All.Can Australia

Pilot project for Action Guide on Efficiencies

20th January 2026

All.Can Australia

Biointelect

Project Objectives and Scope

Objectives: Implement and validate key components of the All.Can Efficiency Action Guide within the Australian context. Support validating and testing of the Action Guide and gathering insights to assess strengths, identify opportunities, and address gaps in cancer care.

Key activities include:

- Testing and validating the Guide using up to two case studies (e.g., metropolitan vs rural area). This approach allows us to generate detailed, context-specific insights and highlight any key differences within the national approach.
- Completing the Action Guide framework for each of these two jurisdictions.
- Conducting stakeholder interviews to supplement desk research findings.

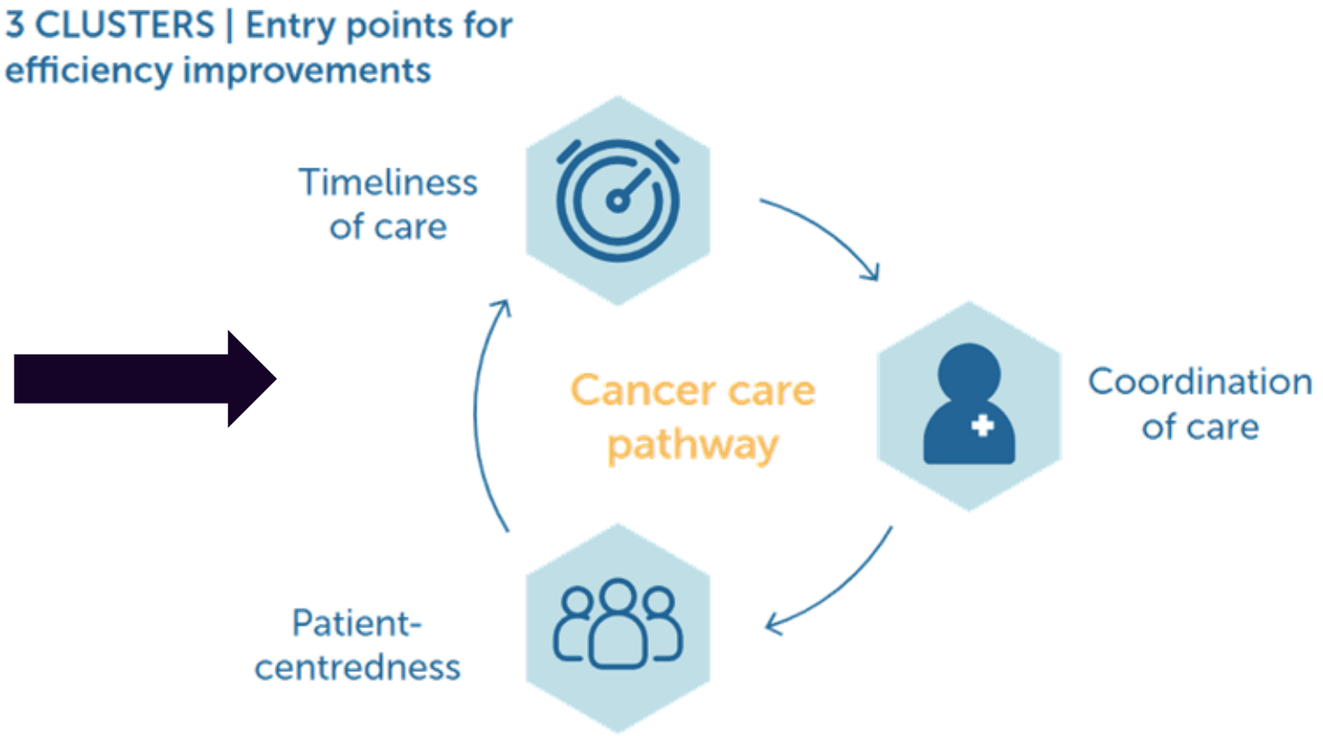
All.Can’s Efficiency Metrics

All.Can is a multi-stakeholder initiative involving patient, clinical, academic and industry experts as well as policymakers. We aim to help define better solutions for sustainable cancer care and improve patient outcomes in the future. The All.Can initiative is made possible with financial support from Bristol-Myers Squibb (lead sponsor), Amgen and MSD (co-sponsors).

All.Can's Efficiency Metrics

Metrics identified in the study conducted by the Health Value Alliance in partnership with the University of Southampton

- Time to diagnosis
- Primary care interval
- Percentage of cancers diagnosed through emergency presentation
- Time from tissue diagnosis to treatment
- Percentage of patients who received chemotherapy in the last 14 days of life
- Percentage of patients documented as having seen a clinical nurse specialist
- Patient experience
- Patient involvement in decision making



Summary of All.Can Efficiency Clusters and Metrics

Cluster	Efficiency Metric	Priority stakeholder types to interview	Key topics / questions
Cluster 1: Timeliness of care	**1. Time to diagnosis**	Cancer Australia, cancer care coordinators, clinicians (GPs, oncologists, pathologists, radiologists)	Where are the main delays? Are there expedited pathways and are they working? Is diagnostic capacity (radiology, pathology) sufficient? How are referrals prioritised and tracked?
	2. % of cancers diagnosed via emergency presentation	Public hospitals, private hospitals, emergency physicians, oncologists	Which cancers are most often first detected in ED, and why (type, geography, CALD)? What factors lead to late presentation?
	3. Primary care interval – days from first GP visit to referral	GPs / clinicians	Are referral criteria clear and easy to use? Do GPs have tools/protocols to support timely referrals? How quickly can patients access community-based imaging/diagnostics? Do GPs receive feedback after referrals?
	4. Time from tissue diagnosis to initial treatment	Clinicians - Surgical oncology, medical oncology, radiation oncology	Average time from diagnosis to treatment? Are there delays due to theatre, radiation, or diagnostic capacity? What processes are in place to prioritise urgent cases?
	5. % receiving chemotherapy in last 14 days of life	Medical oncology leads, palliative care specialists, patient/family advocates	How well are patients transitioned from oncology to palliative care? Is advance care planning in place and followed? Do treatment patterns vary by cancer type or site?
Cluster 2: Coordination of care	**6. % patients documented as having seen a clinical nurse specialist**	Oncology nurses/nurse coordinators, cancer patient navigators, cancer institutes, patient advocacy organisations	Do patients have adequate access to specialist oncology nurses? Is there sufficient coverage by patient navigators? Are there workforce or capacity gaps? How well are nurses integrated with multidisciplinary teams/tumour boards?
Cluster 3: Patient centeredness	**7. Patient experience (PREMs) across the care pathway**	Patient experience leads, PROMs/PREMs program managers, patient advocacy groups	What PREMs are currently collected (tools, frequency)? Do response rates reflect diversity (CALD, rural, First Nations)? How are PREMs results used to improve care and decision-making?
	8. Patient involvement in decision making	Clinicians, consumer representatives, patient advocacy groups	Are decision aids consistently available and used? Is shared decision-making documented in practice? How is interpreter support and cultural safety ensured?

Desk research was performed on each individual question to set foundations

A preliminary readiness assessment was determined based on available data

105 Questions across 3 clusters were interrogated using desk research and followed up by stakeholder interviews

Each jurisdiction was rated according to preparedness:

1 = None / Not ready

2 = Somewhat / Partial readiness

3 = In place / Ready

(Cluster 1 Questions - Representative Example only)

	AUS	ACT	NSW	NT	QLD	SA	TAS	VIC	WA
a) Legal frameworks and strategy, policy context and funding									
Is there a cancer control plan or strategy in place, and is its implementation being monitored at national or federal or regional levels?	3	2	3	2	3	3	2	3	3
Where in the system does the responsibility lie for developing national strategic plans? And for implementing and monitoring them?	3	2	3	2	3	3	2	3	3
Is there a national or federal political debate or clear political will to invest in improving the national health data ecosystem?	3	3	2	2	3	3	3	3	3
Has funding been allocated at national, federal or regional levels to invest in improving the national health data ecosystem, and in particular the cancer data ecosystem?	2	3	2	2	3	2	2	3	2
Is there national, federal or regional regulation of training and organisation for supportive care in oncology?	2	2	2	2	2	2	2	2	2
Is there national, federal or regional regulation of training and organisation for palliative care, including end-of-life care, in oncology?	2	2	3	2	2	2	2	3	2
Are national, federal and regional approaches aligned with respect to long-term cancer control plans?	2	2	3	2	3	3	2	3	3
Are legislation and regulations in place pertaining to cancer data registration and cancer care performance? Is implementation of these monitored at national and regional levels?	3	3	3	3	3	3	3	3	3

Stakeholder expertise was sought to validate and supplement desk research findings

To date, eight different stakeholders have informed research methods, findings, and key gaps

Australian Government
Cancer Australia

Albury Wodonga Health

THE UNIVERSITY OF MELBOURNE

Clinical Oncology Society of Australia

All.Can
Changing cancer care together

ICON CANCER CENTRE

VCCC Alliance
Overcoming cancer together

Acronyms and Abbreviations

ACCN	Australian Comprehensive Cancer Network	***HOPE***	Health Outcomes and Patient Experience
ACNNP	Australian Cancer Nursing and Navigation Program	***IHI***	Individual Healthcare Identifier
ACP	Australian Cancer Plan	***MDT***	Multidisciplinary Team
ACSQHC	Australian Commission on Safety and Quality in Health Care	***MHR***	My Health Record
AIHW	Australian Institute of Health and Welfare	***NCCI***	National Cancer Control Indicators
CCC	Comprehensive Cancer Centre	***NCDF***	National Cancer Data Framework
CQR	Clinical Quality Registries	***OCP***	Optimal Care Pathway
ED	Emergency Department	***PBS***	Pharmaceutical Benefits Scheme
EHR	Electronic Health Record	***PREM***	Patient-Reported Experience Measures
EMR	Electronic Medical Record	***PRM***	Patient-Reported Measures
GP	General Practitioner	***PROM***	Patient-Reported Outcome Measures

Australia’s Cancer Care Landscape

All.Can is a multi-stakeholder initiative involving patient, clinical, academic and industry experts as well as policymakers. We aim to help define better solutions for sustainable cancer care and improve patient outcomes in the future. The All.Can initiative is made possible with financial support from Bristol-Myers Squibb (lead sponsor), Amgen and MSD (co-sponsors).

Generally, Australia has a strong cancer care system

This is anchored by a long-term national reform plan, standardised pathways across tumour types and priority populations, and mandatory reporting supported by a comprehensive national registry and data initiatives.

1. **The Australian Cancer Plan (ACP)** provides a 10-year reform agenda with progress reviewed at 2-year and 5-year milestones against defined goals and actions for six strategic objectives.

2. **Optimal Care Pathways** map the care journey for more than 25 tumour types, plus dedicated pathways for Aboriginal and Torres Strait Islander people and adolescents and young adults with cancer.

3. **Cancer is a notifiable disease** with mandatory reporting across all jurisdictions, supported by a comprehensive national cancer registry operational since 1982, complemented by multiple data collection initiatives.

Australia's health care system is highly fragmented, especially in cancer care

The system operates through a complex division of responsibilities across federal, state/territory, and local governments

The federal government funds out-of-hospital services through Medicare and specific programs like cancer screening, whilst **state and territory governments manage public hospitals and community services**, with shared responsibilities between both.

Coordination of cancer services occurs primarily at state level and through Primary Health Networks at regional level (funded by the federal Government).

The division of roles between government levels can be a barrier to cohesive national reform, with cost and accountability shifting leading to service gaps and budget silos that can undermine efficiency.

The current financing structure reflects a complex system that struggles to provide effective patient-centred care, where some patients may experience lack of integration, coordination, and continuity of care between sectors.

Australia's fragmentation has particularly significant implications for cancer patients who require coordinated multidisciplinary care across multiple providers and settings.

Cancer outcomes in Australia vary dramatically by location

Resource shortages in metro areas are compounded further in regional and remote settings, creating geographic inequality

Analysis of 37 studies found a consistent correlation between location and survival rates.[1] The more remote the location, the worse survival chances, with rural Australians 13% less likely to survive cancer.

Mortality rates for all cancers combined are highest in 'very remote' areas (190.7 deaths per 100,000 population) compared with 'major cities' (150.7 per 100,000), with deaths from cervical cancer occurring at 3.3 times the rate in very remote areas.[2]

Cancer Council NSW's 2021 survey revealed that 41% of regional residents have difficulty accessing cancer care due to location, and 78% were concerned that their location could affect survival chances.[3]

Rural patients can experience longer intervals between treatment stages and face barriers including limited specialist access, high travel costs, and suboptimal care coordination.

These disparities stem from numerous factors, including reduced access to screening and specialist services, workforce shortages, treatment delays, substantial travel and accommodation costs, and limited availability of specialised surgery or therapies outside metropolitan centres.

[1] Association of rurality status with all-cause and cancer-specific survival; [2] Cancer in Rural Australia (Fact Sheet); [3] Cancer Council's regional survey results.

Significant challenges exist in systematic, timely public reporting

Despite extensive data across the cancer care continuum (including workforce, expenditure, screening, and clinical outcomes)

Limited national workforce data availability is a longstanding barrier to fully understanding the distribution of capacity and capability of the healthcare workforce as a basis for workforce planning.

The Australian Cancer Database is used for ad hoc data requests for a variety of stakeholders including government agencies, rather than through automated, systematic public reporting. **Only two cancer registries (VIC/NSW) use automatic data collection,** with most registries developing independently with differing modes of logistical infrastructure.

Health expenditure reporting relies on collation of more than multiple data sources which can only be obtained with significant time lag, normally taking over one year after the financial year end to release reports.

