)

Table 141: Cost model inputs for breast cancer

Item	Value	Source
Cases (2024 estimate, female only)	20,973	AIHW Australian Cancer Database
Age-standardised Incidence (per 100,000 people)	78.1	AIHW Australian Cancer Database
5-year survival	92.0%	Cancer Australia
Proportion of unilateral mastectomy	21.0%	Fefferman M, Nicholson K, Kuchta K, Pesce C, Kopkash K, Yao K. Rates of Bilateral Mastectomy in Patients With Early-Stage Breast Cancer. JAMA Netw Open. 2023;6(1):e2251348. doi:10.1001/jamanetworkopen.2022.51348
Proportion of bilateral mastectomy	12.5%	Fefferman M, Nicholson K, Kuchta K, Pesce C, Kopkash K, Yao K. Rates of Bilateral Mastectomy in Patients With Early-Stage Breast Cancer. JAMA Netw Open. 2023;6(1):e2251348. doi:10.1001/jamanetworkopen.2022.51348
Proportion that have reconstructive surgery	50.0%	RACGP

Source: KPMG (2025)

Table 142: Cost model inputs

Item	Value	Source
Initial facial prosthesis	$6,000	Stakeholder consultation
Replacement facial prosthesis	$4,500	Stakeholder consultation (cost is estimated to be 75% of a new prosthesis)
Ocular prosthesis (new and replacement)	$2,500	Stakeholder consultation
Ocular maintenance (annual polish)	$70	Stakeholder consultation
Initial Artificial limb	$100,000	KPMG assumption (cost range is between $15k and $250k+, it was identified that more than 75% of people over 65 would benefit from a more advanced limb than the relatively basic limbs available through most state-based limb schemes)
Replacement limb	$75,000	KPMG assumption – assumed to be 75% of the cost of a new artificial limb.
Consumables and maintenance (annual)	$3,000	KPMG assumption
External breast prosthesis	$400	EBPRP

Source: KPMG (2025)

Appendix I: Alt text for Figure 5 Overarching review approach

Purpose

Purpose of the review is to understand current cancer prostheses services and schemes in Australia and in comparable countries, to identify barriers to accessing prostheses services for people living with or who have lived experience of cancer, to develop strategies to address identified gaps and barriers, considering the needs of priority population groups, and to consider the costs of a national program that addresses gaps in equity of access to prostheses for people living with or have lived experience of cancer.

Key review questions

There were seven key review questions that the review was looking to answer. These included:

1. What prostheses services/schemes are currently available to people living with or who have lived experience of cancer?
2. What role do state, territory and commonwealth governments currently play in providing access to cancer prostheses?
3. In what health setting/s are people living with or who have lived experience of cancer accessing prostheses?
4. What are the current barriers faced by people living with or who have lived experience of cancer in accessing prostheses?
5. Are there particular prosthesis types that are more difficult than others to access? Are there particular prosthesis types that are not covered by any existing support schemes?
6. Is there a gap in equity and access to prostheses for individuals living with or post a cancer diagnosis?
7. What would be the cost and appropriate delivery model for a national cancer prosthesis program?