The lack of information on cancer stage at diagnosis is a fundamental gap in Australia's national cancer data, with the need for high-quality, comprehensive data on stage, treatment, and recurrence widely recognised but not systematically collected.

Ad hoc reporting commissioned only for specific purposes means that critical data may often not be readily accessible when needed, limiting the system's capacity for real-time learning and responsive adaptation.

Gaps and inconsistencies in data collection and reporting make it challenging to build a complete picture of cancer control, prompting the recent launch of the **National Cancer Data Framework** to enable a consistent approach across all Australian health systems.

Significant inefficiencies exist in translating data back into practice improvements

Despite comprehensive cancer data collection, significant inefficiencies limit the healthcare system's capacity to learn from itself.

Clinical quality registries are intended to drive a self-improving health system through feedback loops, where healthcare providers record data, transfer it to registries, receive benchmarked reports, and improve clinical care. However, optimising this registry feedback loop remains a critical challenge.

In Australian hospitals, EMRs are at various stages of adoption, with each state health department and private hospital adopting their own approach to implementation.

Hybrid records (paper and digital) and multiple systems used in parallel leads to high inefficiencies and difficulties in finding information. This often requires dedicated labour to centralise data across combinations of paper records, scanned medical records, and department-specific EHRs.

Delays in data feedback are a barrier to successful clinical quality registries. The feedback loop should demonstrate translation of data to knowledge, knowledge to practice, and practice back to data.

The fragmentation in health information systems, combined with delayed reporting timelines, means that valuable data often fail to inform real-time clinical practice, quality improvement initiatives, or timely policy decisions.

Ultimately, this limits opportunities to reduce unwarranted variation and improve patient outcomes.

High-level findings across All.Can’s Three Clusters

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Cluster 1: Timeliness of Care

While Australia has strong foundational cancer care infrastructure including a national registry and EHRs, critical gaps in d ata integration, real-time monitoring, and systematic tracking of optimal care pathway compliance are limiting the ability to ensure timely, high -quality cancer treatment.

Data integration

- ✓ **Strong digital health infrastructure investment** and data linkage *capability* exist at national and state levels
- × **The absence of dedicated federal funding for cancer data integration** has resulted in partial and inconsistent EHR interoperability, with data linkage remaining episodic and project-based rather than systematically embedded.

Optimal Care Pathways

- ✓ **Established National Optimal Care Pathways** that embed evidence-based timeframes
- × **Implementation is not mandated and serves as guidance,** with no systematic national monitoring of compliance and limited public reporting of cancer-specific timeliness indicators across jurisdictions.

Electronic Patient Records

- ✓ **National electronic patient records and Individual Healthcare Identifiers exist,** enabling cross-system patient linkage
- × **Time components critical for monitoring diagnosis and treatment pathways are not consistently captured** across health information systems, preventing accurate measurement of care intervals.

Cancer Registry

- ✓ **Australia has had a comprehensive national cancer registry operational for over 40 years** and established data linkage infrastructure
- × **Performance monitoring remains constrained by episodic project-based linkage, significant data lags (3-4 years),** and slow feedback loops that limit real-time system learning.

Data Availability

- ✓ **Five-year survival rates are robustly monitored** and hospital-acquired complications tracked through mandated NSQHS standards
- × **Cancer-specific quality indicators, adverse event reporting, and timeliness metrics are not routinely available** or publicly reported, with incomplete staging data and no near real-time pharmacovigilance systems established.

Proposed Recommendations

- ✓ Federal funding for data integration
- ✓ Systematic OCP timeframe monitoring
- ✓ Standardised time-stamping
- ✓ Routine data linkage
- ✓ Quality and timeliness dashboards

Cluster 1: Timeliness of Care – Key Findings

Strengths

- ✓ A national cancer control plan is in place with a formal Monitoring & Evaluation Framework
- ✓ State and territory cancer strategies are established
- ✓ Clear governance structures exist with defined roles and responsibilities at national and state levels
- ✓ Strong political will and significant government investment in digital health infrastructure
- ✓ Cancer is a notifiable disease with mandatory reporting across all jurisdictions
- ✓ A comprehensive national cancer registry has been operational since 1982
- ✓ National Optimal Care Pathways embed evidence-based timeframes, supportive care, and palliative care principles
- ✓ Palliative care frameworks are established at national and state levels
- ✓ Electronic patient records have been implemented nationally (My Health Record)
- ✓ An Individual Healthcare Identifier system enables cross-system patient linkage.
- ✓ Data linkage infrastructure exists at national and state levels
- ✓ Digital medication management platforms and e-chemotherapy systems are being deployed
- ✓ Five-year survival is robustly monitored at national and state levels
- ✓ National safety and quality standards (NSQHS) are mandated for healthcare organisations
- ✓ Hospital-acquired complications are tracked and reported

Weaknesses

- × Implementation monitoring and accountability vary significantly across jurisdictions
- × No dedicated federal funding stream exists specifically for cancer data integration
- × Waiting time standards are aspirational rather than regulated or mandatory
- × Systematic national monitoring of compliance with Optimal Care Pathway timeframes is absent
- × Public reporting of cancer-specific timeliness indicators is limited
- × Cancer-specific quality indicators and adverse event reporting are not routinely available
- × Staging data coverage is incomplete nationally, limiting outcome evaluation.
- × EHR interoperability across systems is partial and inconsistent
- × Performance data is not available in near real-time (typical lag of 2-3 years)
- × Data linkage is episodic and project-based rather than routine or embedded
- × Time components for monitoring diagnosis and treatment pathways are not consistently captured
- × Near real-time pharmacovigilance systems for cancer drugs are not established
- × National adoption rates of digital medication management systems are not quantified
- × Feedback loops from data to practice improvement are slow, limiting real-time system learning

Cluster 2: Coordination of Care

Despite significant federal investment in patient navigators and the establishment of Comprehensive Cancer Centers, Australia's cancer care coordination is undermined by fragmented workforce monitoring, inconsistent task-sharing regulation, incomplete population coverage by CCCs, and lack of standardized oncology nurse-to-patient ratios.

Workforce monitoring

- ✓ **The National Medical Workforce Strategy 2021-2031 and ACP** provide long-term planning frameworks.
- × **Cancer workforce monitoring remains fragmented** without standardised disease-specific or regional metrics, and systematic evaluation of workforce program impact is largely absent, preventing evidence-based planning.

Cancer Navigation Services

- ✓ **Significant federal investment** ($193 million through the Australian Cancer Nursing and Navigation Program) and Queensland's mature navigator model with 400+ positions since 2017.
- × **Patient navigator role lacks any regulation,** no national workforce ratios exist, and significant access disparities persist between and within states.

Oncology Nurses

- ✓ **Oncology nurses are regulated nationally** through the Nursing and Midwifery Board of Australia and some jurisdictions have mandated nurse-to-patient ratios.
- × **No federal standards exist for minimum oncology nurse-to-patient ratios** specific to cancer care settings such as chemotherapy administration, oncology wards, or palliative care.

Shortages and Task sharing

- ✓ **Workforce Incentive Program** are deployed for regional, rural, and remote areas.
- × **No comprehensive national guidance for task sharing** or substitution amongst cancer professionals, leaving role delineation, accountability frameworks, and quality monitoring undefined and inconsistent.

Comprehensive Cancer Centres (CCCs)

- ✓ **The Australian Comprehensive Cancer Network rollout,** established CCCs in major metropolitan areas, and regular MDT meetings.
- × **CCCs do not provide complete population coverage,** communication challenges persist with fragmented EHRs, and no mandates for MDT composition, meeting frequency, or formal accreditation processes.

Proposed Recommendations

- ✓ Standardised workforce metrics
- ✓ National patient navigator standards
- ✓ Oncology nurse-to-patient ratios
- ✓ Integrated task sharing models
- ✓ ACCN expansion for rural/remote access

Cluster 2: Coordination of Care – Key Findings

Strengths

- ✓ National cancer control plan (ACP) with Strategic Objective 5 focused on workforce transformation
- ✓ National Medical Workforce Strategy 2021-2031 provides long-term planning framework
- ✓ Oncology nurses regulated nationally through Nursing and Midwifery Board of Australia
- ✓ Four jurisdictions have legislated nurse-to-patient ratios with additional states implementing
- ✓ Significant federal investment ($193 million for Australian Cancer Nursing and Navigation Program)
- ✓ Queensland has established mature nurse navigator model with 400+ positions since 2017
- ✓ Cancer Australia's Principles of Multidisciplinary Care provide national MDT guidelines
- ✓ Multidisciplinary tumour boards widely practiced with high clinician participation
- ✓ Australian Comprehensive Cancer Network (ACCN) rollout underway
- ✓ Established comprehensive cancer centres in major metropolitan areas
- ✓ Innovative networked CCC models exist (e.g., South Australia's SACCaN)

Weaknesses

- × Cancer workforce monitoring fragmented without standardised disease-specific or regional metrics
- × No federal standards for minimum oncology nurse-to-patient ratios in cancer care
- × Patient navigator role not regulated nationally or at state levels
- × No published national ratio for patient navigators per population
- × Significant interstate access disparities for navigators, with some states not funding roles
- × No comprehensive national legislation regulating task sharing or substitution among cancer professionals
- × Comprehensive data on shared care implementation and outcomes absent
- × No legislation mandating MDT composition, meeting frequency, or case discussion requirements
- × National-level monitoring of MDT case discussion rates does not exist
- × No formal national certification system or legislated definition for comprehensive cancer centres
- × Comprehensive cancer centres do not provide universal population coverage
- × Implementation of workforce policies varies significantly across jurisdictions
- × Systematic evaluation of workforce program impact largely absent
- × Communication challenges persist with fragmented EHRs and inadequate feedback loops
- × Digital medication traceability systems absent in many centres

Cluster 3: Patient-centredness

While Australia has established frameworks for patient-reported measures and patient rights, implementation remains inconsistent with fragmented PROM/PREM collection, limited integration into EHRs, variable patient engagement in treatment decisions, and inadequate education services for culturally diverse and regional populations.

PROM/PREM Requirements

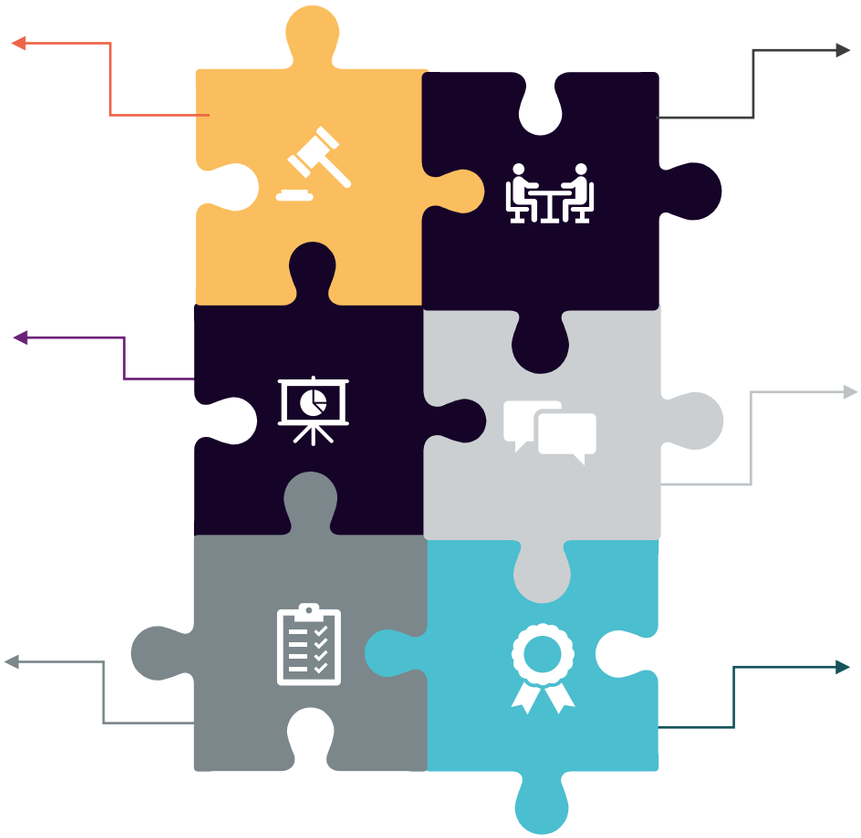
- ✓ **The ACP recognises patient-reported measures** as essential and progress continues through the Pan Cancer project (Australian Real World Cancer Evidence Network)
- × **No mandatory requirements** (with predominantly metro centres collecting PROMs), no consistent reporting framework in place, and federal coordination severely limited to pilots rather than routine practice.

Monitoring PROMs/PREMs

- ✓ **MHR provides consumer-controlled access** for 24.5M Australians after significant federal investment
- × **Integration of PROMs/PREMs into EHRs is not standard practice,** health IT infrastructure lacks standardised data fields or workflows for patient-reported measures, and only one-third of people with MHR s have accessed their own records.

Standardised PROMs/PREMs

- ✓ **Australian Commission maintains validated PROM lists for some conditions,** leading centres provide quantitative outcomes, and ongoing initiatives (OECD PaRIS, ICHOM).
- × **Implementation methodologies vary across jurisdictions**, PROMs/PREMs initiatives remain fragmented without consistent national approach, and national benchmarking and systematic feedback loops are underdeveloped.



Patient Involvement

- ✓ **The Australian Charter of Healthcare Rights (2019)** establishes fundamental rights including partnership and the **ACP was developed through extensive consultation**
- × Mostly guidance rather than mandates, and patient engagement in MDT discussions varies dramatically without standardised requirements for shared decision-making.

Patient Education

- ✓ **Cancer education policies exist** through initiatives such as the Cancer Council helpline and navigation program.
- × **Implementation of patient education services varies widely** especially in regional areas, leaving culturally diverse communities and regional populations underserved.

Proposed Recommendations

- ✓ Mandate PROMs/PREMs collection
- ✓ PROMs/PREMs integration into digital health systems
- ✓ Federal coordination body for standardisation
- ✓ Federal patient rights standards
- ✓ Culturally appropriate mechanisms for diverse populations

Cluster 3: Patient-centredness – Key Findings

Strengths

- ✓ National cancer plan recognises patient-reported measures as essential
- ✓ Australian Charter of Healthcare Rights (2019) establishes seven fundamental rights including partnership
- ✓ Queensland's Human Rights Act 2019 provides legislative mandate for patient rights
- ✓ Progress in PROMs/PREMs ongoing through Pan Cancer project and Australian Real World Cancer Evidence Network
- ✓ Australian Commission maintains validated PROM lists for high-burden cancers
- ✓ Some clinical quality registries successfully incorporate PROMs (e.g., National Gynae-Oncology Registry)
- ✓ MHR system provides consumer-controlled access for 23.8 million Australians
- ✓ ACP developed through extensive consumer consultation
- ✓ Cancer education policies exist (Cancer Council 13 11 20 helpline, navigation program)
- ✓ Leading centres demonstrate PROMs value through improved survival and reduced ED visits
- ✓ Australia engaged with international PROMs initiatives (OECD PaRIS, ICHOM)
- ✓ Significant recent federal investment in digital health

Weaknesses

- × Political commitment to PROMs/PREMs has not translated into mandatory requirements or funded implementation
- × PROMs/PREMs initiatives fragmented without consistent national approach
- × Federal coordination of PROMs/PREMs severely limited, confined to pilot programs
- × Implementation methodologies and measurement instruments vary dramatically across jurisdictions
- × Integration of PROMs/PREMs into EHRs not standard practice
- × Only one-third (6.7 million) of people with My Health Records actively access them
- × Less than one-third of GPs routinely enter patient data into My Health Record
- × Health IT infrastructure lacks standardised data fields or workflows for patient-reported measures
- × No federal mandate or consistent reporting framework for PROMs/PREMs collection
- × Incentive mechanisms for patient-reported data gathering largely absent
- × MHR modernisation does not address patient-reported measures integration
- × Patient engagement in MDT discussions varies dramatically by institution and geography
- × Regional patients face barriers: absent navigators, limited specialist access, insufficient consultation time
- × National benchmarking and systematic feedback loops for patient-reported outcomes underdeveloped
- × Implementation of patient education services varies widely, especially in regional areas

Summary and Recommendations

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Progress Summary – Cluster 1: Timeliness of Care

Theme	Measure	New data since 2023	Change since 2023	On or off track to target by 2033
National Strategy	National Cancer Plan with M&E Framework	Draft National Cancer Data Framework released for consultation	↑	**On track**
Cancer Registries	Population-based cancer registries operational	None (registries operational since 1982)	–	**No target set**
Digital Health Infrastructure	MHR interoperability	$45-50M FHIR server tender awarded	↑	**On track**
Optimal Care Pathways	Systematic monitoring of OCP timeframes	Planning of pilot programs	✗	**Lagging**
Waiting Time Standards	Regulated maximum waiting times for diagnosis/treatment	N/A	✗	**Lagging**
Staging Data	National staging coverage across cancer types	Funding of ongoing projects	↑	**Ongoing**
Data Linkage	Routine linkage for timeliness monitoring	National Primary & Acute Care Data Linkage Project in design phase	↑	**Ongoing**
Quality Indicators	Cancer-specific adverse events and quality reporting	None (cancer-specific indicators not routinely reported)	✗	**Lagging**
Digital Medication Management	E-chemotherapy and e-prescribing adoption nationally	PBS e-Chemo Chart project progressing; state e-Meds deployments	↑	**No target set**
Real-time Performance Data	Near real-time timeliness and outcomes monitoring	None (2-3 year data lags persist)	✗	**Lagging**

Progress Summary – Cluster 2: Coordination of Care

Theme	Measure	New data since 2023	Change since 2023	On or off track to target by 2033
Workforce planning	National cancer workforce monitoring system	Cancer Australia workforce modelling initiatives	↑	**Ongoing**
	Disease-specific workforce data collection	Limited progress on standardised metrics	—	**Lagging**
Workforce communication	GP-specialist communication systems	Canrefer and standards exist; implementation gaps persist	—	**Ongoing**
Workforce wellbeing	Monitoring of workforce conditions	Inconsistent monitoring across jurisdictions	—	**Lagging**
Oncology nursing	Legislated nurse-to-patient ratios	SA legislation passed 2025; ACT phase 2 ratios 2024	↑	**Ongoing**
	Number of oncology nurses	8,234 nurses (2024), up from 6,825 (2021)	↑	**No target set**
	Federal nurse-to-patient ratio standards	No federal standards developed	✗	**Lagging**
Patient navigation	Regulation of navigator role	No national regulation established	✗	**Lagging**
	Number of patient navigators	ACNNP $193M investment (Nov 2023); QLD 400+ navigators	↑	**No target set**
	National navigator ratio per population	No published ratio established	✗	**Lagging**
Task sharing	National legislation for task substitution	Strengthening Medicare report advocacy only	—	**Ongoing**
	Shared care model implementation data	No comprehensive data collection system	✗	**Lagging**
Multidisciplinary care	MDT case discussion monitoring	Cancer Australia developing indicators	↑	**Ongoing**
	MDT quality assurance frameworks	Victoria progressing frameworks	↑	**Ongoing**
Comprehensive cancer centres	CCC standards of excellence	Key standards of excellence established	↑	**On track**
	ACCN network implementation	ACCN framework published; membership open	↑	**On track**

Progress Summary – Cluster 3: Patient-centredness

Theme	Measure	New data since 2023	Change since 2023	On or off track to target by 2033
PROMs/PREMs	Mandatory PROMs collection requirements	No mandatory requirements legislated	✗	**Lagging**
	Pan Cancer project implementation	Pan Cancer project initiated; ongoing rollout	↑	**On track**
	National coordination framework	No federal coordination body established	✗	**Lagging**
	Integration into EHRs	Not standard practice; planning in progress	—	**Lagging**
Patient engagement	Legislative protections for patient rights	No new legislation	—	**Ongoing**
	Patient participation in MDT discussions	No systematic monitoring established	✗	**Lagging**
Digital health	MHR active usage	6.7M active users of 23.8M records	—	**Ongoing**
	Pathology/imaging upload mandate	Legislation passed 2025; implementation Dec 2024	↑	**On track**
	PROMs/PREMs in My Health Record	Planning in progress	✗	**Lagging**

Proposed Key Recommendations

Cluster 1: Timeliness of Care

1. **Establish dedicated Commonwealth funding for cancer data standardisation,** interoperability and real-time linkage across registries, EHRs and administrative datasets.
2. **Implement regulated routine measurement and public reporting of Optimal Care Pathway** compliance with diagnosis and treatment time standards across cancer types and jurisdictions.
3. **Integrate consistent capture of key timepoints** (referral, diagnosis, treatment commencement) across all health information systems to measure care intervals and identify bottlenecks.
4. **Embed routine automated linkage** of cancer registry, hospital, pathology, pharmacy and primary care data to enable continuous monitoring of timeliness, quality and outcomes.
5. **Establish publicly accessible, regularly updated national dashboards** reporting cancer-specific adverse events, medication safety, waiting times, OCP adherence and treatment quality indicators.

Cluster 2: Coordination of Care

1. **Develop standardised metrics tracking cancer workforce** supply and demand at disease-specific, regional and jurisdictional levels for evidence-based planning.
2. **Create national professional standards for cancer patient navigators** including competency, scope of practice and minimum workforce ratios with consistent funding across all jurisdictions.
3. **Implement federal standards for oncology nurse-to-patient ratios** specific to chemotherapy administration, oncology wards and palliative care settings.
4. **Establish comprehensive national guidance regulating task sharing** among cancer professionals with clear role delineation, accountability frameworks and quality monitoring.
5. **Expand the Australian Comprehensive Cancer Network** to ensure rural and remote populations access specialist expertise, clinical trials and advanced treatments through telehealth, virtual MDTs and coordinated referral pathways.

Cluster 3: Patient-centredness

1. **Integrate mandatory collection of standardised patient-reported outcome and experience measures** for all cancer patients with dedicated federal funding for implementation.
2. **Embed PROMs and PREMs into MHR** and electronic medical records through standardised data fields and automated collection mechanisms.
3. **Create a federal coordination body to standardise measurement instruments,** collection methodologies and timepoints with public reporting of aggregated outcomes.
4. **Develop federal patient rights standards for clinicians and patients,** requiring meaningful patient engagement in shared decision-making, treatment planning and service design.
5. **Invest in culturally appropriate, accessible mechanisms** for Aboriginal and Torres Strait Islander peoples, culturally diverse communities and regional populations to report care experiences.

Discussion on assessment and considerations for All.Can's efficiency metrics

Strengths

The three-cluster structure (timeliness of care, coordination of care, and patient-centredness):

- effectively organises the eight core metrics in a manner that reflects patient priorities,
- enables systematic assessment across health system levels,
- covers the complete cancer care continuum, and
- balances technical process measures with patient-reported experiences.

Considerations

- Developing tiered question sets and metric subsets could be better based on country archetypes (basic, intermediate, advanced) to reduce assessment burden and enhance practical implementation across diverse health system to:
  - Account for health system maturity,
  - Centralised vs provincial systems,
  - Data infrastructure capacity, financing models, and
  - Geographic contexts
- Methods to enable standardised reporting and semi-quantitative measures across countries for meaningful comparison
- **Consider how to prioritise key metrics to allow for variable commitment level (resource and finance) and adoption based on country status.**

Appendices

Detailed analysis and findings for each Cluster

All.Can is a multi-stakeholder initiative involving patient, clinical, academic and industry experts as well as policymakers. We aim to help define better solutions for sustainable cancer care and improve patient outcomes in the future. The All.Can initiative is made possible with financial support from Bristol-Myers Squibb (lead sponsor), Amgen and MSD (co-sponsors).

Cluster 1: Timeliness of care

Cluster 1 – Timeliness of care (1 of 2)

Timeliness of care - Preconditions for metrics implementation:

- Legal frameworks and strategy, policy context, funding
- Data governance
- Data use and performance monitoring

#	Efficiency Metric	Why it matters (AU context)	Priority stakeholder types to interview	Key topics / questions	Indicative data sources
1	Time to diagnosis - days from first relevant presentation to confirmed diagnosis	Timeliness is central to optimal care pathway (OCP), reduces stage progression.	Cancer Australia, clinicians, cancer care coordinators.	• Where are the main delays? • Expedited referral and diagnostic processes? • Diagnostic capacity (radiology, pathology) • How are referrals prioritised and tracked?	Hospital EHR, pathology/radiology systems, OCP audits.
2	% cancers diagnosed via emergency presentation - proportion of diagnoses first detected in ED.	High ED-first diagnosis suggests access/awareness issues and late presentation.	Public hospitals, private hospitals, clinicians.	• Which cancers are most often first detected in ED and why (cancer types, geography, CALD status)? • What factors lead patients to present late?	ED datasets, linkage GP to ED, screening program data extracts.
3	Primary care interval - days from first GP presentation to first referral.	Critical OCP step, influenced by access to imaging/diagnostics in primary care and referral criteria.	Clinicians / GPs	• Referral criteria clarity and use by GPs? • Are there tools or protocols to support timely referrals? • How quickly can patients access community-based imaging/diagnostics? • Feedback loops from hospital back to GP?	Referrals, PHN/LHD data

Cluster 1 – Timeliness of care (2 of 2)

Timeliness of care - Preconditions for metrics implementation:

- Legal frameworks and strategy, policy context, funding
- Data governance
- Data use and performance monitoring

#	Efficiency Metric	Why it matters (AU context)	Priority stakeholder types to interview	Key topics / questions	Indicative data sources
4	Time from tissue diagnosis to initial treatment.	Queensland dashboards show implementable timeliness targets across modalities.	Clinicians - surgical oncology, medical oncology, radiation oncology heads.	• Average time from diagnosis to treatment? • Delays due to theatre, radiation or diagnostic capacity? • Processes in place to prioritise urgent cases?	Local OCP audits.
5	% receiving chemotherapy in the last 14 days of life.	End of life chemo is a recognised low-value care marker, NCCI cites palliative/experience gaps nationally.	Clinicians - Medical oncology leads, Palliative care heads.	• Pathways from oncology to palliative care services? • Is advance care planning in place and followed? • Do treatment patterns vary significantly by cancer type or site?	Oncology EMR (treatment end dates), palliative care datasets.

Australia has a national cancer plan with state and territory strategies underneath

Implementation monitoring is improving, but consistent national reporting remains patchy

Q1,2,7 The **Australian Cancer Plan (ACP)** provides a 10-year national strategy with a formal **Monitoring & Evaluation Framework** that includes 2-, 5-, and 10-year review checkpoints, positioning Australia to track progress systematically over time.[1] The ACP comprises **six Strategic Objectives and 46 actions** to reform Australia's cancer system.

Q1,7 **Most state and territory cancer plans** operate beneath the ACP.[2] These individual plans have varying levels of maturity: NSW (2022-2027), Victoria (2024-2028), Queensland (2024), WA (2020-2025), and SA all have current plans, while **Tasmania is developing a new plan (due 2025)**[3] and the **NT's Cancer Care Strategy (2018-2022) is now dated**.