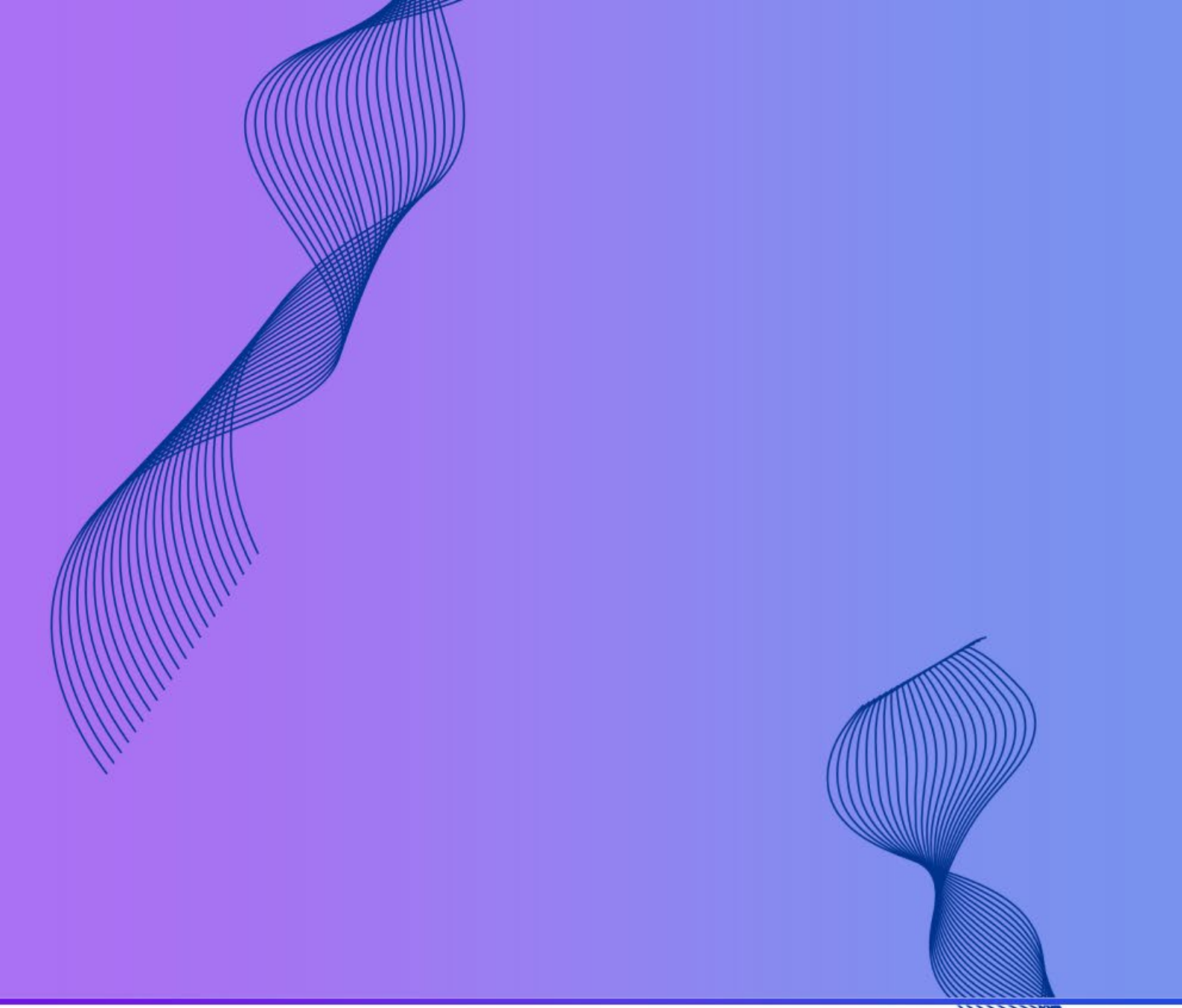
Data sources

Data sources to answer the key review questions included primary and secondary data. Primary data included views and experiences of key stakeholders gained through consultation and surveys, including Department of Health, Disability and Ageing, National Disability Insurance Agency, Department of Veterans Affairs, State and territory health departments, Clinicians and retailers of prostheses, People living with or who have lived experience of cancer and their carers and Peak bodies and advocacy groups. Secondary data included Documents related to cancer prostheses schemes, programs and approaches used in Australia, Grey and academic literature related to cancer prostheses schemes, programs and approaches used internationally, Australian Institute of Health and Wellbeing cancer data and Australian Bureau of Statistics cancer data.

Outputs

The outputs of the project include a draft and final review report.

Return to Figure 5.



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This report has been prepared as outlined with the Australian Government Department of Health, Disability and Ageing in the scope section of the engagement letter / contract executed on 3 March 2025. The services provided in connection with this engagement comprise an advisory engagement, which is not subject to assurance or other standards issued by the Australian Auditing and Assurance Standards Board and, consequently no opinions or conclusions intended to convey assurance have been expressed.

No warranty of completeness, accuracy or reliability is given in relation to the statements and representations made by, and the information and documentation provided by Australian Government Department of Health, Disability and Ageing stakeholders consulted as part of the process. KPMG has indicated within this report the sources of the information provided. We have not sought to independently verify those sources unless otherwise noted within the report. KPMG is under no obligation in any circumstance to update this report in either oral or written form, for events occurring after the report has been issued in final form.

This report is solely for the purpose set out in the Statement of Work in the Order for Service and for the Department of Health, Disability and Ageing's information, and is not to be used for any purpose not contemplated in the engagement letter / contract or to be distributed to any third party without KPMG's prior written consent.

This report has been prepared at the request of the Department of Health, Disability and Ageing in accordance with the terms of KPMG's engagement letter/contract executed on 3 March 2025. Other than our responsibility to the Department of Health, Disability and Ageing, neither KPMG nor any member or employee of KPMG undertakes responsibility arising in any way from reliance placed by a third party on this report. Any reliance placed is that party's sole responsibility.