Q2 Stakeholders such as governments, health organisations, clinicians, and industry are **responsible for implementing actions under the Plan** and evaluating the effectiveness of their programs, reporting progress to Cancer Australia. Cancer Australia leads evaluations for its own activities and consolidates outcomes in annual reports.[1]

Q1,7 **The ACP was developed through extensive engagement** with consumers, health professionals, researchers, and peak bodies. The Plan is intended to **complement existing strategies rather than to replace or duplicate**, providing guidance and highlighting areas of potential for coordinated care across jurisdictions.[4]

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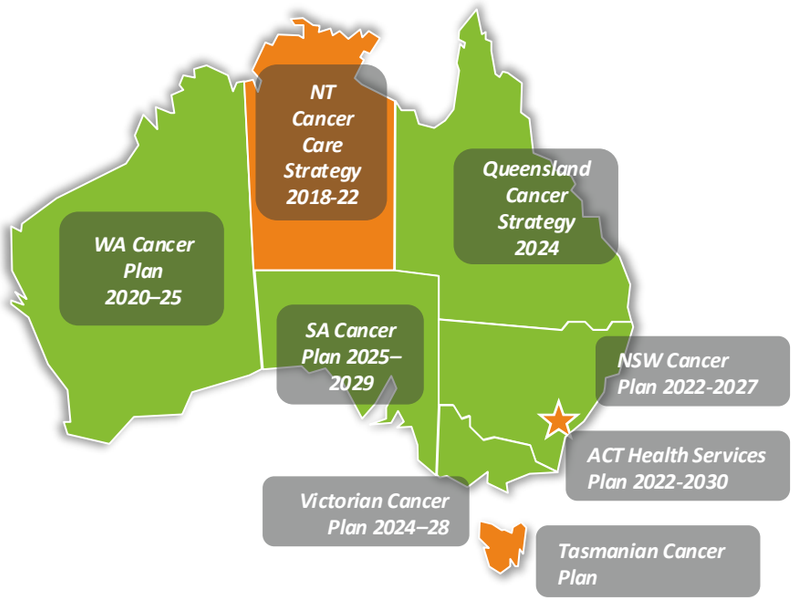
Jurisdictional highlight

*NSW publishes **Implementation Plan progress snapshots** and a **Performance Index***



National architecture is strong, but uneven monitoring maturity across jurisdictions limits the speed of system-wide improvement.

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Source: [1] Monitoring and evaluation framework; [2] Plans relevant to the Australian Cancer Plan; [3] Tasmanian Cancer Plan; [4] Australia Cancer Plan Implementation – Key Themes and Responses

Responsibility for cancer planning and monitoring is clearly defined

National and local roles are established, but accountability for execution varies

Q2,7,13 **Cancer Australia leads national strategy development** and coordination under the Australian Government, collaborating with multiple stakeholders,[1] while jurisdictions are responsible for **local implementation and monitoring.** This creates a federated system where **alignment is improving but historical fragmentation persists.**

Q2,5 **States and territories manage on-the-ground service delivery,** such as hospital management and screening programs, through their respective cancer agencies and health departments. However, **Cancer Institute NSW** serves as custodian of the NSW Cancer Plan, with governance provided by a dedicated advisory committee.[2]

Q8 **Cancer Institute NSW** is the only state-wide statutory cancer control agency in Australia. Other states manage cancer control within their health departments, supported by state-specific Cancer Councils (non-Government cancer control agencies) and various clinical networks, but do not have a direct equivalent.

Q10 While governance structures are clear, **monitoring depth varies.** For example, NSW publishes Implementation Plan progress snapshots and a Performance Index[4] and VIC's Integrated Cancer Services conducts regular audits,[5] whereas **smaller jurisdictions have less publicly visible accountability mechanisms.**

National Preparedness

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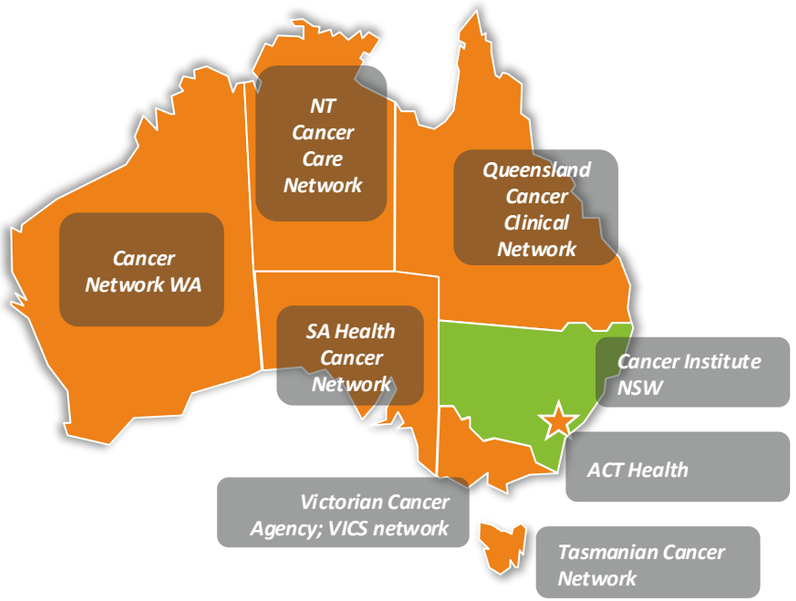
Jurisdictional highlight

Cancer Institute NSW *is a statutory cancer control agency established under legislation*



Defined roles support coordination, but the consistency of implementation accountability differs significantly by jurisdiction.

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Source: [1] Who we work with | Cancer Australia; [2] The NSW Cancer Plan; [3] Cancer Australasian Association of Cancer Registries; [4] Performance index | Cancer Institute NSW; [5] Cancer Service Performance Indicator (CSPI) audits

Australia has clear political will to improve the national health data ecosystem

National strategies signal strong commitment; cancer-specific digitalisation is emerging

Q11,12

The **Digital Health Blueprint & Action Plan (2023–2033)** sets long-term national direction for overall digital health in Australia.[1] In 2023, the Australian Government committed **$951.2 million over four years** to enhance digital health, improve interoperability, and advance data capabilities.[2]

Q26

The **Australian Digital Health Agency (ADHA)** is leading efforts to modernise My Health Record, including a recent **$45-50 million tender for advanced server capability** to enable interoperability.[3] Such initiatives signalling concrete investment in technical infrastructure nationwide, setting foundations for future cancer data integration.

Q20

The ACP acknowledges the need to uplift cancer data capabilities. **Cancer-specific digital strategies** are emerging through the recent launch of the **National Cancer Data Framework[4] and the Roadmap for Digital Health in Cancer Care**, which aim to harmonise cancer data governance and establish indicators for monitoring care quality.

Q3

Political debate continues on the pace of execution. The **Productivity Commission** has noted that better integration of digital technology could save over **$5 billion annually**,[5] while current information management has been described as uncoordinated and disconnected across jurisdictions.

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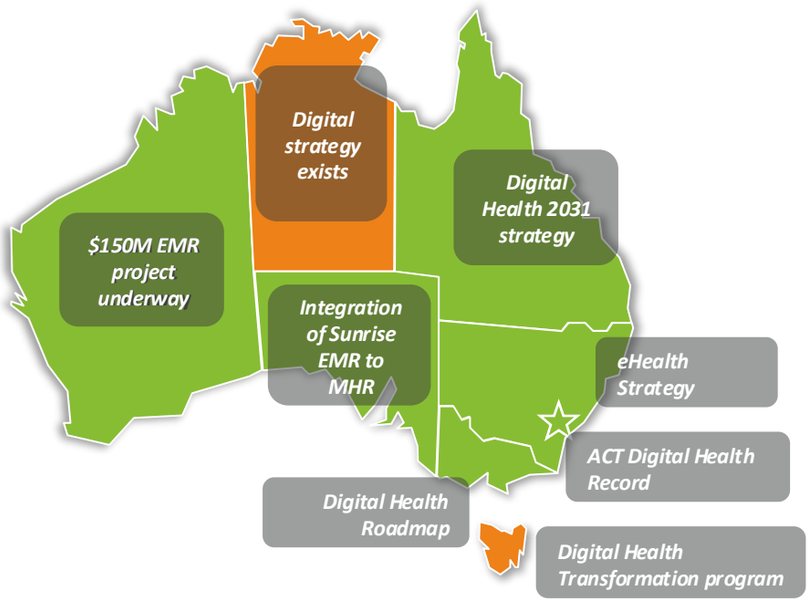
Jurisdictional highlight

***WA has a $150M EMR project** underway that aims to implement a unified digital system across public hospitals*



Policy intent is strong and funding is materialising, but cancer-specific data integration remains uneven across the system.

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Source: [1] The Digital Health Blueprint and Action Plan 2023–2033; [2] Budget 2023 Update; [3] RFT 11598: AusTender; [4] National Cancer Data Framework; [5] Leveraging digital technology in healthcare

National Optimal Care Pathways have been developed for many cancer types

OCPs include standards for maximum waiting times, interdisciplinary cooperation, roles, responsibilities, and referral processes

Q9,14 **Standardised patient pathways via national OCPs** have been developed, with over 30 tumour-specific or population-specific OCPs currently available, providing optimal timeframes, diagnostics, referrals, and necessary health professionals throughout the patient journey.[1] Updates have occurred, but not on a regular cadence for all cancers.

Q15,16 **Standards for maximum waiting times** (e.g., time to diagnosis, time to treatment) are referenced within OCPs and selected public indicators (e.g., AIHW cancer surgery waiting times), **based on expert consensus** from cancer-specific working groups. However, these standards are **not mandated and monitoring remains limited.**

Q15,16 While OCPs are embedded in the ACP as national standards, there is **no systematic national reporting** of whether healthcare services are achieving these timeframes by either cancer or population type. **Pilot work to establish adherence indicators to OCPs is planned under the National Cancer Data Framework**, with pilots due by 2029.[2]

Q17,18 **Limited public timeliness indicators** are available. AIHW publishes **elective surgery waiting times for cancer**,[3] and the National Cancer Control Indicators (NCCI) portal includes **radiotherapy waiting times**.[4] While NCCI and some state dashboards report selected measures, the full timeliness picture is not routinely published.

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Jurisdictional highlight

Over 30 individual ***Optimal Care Pathways have been developed nationally***

Without consistent compliance tracking and public timeliness indicators, system accountability and patient outcomes are constrained.

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Source: [1] Optimal Care Pathways; [2] National Cancer Data Framework; [3] Cancer surgery waiting times; [4] Radiotherapy waiting times | National Cancer Control Indicators

Supportive and Palliative care is embedded in national pathways and state practice

Optimal Care Pathways mandate supportive care; implementation detail varies by jurisdiction

Q5,9 **OCPs explicitly include supportive care as one of seven key principles,** with detailed guidance on assessing patient needs at every step of the pathway and referral to appropriate health professionals or organisations. OCPs recognise **Fitch's tiered model**, targeting the type and level of intervention required across numerous domains.[1]

Q6,9 **OCPs advocate for early referral** to multidisciplinary palliative care services, with the pathways noting that palliative care may be required at multiple stages and emphasising improving **quality of life and end-of-life experience** for people with cancer and their families.[2]

Q5,46 Palliative and supportive care is governed by a combination of an overarching **National Palliative Care Strategy,** and specific policies / frameworks in each state**. The ACP reinforces supportive care through its emphasis on enhanced consumer experience**. However, **monitoring of supportive care delivery is not consistently reported.**

Q5 **State-level implementation and policies varies in depth:** Victoria has a specific Supportive Care Policy guiding optimal cancer care, NSW's Cancer Institute supports local health districts to embed supportive care through the Cancer Care Pathways toolkit, and ACT's Canberra Health Services has a dedicated Cancer Supportive Care Team.

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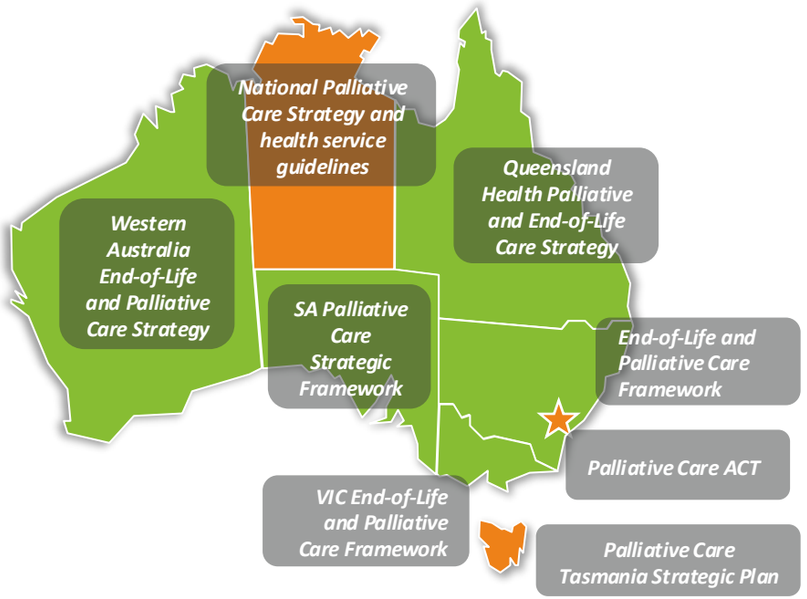
Jurisdictional highlight

*Victorian Cancer Plan includes to increase the proportion of cancer patients who **receive specialist palliative care within 12 months before death to 90%.***



Supportive care is mandated nationally via OCPs, but measuring and monitoring its consistent delivery across jurisdictions remains a gap.

Source: [1] Principles – Optimal Care Pathways; [2] Supportive Care; [3] https://www.health.gov.au/topics/palliative-care/related-work; [4] The-national-palliative-care-strategy-2018

Public quality and safety indicators exist but cancer-specific reporting is limited

While Hospital-Acquired Complications (HAC) are tracked, cancer-specific clinical quality reporting remains fragmented and siloed.

Q19,36 Australia mandates the **NSQHS Medication Safety Standard** which now includes specific actions for High-Risk Medications (including chemotherapy)[5], and a **User Guide for Medication Management in Cancer Care** addresses **oncology-specific risks** following **adverse incidents.**[1] The NSW Government's **eviQ protocols** support **evidence-based chemotherapy practice**.

Q18 Although not specific to cancer care, the **Australian Commission on Safety and Quality in Health Care (ACSQHC)** lists **16 hospital-acquired complications (HACs)** for which clinical risk mitigation strategies may reduce occurrence, including healthcare-associated infections and medication complications.[2]

Q18,43 **Public reporting** of HACs has occurred through AIHW's MyHospitals platform and state reports, however, the portals are not well known or understood.[3] Moreover, **cancer-specific adverse event indicators are not routinely separated or reported**, leading to minimal data on such occurrences.

Q18 **Quality-of-care indicators** for cancer care are limited in public reporting. Despite improved data liquidity via the NCDC, cancer-specific quality reporting remains fragmented; Australia lacks a unified public dashboard to benchmark clinical safety and performance.

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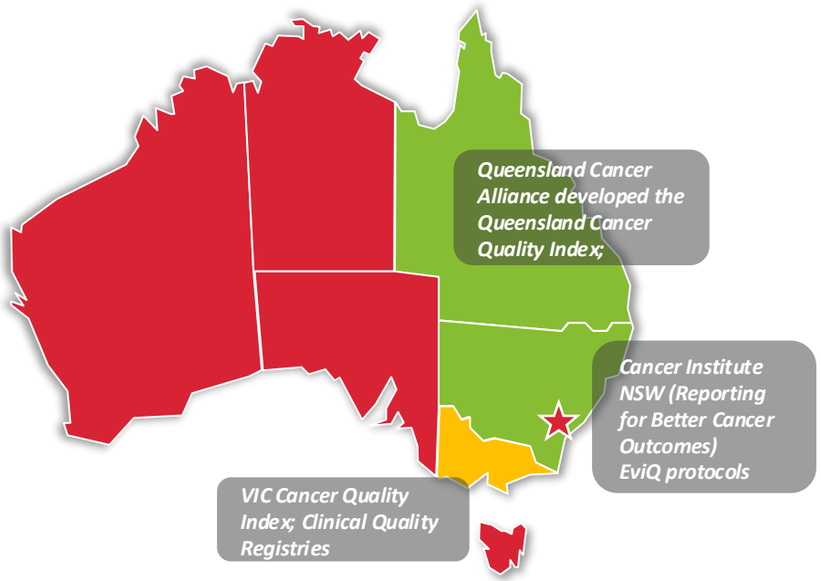
Jurisdictional highlight

Queensland Cancer Quality Index *(updated 2025) publicly reports on 15+ cancer types.*[6]



Cancer-specific public quality and adverse event indicators need expansion to enable transparency and drive improvement.

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Source: [1] User Guide for Medication Management in Cancer Care; [2] Hospital-acquired complications (HACs); [3] Public reporting of safety and quality in public and private hospitals; [4] Victorian Cancer Quality Index 2008 – 2015 [5] nsqhs-standards action-415 [6] https://canceralliancegld.health.qld.gov.au/cancer-quality-index/

Australia's cancer data is embedded in national strategies for data collection

Mandates and infrastructure support comprehensive data collection and governance, but lags in timeliness are a barrier

Q20-23 **Cancer data is specifically included** in the national strategy for data collection, notably through the **ACP and the National Cancer Data Framework (NCDF)**[1] with the **National Cancer Control Indicators (NCCI)**[2] providing the primary public-facing dashboard for monitoring national trends. **Cancer is a notifiable disease** in all Australian states and territories, with relevant legislation requiring organisations to notify all new cases.

Q22,22 The **Australasian Association of Cancer Registries (AACR)**, comprising all state and territory registries, the New Zealand Cancer Registry, and Australian Institute of Health and Welfare (AIHW), was established in 1982 to promote **uniformity in data collection and classification**.[3]

Q24,34 **AIHW serves as the national custodian, managing the Australian Cancer Database (ACD)** by cleaning and standarding data from all state and territory registries, ensuring coverage of cancer incidence and outcomes. **Five-year cancer survival** is monitored at both national and regional levels, with data published by the **AIHW** and state registries.[3]

Q25 **Socioeconomic and geographic data** are included in the registry, but data on education level and disability are limited or absent.[4] The NCDF explicitly embeds principles for Aboriginal and Torres Strait Islander data governance.[1] **Comprehensive staging data is available in some states**, with NSW being the first cancer registry to include data on cancer stage, treatment and quality of care.[5]

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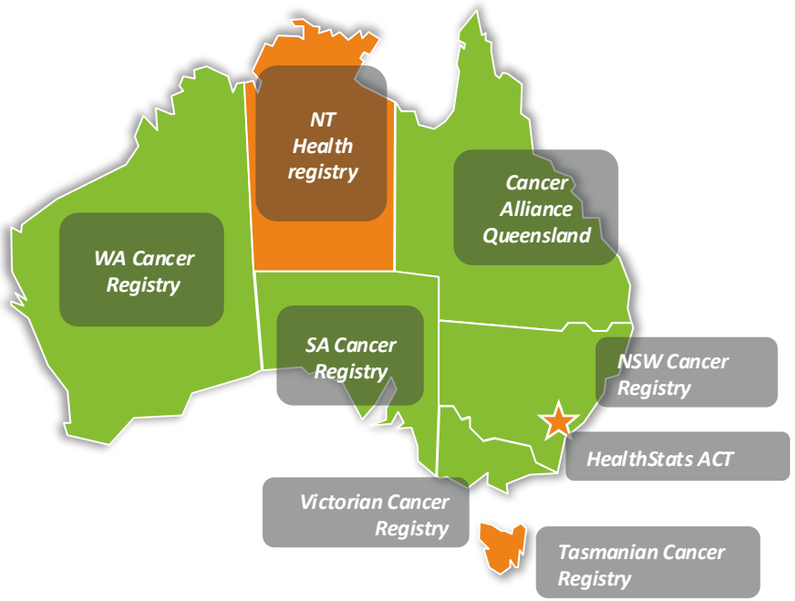
Jurisdictional highlight

NSW Cancer Registry *includes comprehensive staging data*



Current foundations enable consistent data collection, but gaps in real-time updates and quality indicators limit system responsiveness.

Source: [1] National Cancer Data Framework [2] National Cancer Control Indicators [3] Cancer data in Australia; [4] Stakeholder interviews, Interpreting cancer data, Interpreting cancer statistics; [5] NSW Cancer Registry

Australia has national digital infrastructure but e-prescribing is still in progress

National frameworks (MHR and IHI) provide building blocks, though front-line EMR integration is inconsistent across states

Q26,28

My Health Record (MHR) is Australia's national EHR, initially operating on an opt-out basis and now housing over 1.8 billion clinical documents.[1] However, the Productivity Commission notes it continues to be plagued by incomplete records and poor usability.[2] An **Individual Healthcare Identifier (IHI)** is implemented, enabling **cross-system linkage.**[3]

Q27

Policies promoting digitalised cancer medication management are in progress, with national and state initiatives aiming to improve safety and efficiency. Examples include the **PBS Electronic Chemotherapy Medication Chart project** and state-based electronic medication management systems.

Q30

The National Healthcare Interoperability Plan 2023-2028 aims to improve the interoperability of clinical information.[4] Linkage with MHR and provider-level EMRs vary in their ability to connect and exchange information. Some states, such as Tasmania, have isolated systems with limited interoperability.

Q35,36

Several states are implementing electronic medication management systems, such as e-Meds in NSW, alongside oncology-specific platforms like ARIA, Charm, and iQemo used across various jurisdictions. WA is also introducing new oncology prescribing systems to enhance safety, streamline workflows, and support integrated cancer care.[5]

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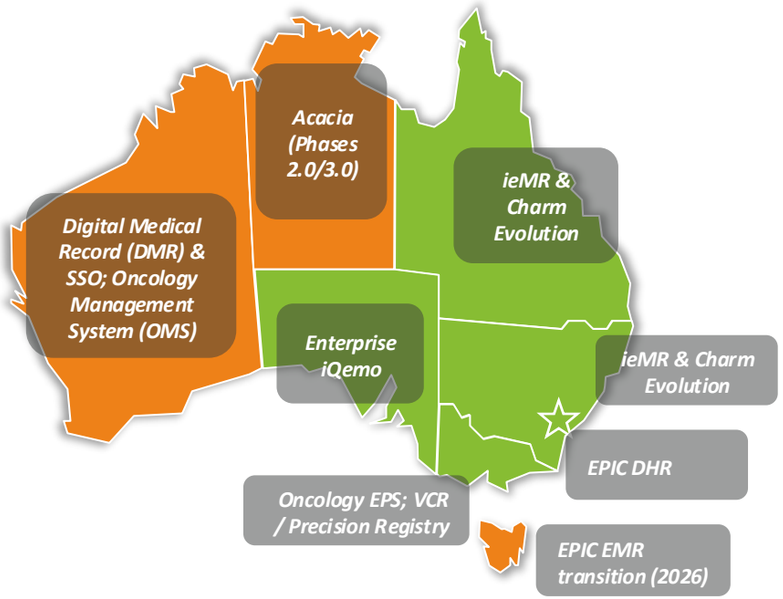
Jurisdictional highlight

*SA the first state to implement a **single statewide electronic chemotherapy prescribing system (iQemo)** across all adult cancer services.*[6]



Achieving routine, real-time interoperability for cancer data requires sustained investment in standardisation and integration.

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Source: [1] Another leap forward in modernising My Health Record with FHIR®; [2] Leveraging digitaltechnology in healthcare; [3] Individual Healthcare Identifiers; [4] Connecting Australian Healthcare [5] WA DMR OMS [6] iQemo

Performance data and data linkage exists but is not available in near real-time

Decision-makers rely on annual, lagged datasets,

Q37 **National and state datasets** focus primarily on **incidence and survival** through the Australian Cancer Database (ACD)[1] and state dashboards, but performance data on care quality, timeliness, and pathway adherence is **not comprehensively or routinely reported**.

Q38 Australia has **robust data linkage infrastructure** through AIHW (the national linkage unit)[2] and state-based units as part of the national data linkage network - **the Population Health Research Network[3],** including **Centre for Health Record Linkage (CHeReL)** in NSW/ACT[4], **SA NT DataLink**[5], **WA Data Linkage Services**[6]. **Linked, de-identified data** can be used for effectiveness research under governance frameworks units[7,8].

Q40 Most cancer registries in Australia operate with a **three- to four-year reporting lag,** whereas the **Victorian Cancer Registry (VCR) typically provides data with just a 12-month lag**, the fastest among the states.[9, 10]

Q41,42 Linkage across cancer registries, mortality data, and administrative sets (MBS/PBS) has demonstrated significant value, such as the AIHW's proof of the **National Bowel Cancer Screening Program**'s impact on mortality[12]. However, linkage remains largely project-based; the **VCCC Alliance Data Connect platform[13]** represents a best-practice shift toward routine primary-acute integration; the **National Primary and Acute Care Data Linkage Project** remains in its design phase through late 2025[14].

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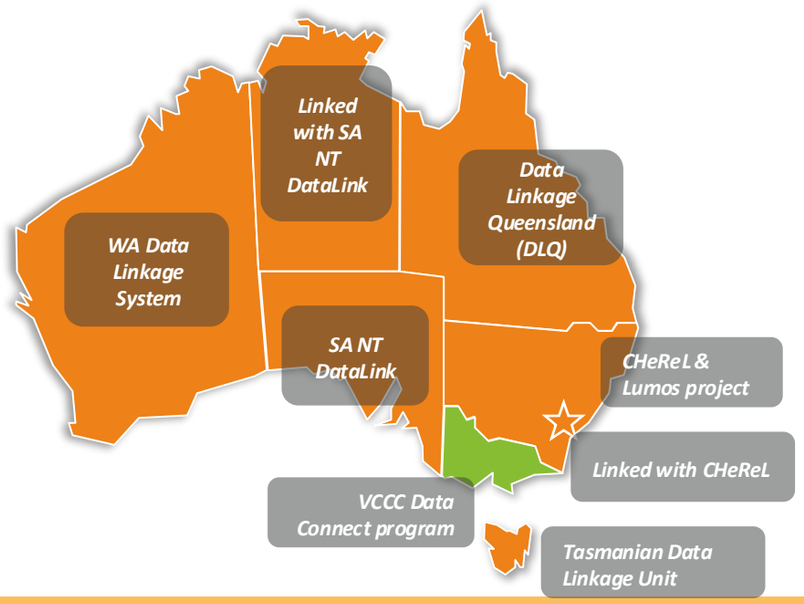
Average 3 to 4 year time lag

Jurisdictional highlight

***VCCC Data Connect** first to successfully link primary care data, statewide hospital data and the VCR[11]*



Operationalising routine linkage with standardised time stamps would unlock real-time timeliness monitoring and drive system improvement.

Source: [1] Australian Cancer Database [2] AIHW [3] PHRN [4] CHeReL [5] SA NT DataLink [6] WA Data Linkage Services [7] OAIC De-identification Decision-Making Framework [8] AIHW Data Governance [9] Stakeholder consultations [10] victoria-cancer-registry 2024 [11] VCCC Data Connect [12] AIHW National Bowel Cancer Screening Program [13] VCCC ALLIANCE DATA STRATEGY 2024-2029 [14] National Primary and Acute Care Linkage Project

Cluster 2: Coordination of care

Cluster 2 – Coordination of care

Coordination of care - Preconditions for metrics implementation :

- Workforce capacity
- Oncology nurses and cancer patient navigators
- Task sharing and substitution
- Multidisciplinary teams/tumour boards
- Comprehensive cancer centres (CCCs)

#	Efficiency Metric	Why it matters (AU context)	Priority stakeholder types to interview	Key topics / questions	Indicative data sources
6	% patients documented as having seen a clinical nurse specialist (e.g., Breast Care Nurse).	Specialised nurse engagement improves coordination, local breast study flagged sub-optimal BCN timing.	Cancer institutes, oncology nurses/nurse coordinators, cancer patient navigators, patient advocacy organisations.	• Workforce capacity • Oncology nurses – access to oncology nurses / specialist nurses • Cancer patient navigators – coverage • Task sharing and substitution • Access to multidisciplinary teams or tumour boards • Comprehensive cancer centres	Ratio of nurse specialists to patients, Access to patient navigators, PREMs comments.

Australia's workforce strategy remains fragmented despite national policy ambitions

National frameworks signal commitment to workforce sustainability, yet cancer-specific planning lacks coordination

Q47 **National policy frameworks demonstrate political will** through the *National Medical Workforce Strategy 2021-2031*[1] and the ACP, prioritising workforce development and cultural safety training. However, sustained funding and coordination mechanisms in cancer care are required for long-term workforce capacity building.

Q48 **Cancer workforce shortages are widely acknowledged** across cancer care stakeholders.[2] Yet **monitoring remains fragmented**, with workforce data collected at national and professional levels rather than disease-specific or regional levels, creating significant blind spots in understanding capacity gaps, particularly in regional and remote areas.

Q49 **Cancer Australia has conducted cancer-specific workforce modelling** to identify gaps and guide planning,[2] but substantial challenges persist in accurately capturing specialists working across multiple disease areas. **No standardised metrics exist for monitoring workforce-to-population ratios** limiting effectiveness of targeted interventions.

Q49,51 **Funding initiatives** such as the Workforce Incentive Program and the Australian Cancer Nursing and Navigation Program aim to address gaps and incentivise care coordination. However, **implementation varies significantly across jurisdictions**, with regional areas experiencing disproportionate workforce deficits and limited access to specialist roles.

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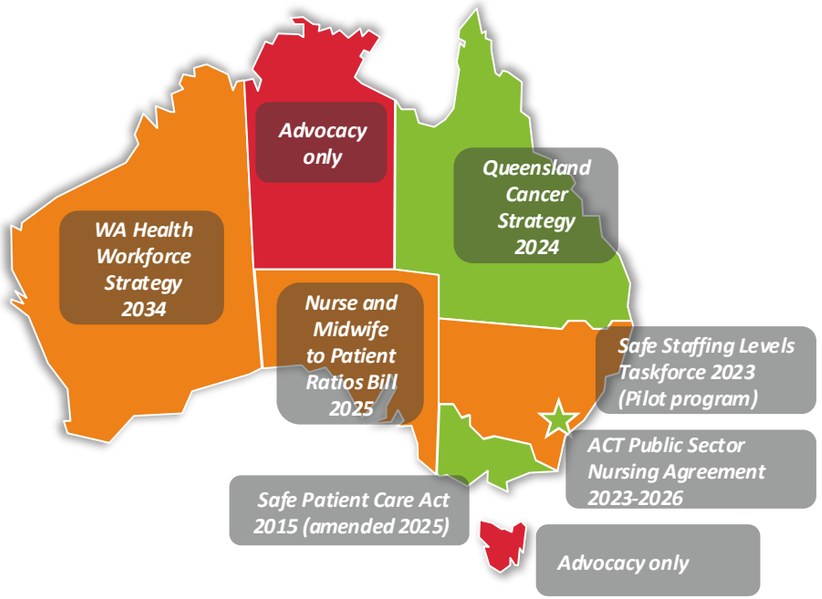
Jurisdictional highlight

QLD Cancer Strategy 2024, ***400+ nurse navigators since 2017***[3]



Fragmented workforce planning and inconsistent monitoring critically undermine equitable cancer care; sustained funding essential.

Source: [1] National Medical Workforce Strategy 2021–2031; [2] Stakeholder interviews; [3] Queensland Cancer Strategy 2024

Workforce policy implementation falters on inadequate reform and monitoring

Poor data, fragmented communication systems, and regional disparities limit their effectiveness in improving cancer care delivery

Q51,53 **Workforce Incentive Programs are actively deployed** to improve access to services in underserved areas.[1] Yet **systematic monitoring and evaluation of their impact on cancer care outcomes is largely absent**, making it impossible to determine whether substantial investments are achieving intended goals or require modification.

Q54 **National funding is available** to trial innovative care coordination approaches including telemedicine and multidisciplinary case conferencing. However, **significant regional disparities persist**, with some states without funding for critical roles and services, forcing patients to navigate complex cancer pathways without dedicated support.[2]

Q50 **Workforce challenges can stem from a poor organisational culture,** where retention is low, care pathways are fragmented, and monitoring is almost non-existent. Stakeholders have noted that simply adding staff without addressing cultural problems perpetuates inefficiencies and harmful practices, with up to 40% of care being low-value or harmful.[2]

Q50 **Workforce solutions can lie in creating a healthy workplace culture that prioritises collaboration, accountability, and value-based care.** Current arguments mention that cultural reform is currently limited and must become the top priority, as without it, any strategy or investment will fail to deliver sustainable improvements.[2]

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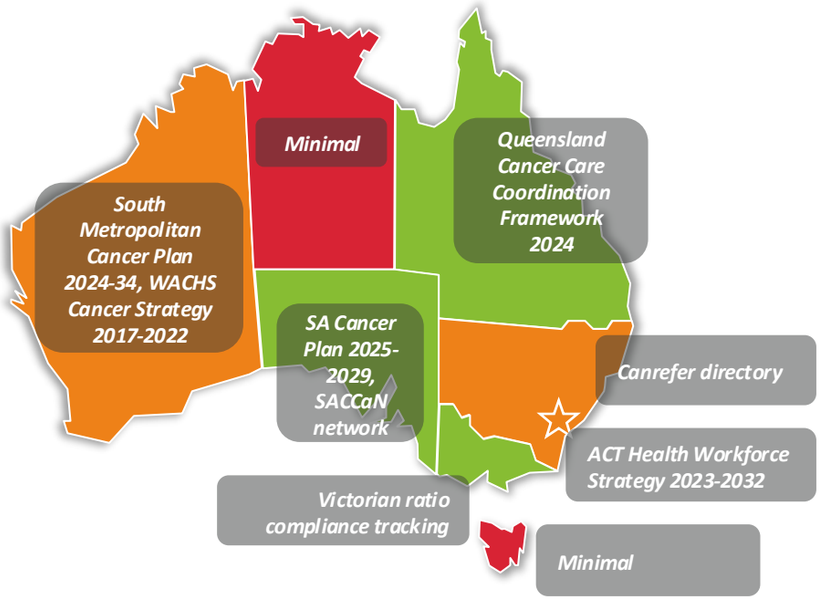
Jurisdictional highlight

SA Cancer Plan 2025–2029, ***funds expanded specialty nursing and medical roles,*** *and a new Statewide Cancer Medication Management Model with 24-hour on-call support*[3]



Robust monitoring frameworks, interoperable digital systems, and equitable resource distribution is required to bridge policy-practice gaps.

Source: [1] Workforce Incentive Program; [2] Stakeholder interviews [3] SA Cancer Plan 2025-2029

Oncology nurses have state-led ratios but lacks national regulations

Professional regulation exists nationally, but the absence of ratios and limited monitoring systems hinder workforce optimisation

Q55,56 **Oncology nurses are regulated nationally** through the Nursing and Midwifery Board of Australia, with professional frameworks from the Cancer Nurses Society of Australia.[1] Yet **Australia lacks federal standards for minimum oncology nurse-to-patient ratios** specific to cancer care or chemotherapy administration.

Q57,58 **Some jurisdictions have legislated nurse-to-patient ratios**: VIC (Safe Patient Care Act 2015), QLD (from 2016), ACT (phase-two including cancer services from 2024), SA (legislation passed 2025, implementation by March 2026), and NSW (currently phasing in a Safe Staffing Levels policy on a hospital-by-hospital basis).[2,3]

Q62-64 **National monitoring of oncology nurse staffing is severely limited**. The Cancer Nurses Society tracks 8,234 nurses working in cancer care (approximately 2% of national nursing workforce) as of 2024.[4] However, **no systematic data collection exists to monitor nurse involvement in care delivery, patient access, or impact on patient outcomes.**

Q65 **Oncology nurses have direct patient contact and MDT integration** working alongside oncologists and specialists.[5] However, the absence of digital traceability systems and capacity to quantify contributions of different specialities creates challenges in demonstrating the value of oncology nursing investment.

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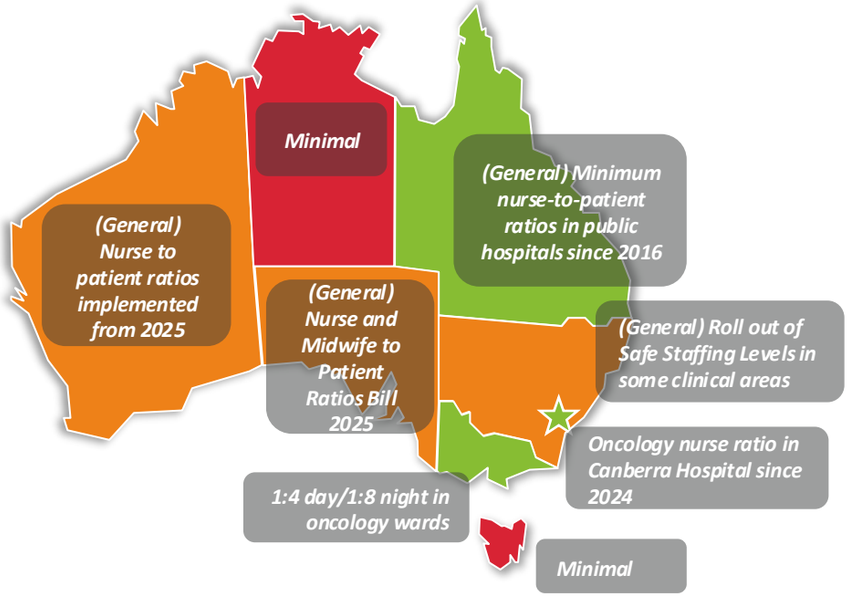
Jurisdictional highlight

*VIC leads in oncology nurse-to-patient ratio compliance tracking via legislated mandates in the **Safe Patient Care Act 2015.**[3]*



National oncology nurse ratios, monitoring systems, and strategic investment critical for safe staffing and optimal patient outcomes.

Source: [1] Nursing and Midwifery Board of Australia; [2] Ratios in the Public Health System NSWNMA; [3] VIC Safe Patient Care Act 2015 [4] National Health Workforce Data Release 2024; [5] Examples of multidisciplinary care teams

Cancer navigation expands through federal investment but lacks professional identity

Navigation services have improved, but the absence of workforce metrics and state funding creates significant access inequities

Q66,67 **The Australian Government invested $193 million** to establish the Australian Cancer Nursing and Navigation Program in November 2023, with Cancer Council Australia leading delivery.[1] However, **cancer patient navigators are not regulated as a distinct profession**, resulting in highly variable role definitions, mandates, and competency.

Q68 However, **no published national ratio exists for patient navigators**, with states relying on localised funding and initiatives. Regional patients can experience particularly limited navigation support. **Queensland leads in navigator workforce development** with over 400 nurse navigators integrated since 2017, though these are not specific to oncology.[2]

Q69 **National regulations governing navigator access to clinical data and waiting lists are absent**, and **no systematic data collection framework exists** to monitor the impact of navigators on clinical outcomes, patient experience, care continuity, or healthcare utilisation such as emergency department presentations and hospital readmissions.

Q70,71 **Navigator roles vary substantially** between clinical nurse navigators with advanced credentials, non-clinical lay navigators providing psychosocial support, and disease-specific navigators. This **lack of role clarity and standardisation** means the extent to which navigators manage complete care pathways varies dramatically.

National Preparedness

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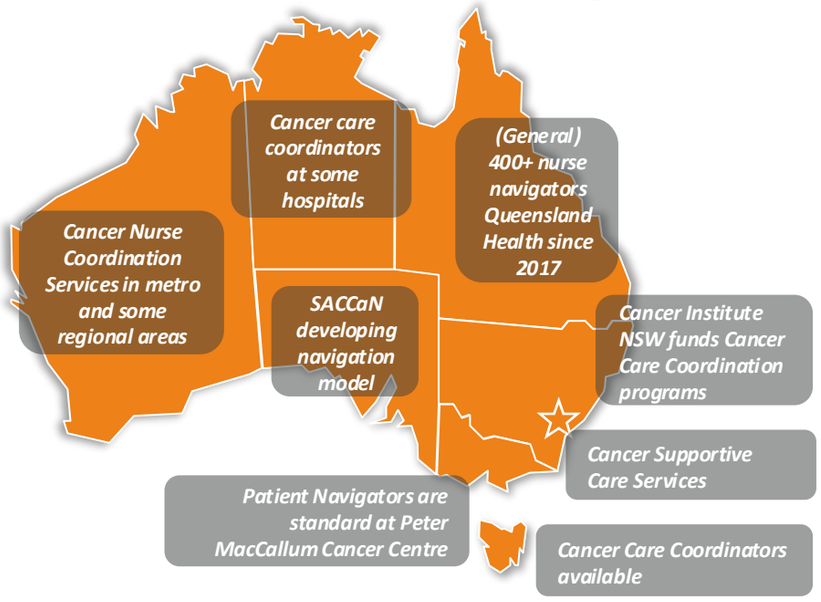
Jurisdictional highlight

$193M Government funding invested for the ***Australian Cancer Nursing & Navigation Program***



National standards, professional regulation, and mandatory data collection will be essential for equitable access and demonstrated value.

Source: [1] Australian Cancer Nursing and Navigation Program; [2] Nurse Navigators a win for coordination;

Task sharing occurs informally without legislative authority or guides for best practice

The absence of national legislation and implementation frameworks limits systematic adoption across cancer services

Q72 **The Strengthening Medicare Taskforce Report advocates** for shared responsibility across primary care and multidisciplinary teams with appropriate governance.[1] However, **no comprehensive guidance exists to regulate task sharing or substitution among cancer professionals**, leaving implementation to local discretion and creating legal uncertainty.

Q73 **Task sharing occurs informally and inconsistently** across cancer care settings, particularly involving cancer care coordinators, specialist oncology nurses, general practitioners, and allied health providers. **Formal guidance on team member roles, delegation boundaries, and accountability frameworks remains severely limited.**[2]

Q73,74 **Comprehensive data on shared care implementation during treatment is absent**. There is currently no national registry tracking where shared care follow-up models operate, which healthcare providers participate, what clinical outcomes result, or how task substitution affects patient safety, care quality, or healthcare costs.

Q74 **Regional and remote areas face compounded challenges** in implementing task sharing due to chronic workforce shortages, professional isolation, and limited specialist backup. **Without clear national guidance, rural practitioners express concerns** about undertaking expanded roles in cancer care, even when patient need is urgent.

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Jurisdictional highlight

No standardised practices

National legislation, clinical governance models, and quality monitoring systems needed to ensure safe, effective task sharing in cancer care.

Source: [1] Strengthening Medicare Taskforce Report; [2] RACGP - Shared care key for cancer survivors;

MDT boards operate widely without mandatory requirements and quality oversight

Absence of legislation and limited quality monitoring create coverage gaps, particularly for complex and rare cancers

Q75,76 **Cancer Australia's Principles of Multidisciplinary Care provide national guidelines** recommending MDT composition.[1] However, **no federal or state legislation mandates MDT composition, meeting frequency, or case discussion requirements**, meaning adherence depends entirely on institutional culture and leadership commitment.

Q77,78 **Access to MDTs varies significantly** across jurisdictions. Metropolitan comprehensive cancer centres generally offer disease-specific MDTs for common cancers, but **regional centres may rely on a single MDT that covers all cancers or, where specialist expertise is lacking locally, virtual participation in metropolitan meetings** via telehealth.

Q79 **National-level monitoring of MDT case discussion rates does not exist**, although Cancer Australia is developing quality indicators. Victoria has made progress in establishing quality frameworks and auditing mechanisms,[2] but **most jurisdictions lack systematic processes to track what proportion of cancer patients have cases discussed in MDTs**.

Q80 **Integration of MDT access into quality assurance mechanisms remains inconsistent**. The ACP acknowledges multidisciplinary care as essential but **formal accreditation requirements, performance benchmarking, or external peer review processes are absent in most settings**.

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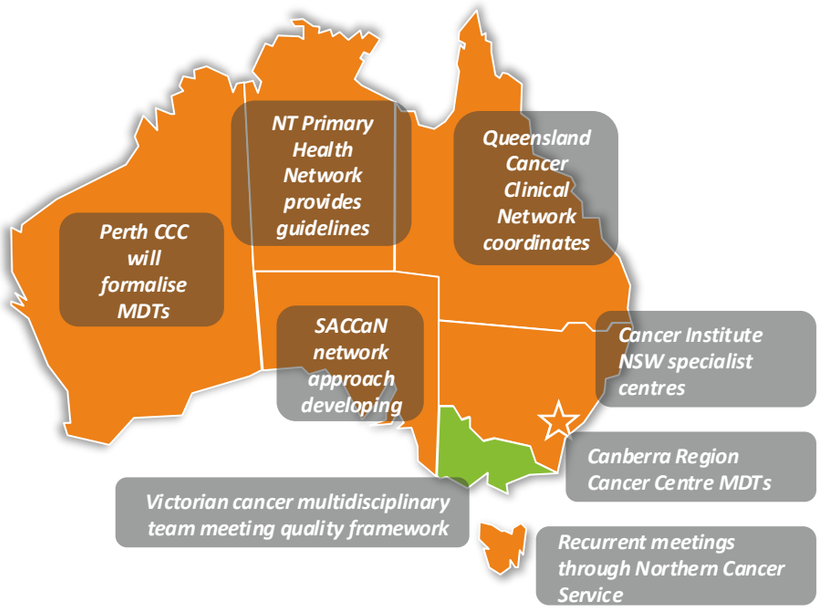
Jurisdictional highlight

TAS's Northern Cancer Service publishes their ***MDT schedules****



National monitoring, quality assurance frameworks, and regional virtual access is essential for equitable evidence-based care planning.

Source: [1] Principles of multidisciplinary care; [2] Victorian cancer multidisciplinary team meeting quality framework; [*] Multidiscipline team meetings

CCCs advance network connectivity while universal coverage remain aspirational

The ACCN represents strategic progress, yet incomplete geographic coverage perpetuate access inequities for regional populations

Q81-86 **The Australian Comprehensive Cancer Network (ACCN)** represents a strategic initiative to connect comprehensive cancer centres with regional services and primary healthcare.[1] However, **Australia has no formal national certification system or legislated definition for comprehensive cancer centres**.

Q85 **Comprehensive cancer centres do not provide universal population coverage**. Well-established centres exist in major metropolitan areas (VIC's VCCC)[2] and emerging networked models (SA's SACCaN)[3] demonstrate excellence, but **significant geographic access disparities persist**, particularly for regional, rural, and remote communities.

Q83 **State and territory approaches vary considerably**. Some jurisdictions invest in one comprehensive cancer centre infrastructure (WA's Perth CCC)[4], while others develop distributed network models linking regional centres to metropolitan expertise (SACCaN). This **jurisdictional variability** perpetuates inequitable access patterns.

Q86 Australia has no **mandatory certification requirements tied to funding or regulatory approval. The ACCN is developing standards of excellence**[1] aligned with OCPs to enable centres to demonstrate quality through peer-reviewed data and performance benchmarking.

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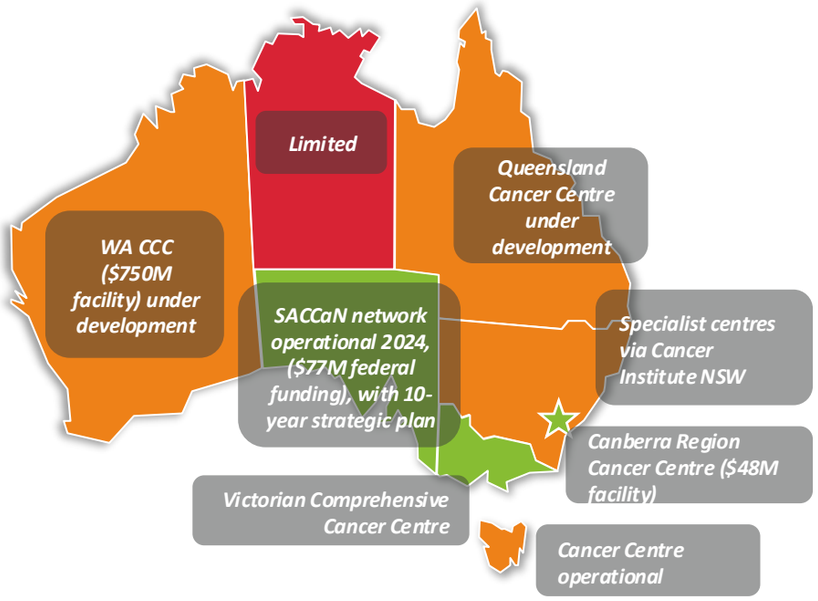
Jurisdictional highlight

Victorian Comprehensive Cancer Centre *opened 2016, $1B+ facility, 10-partner Alliance*[5]



Network expansion, transparent standards, and strategic investment needed to close geographic access gaps for all Australians.

Source: [1] Australian Comprehensive Cancer Network; [2] Victorian Comprehensive Cancer Centre; [3] South Australian Comprehensive Cancer Network (SACCaN); [4] Western Australian Comprehensive Cancer Centre [5] VCCC Alliance

Cluster 3: Patient-centeredness

Cluster 3 – Patient-centeredness

Patient centredness - Preconditions for metrics implementation:
- Legal frameworks and strategy, policy, context, funding
- Data governance, use and reporting

#	Efficiency Metric	Why it matters (AU context)	Priority stakeholder types to interview	Key topics / questions	Indicative data sources
7	Patient experience (PREMs) across the care pathway.	National push to embed PRMs into performance monitoring, Movember Pan-Cancer program is building benchmarking infrastructure.	Patient experience/consumer engagement leads; PROMs/PREMs program owners; Patient advocacy groups.	• What PREMs are used now (tools, frequency)? • Response rates and representation (CALD, rural, First Nations)? • Feedback loops to services - how PREMs inform decisions.	Local PREMs programs, state PRMs platforms, the emerging national benchmarking platform.
8	Patient involvement in decision making (shared decision-making).	Identified national gap (patient experience/SDM under-measured), local study showed low SDM documentation.	Clinicians, Consumer representatives, patient advocacy groups	• Availability of decision aids • Documentation of shared decision making • Interpreter utilisation and cultural safety	Clinic notes/consent forms, interpreter booking system, PREMs/shared decision making items.

Patient voices increasingly shape cancer care, with national frameworks present

The absence of mandated participation structures and consistent shared decision-making practices limits systematic integration

Q87,91 **Active political debate surrounds patient involvement in cancer care decision-making**, with the ACP developed through extensive consultation. However, this **engagement remains inconsistent across cancer types and jurisdictions**, with some tumour streams and regional areas experiencing limited consumer representation.

Q95 **The Australian Charter of Healthcare Rights establishes seven fundamental rights**[1] including access, safety, respect, partnership, information, privacy, and feedback. Specifically, patients have a right to make decisions with their healthcare provider and share their experience and participate to improve the quality of care and health services.

Q88,89 **PROMs and PREMs are gaining recognition in policy discourse**. The ACP and Pan Cancer Initiative[2] prioritise their integration as essential tools for measuring care quality from patient perspectives. However, **there are currently no mandatory data collection requirements** or funded implementation frameworks, leaving adoption highly variable.

Q92 **MDT guidelines, such as the Victorian cancer MDT meeting quality framework,**[3] **encourage patient engagement** in treatment planning following case reviews. The presenting clinician is responsible for explaining the options discussed back to the patient, and patient preferences should be recorded.[3,4] However, monitoring is difficult.

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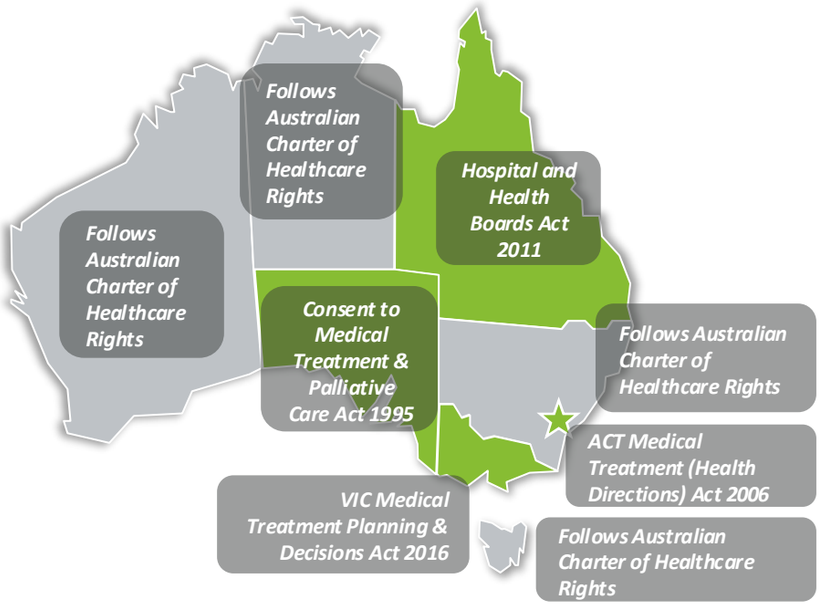
Jurisdictional highlight

*QLD's Hospital and Health Boards Act requires health services to have **consumer engagement strategies***



Patient participation, funded implementation of systematic PROMs/PREMs collection, and structural reforms ensure equitable access.

Source: [1] Australian Charter of Healthcare Rights; [2] The Pan Cancer Initiative; [3] Victorian cancer multidisciplinary team meeting quality framework; [4] Stakeholder interviews

PROMs/PREMs collection occurs without national coordination or standardisation

Despite growing evidence of PROMs benefits, Australia's fragmented approach lacks systematic collection frameworks

Q93,94 **PROMs/PREMs initiatives exist but remain fragmented and unstandardised**. A 2024 survey revealed only 60% of responding clinical practices collect PROMs, predominantly in metropolitan centres and public hospitals.[1] Of these, only **58% collect PROMs across all cancer types**, and only 31% collect data for over 75% of their patients.

Q96,97 The ACSQHC maintains a generic PROMs list as well as condition-specific lists[2] and some registries incorporate PROMs for specific tumours.[3] However, **implementation methodologies, measurement instruments, and data management systems can vary** across states and organisations,[1] preventing standardised benchmarking and reporting.

Q98,99 **Federal coordination of PROMs/PREMs data collection remains severely limited**. Most efforts are confined to pilot projects or research studies. The ACP envisions embedding PRMs through the Pan Cancer Initiative, with over $22.5m invested in a national platform,[4] but **coordinated efforts will be required for** systematic adoption.

Q95 **Cancer education and information is provided through Cancer Council's helpline, resources, and guides,[5] as well as through patient navigators.** However, implementation reach may differ widely in areas where digital literacy barriers, language diversity, and absence of culturally appropriate resources create significant access inequities.

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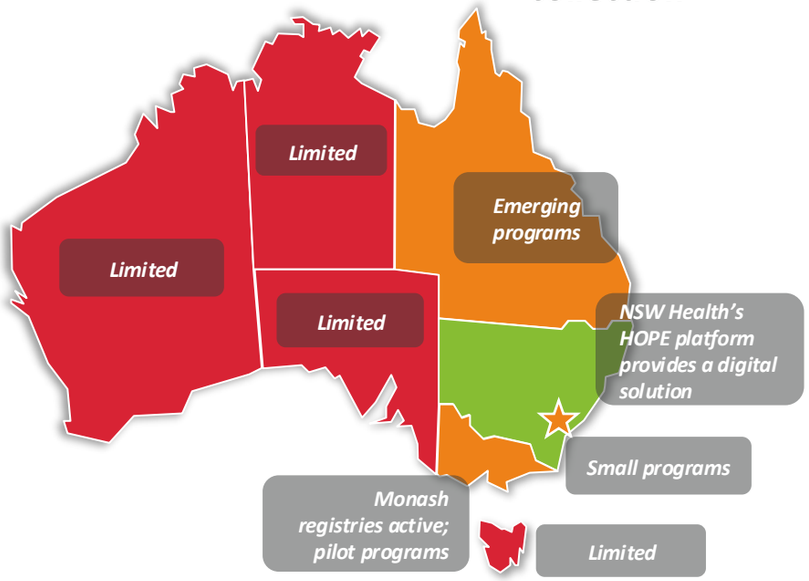
Jurisdictional highlight

NSW's Health Outcomes and Patient Experience (HOPE) platform ***enables real-time PRMs collection***



Standardised frameworks with federal coordination and dedicated resourcing ensure all patient voices inform quality improvement.

Source: [1] The use of patient reported outcome measures; [2] PROMs lists; [3] Stakeholder interviews; [4] Government invests $5m into the Australian Real World Cancer Evidence Network; [5] Patient Resources;

MHR provides patient data access, but poor integration undermine its utility

Incomplete clinical uploads, poor interoperability, and absence of patient-reported measures limit its value for care coordination

Q100 **Patients have access to clinical data through MHR**, encompassing 23.8 million records with consumer-controlled access to medications, allergies, immunisations, pathology reports, and discharge summaries. However, **only one-third (6.7 million) have accessed their records, and approx. 2% of documents are viewed by other healthcare providers**.[1]

Q101-2 Current health IT infrastructure lacks standardised data fields or clinical workflows to capture PRMs. **Less than one-third of GPs routinely enter patient data into MHR**,[2] and the absence of automated PROMs/PREMs upload functionality means many of these perspectives remain in paper forms or isolated systems.[3]

Q104 No federal mandate or consistent reporting framework exists, restricting mechanisms of feedback. PROMs/PREMs data are used for quality improvement in some health services, however, **these feedback mechanisms have long delays and rely on deidentified bulk patient data, limiting their specificity and potential for timely and direct impact**.[3]

Q105 With no incentive mechanisms, current collection relies on voluntary commitment or research funding rather than coordinated national policy. The Australian Government's investment in MHR modernisation **prioritises clinical data sharing but not patient-reported measures**, representing a missed opportunity to embed patient voice.

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Jurisdictional highlight

*NSW's HOPE platform is **integrated with the NSW Health Electronic Medical Record***

Integration into MHR with technical standards and clinical workflow support is critical to realising patient-centred digital infrastructure.

Source: [1] Report finds My Health Record 'plagued' with poor usability; [2] 'Overhaul My Health Record'; [3] Stakeholder interviews;

Scaling patient-centred measurement requires unified infrastructure and investment

Fragmented implementation, resource constraints, and absent national strategy prevent systematic adoption across cancer care

Q105 **The ACP recognises patient-reported data as essential** for system improvements and equitable outcomes.[1] However, **efforts remain hampered by fragmented systems and limited interoperability** between cancer registries, electronic medical records, and MHR, preventing systematic capture and feedback mechanisms.

Q104 **Quality improvement based on PROMs/PREMs remains confined to pilot projects**, such as cancer centre dashboards or clinical quality registries demonstrating benefits including improved mortality and reduced readmissions.[2] As such, the value of patient-reported measures and the gathered insights is currently underutilised.

Q104 **National benchmarking and systematic feedback loops remain underdeveloped**, limiting ability to identify high-performing services, disseminate best practices, or provide consumers with transparent quality comparisons. **Australia has significant opportunity to lead internationally** by learning from mature PROMs programs.

Q104 Cancer care services will highly benefit from establishing mandatory collection with appropriate resourcing, and **ensuring Aboriginal and Torres Strait Islander peoples, culturally diverse communities, and regional populations have culturally appropriate, accessible mechanisms** to report their care experiences.

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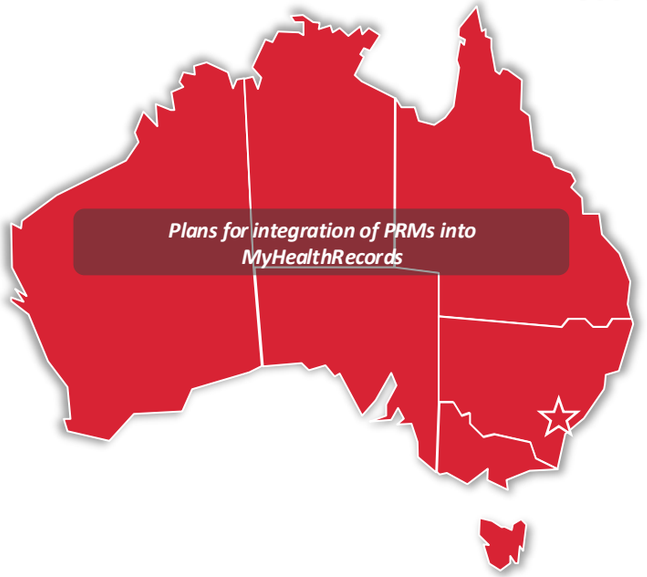
Jurisdictional highlight

*NSW's HOPE platform is **planning for integration** into NSW's Health's Single Digital Patient Record*



Coordinated national strategy, adequate resourcing, interoperable digital infrastructure, and co-design with diverse communities is required.

Source: [1] 4.5.1: ACP; [2] Stakeholder interviews

A national platform to track the outcomes and experiences of cancer patients

Promoting a unified approach to collecting patient-reported measures (PRMs) across cancer Clinical Quality Registries (CQRs)

Since launching the framework in late 2023, the *Australian Real World Cancer Evidence Network (The Pan Cancer Initiative)* has established national consensus, built critical infrastructure, and created the foundation for patient-centred, data-driven improvements in cancer care

Consensus achieved

✓ National Core Outcome Set established: 8 patient-reported outcome domains + 6 patient-reported experience domains agreed through rigorous Delphi process

Extensive engagement

✓ 350+ stakeholders engaged: 97 people with lived experience, 121 sector professionals, 197 Delphi participants

✓ All Australian states and territories represented, over 50% from priority populations

Infrastructure built

✓ ePRMs collection platform developed

✓ National benchmarking framework established with expert Advisory Group

✓ Steering Committee operational with lived experience representation

Evidence generated

✓ Two comprehensive engagement reports published documenting barriers, enablers, and priorities

✓ Foundation laid for national performance monitoring and public data transparency

Sector mobilised

✓ 3 Advisory Groups across key work packages

✓ Partnerships with CQRs, Cancer Australia, AIHW, and state health departments

✓ Grants awarded for implementation projects

Pathway forward

✓ Prostate cancer pilot advancing with people with lived experience co-design

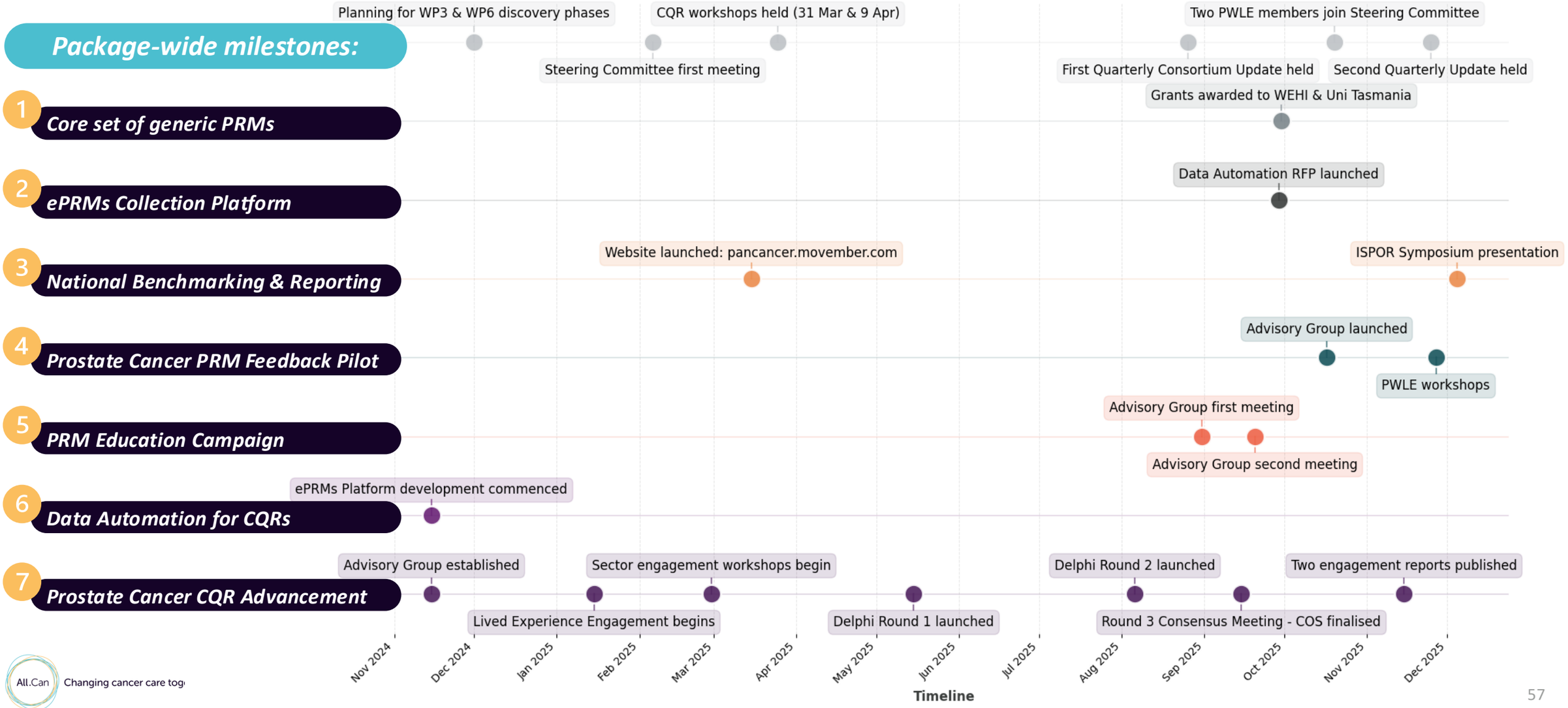
✓ Data automation discovery underway to reduce registry burden

✓ Public awareness campaign launched with quarterly stakeholder updates

All.Can Changing cancer care together

Timeline: Australian Real World Cancer Evidence Network (Pan Cancer Initiative)

Key Milestones across the 7 work packages



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This report is a summary of analysis undertaken by Biointelect Pty Ltd in respect of Australia's Cancer Care Landscape relating to All.Can International's Action Guide for Efficient Cancer Care (Subject Matter). This report has been prepared at the request of and for the sole benefit of Palin Communications / All.Can Australia (Client) and may not be relied upon by any other person.

This report has been prepared solely for the purpose of assisting the Client in its consideration of the All.Can International Action Guide in the Australian context. It is limited in scope and relies on financial and other information provided to us by or on behalf of the Client together with other publicly available information.

The completeness, accuracy or authenticity of that information has not independently verified by Biointelect.

This report should not be treated as a substitute for advice on matters of specific concern to the Client and is given as of 20 January 2026.

All.Can

Changing cancer care together

Together, we all.can

#WeAllCan

All.Can is a multi-stakeholder initiative involving patient, clinical, academic and industry experts as well as policymakers. We aim to help define better solutions for sustainable cancer care and improve patient outcomes in the future. The All.Can initiative is made possible with financial support from Bristol-Myers Squibb (lead sponsor), Amgen and MSD (co-sponsors).