Australian Government
Cancer Australia

Summary Report – Understanding the Cancer Workforce Workshop

6 January 2026

Statement of Acknowledgement

Cancer Australia acknowledges Aboriginal and Torres Strait Islander people as the Traditional Custodians of Country throughout Australia. We pay our respects to Elders, past and present.

We celebrate the ongoing connections of Aboriginal and Torres Strait Islander peoples to Country, culture, community, family and tradition and recognise these as integral to health, healing and wellbeing.

Cancer Australia acknowledges great diversity among Aboriginal and Torres Strait Islander peoples, and the contribution of the many voices, knowledge systems and experiences that guide all efforts to create a culturally safe and responsive cancer system that is equitable to all.

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ISBN Online: 978-0-9586732-0-4

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Acronyms and glossary

Term	Description
ACCHOs	Aboriginal Community Controlled Health Organisations
AI	Artificial Intelligence
EMR	Electronic Medical Records
GPs	General Practitioners
NACCHO	National Aboriginal Community Controlled Health Organisation
Nous	Nous Group
The Department	Department of Health, Disability and Ageing
The workshop	Understanding the Cancer Workforce Workshop

Executive summary

The '*Understanding the Cancer Workforce Workshop*', hosted virtually by Cancer Australia on 15 July 2025, brought together over 60 participants from government, community organisations, peak bodies, and health professional colleges. Facilitated by Nous Group (Nous), the workshop aimed to provide a forum for discussion and collaboration to identify critical challenges facing the cancer workforce and explore future opportunities to address them. Aligned with the Australian Cancer Plan, the workshop was an important step in support of *Strategic Objective 5: Workforce to transform the delivery of cancer care* and Action 5.2.1, which focuses on identifying cancer workforce undersupply and initiating sector-wide planning to build future capacity and capability.

The workshop opened with Professor Dorothy Keefe, CEO of Cancer Australia, outlining workforce aspirations under the Australian Cancer Plan. This was followed by presentations from the Department of Health, Disability and Ageing (the Department) on national cancer workforce modelling and broader strategic workforce challenges. A series of subsequent plenary and breakout group sessions were held on three cancer workforce topics: supply and demand, capability, and equity.

Topic 1: Supply and demand

Australia's cancer workforce is under growing pressure due to rising cancer incidence, demographic shifts, and evolving care models. Cancer incidence is expected to rise by 2.4 per cent annually, with an estimated 192,000 new cases by 2030, amplifying the need for a well-prepared, multidisciplinary workforce.

Workforce supply is limited by structural challenges. Many professionals are nearing retirement, and growth across two-thirds of cancer-related sub-specialties is anticipated to fall short of future service requirements. The shift toward outpatient care and increasing survivorship further highlight the need for a diverse, skilled workforce, yet training opportunities and specialist roles remain limited. Retention issues are compounding supply constraints. Burnout, limited career progression, and lack of mentorship are driving attrition, which can be amplified by poor workplace culture.

Future considerations to address cancer workforce supply and demand include:

- Identifying gaps across disciplines, levels of remoteness and specialisation through harnessing broader national approaches to workforce planning.
- Promoting multidisciplinary based models of tertiary training for medical, nursing and allied health students to prepare students to enter the cancer workforce and practice in multidisciplinary clinical settings.
- Advocating for innovative practices that enhance work-life balance and promote the supervised, professional development of the cancer workforce and improve workplace culture and staff retention.
- Considering fresh approaches to fostering healthy workplace culture as the foundation for workforce wellbeing, engagement, health equity and productivity.

See Section *Topic 1 Summary: Supply and demand* for further detail.

Topic 2: Capability

Australia's cancer workforce is adapting to meet the growing complexity of care, rising service demands, and rapid changes in care delivery and technology. With increasing pressure on specialist roles and widespread workforce shortages, there is a clear opportunity to better utilise the existing capabilities of healthcare professionals across all settings.[1] This includes enabling staff to consistently operate at the upper limits of their training and qualifications, even as many of these roles face resourcing constraints.

The workforce spans diverse roles and settings, this includes those whose work is entirely focused on cancer, such as oncologists and cancer nurses, as well as generalists like General Practitioners (GPs), allied health practitioners, Aboriginal and Torres Strait Islander Health Workers and Practitioners, and psychosocial support providers. This diversity calls for a coordinated, system-wide approach to capability development that equips all professionals to contribute meaningfully to cancer care.

Ensuring that all health professionals can practise to the full extent of their skills is vital. This may require consideration of potentially unnecessary regulatory barriers as well as issues around funding and training capacity while adopting new models of care and digital technologies to enhance workforce effectiveness.

Future considerations to address cancer workforce capability include:

- Investment in enhancing digital platforms and increasing digital literacy across the cancer workforce, including through digital training and upskilling, adopting AI tools and integrating digital health solutions.
- Leveraging models of care, such as innovative nurse-led and allied-health led models, as well as primary care-led survivorship models to harness and expand existing cancer workforce capabilities.
- Advocating for innovative, blended funding models to support holistic, team-based care and enable the cancer workforce to operate at the top of their scope of practice.

See Section *Topic 2 Summary: Capability* for further detail.

Topic 3: Equity

Marked disparities in cancer outcomes and care experiences persist across priority population groups in Australia. The workshop placed particular emphasis on two such groups: Aboriginal and Torres Strait Islander people, and people residing in rural and remote communities.

Cancer is the leading cause of death among Aboriginal and Torres Strait Islander people, with a widening survival gap compared to non-Indigenous Australians. People living in rural and remote areas also experience poorer cancer outcomes compared to those in metropolitan centres with mortality rates 1.3 times higher, and five-year survival rates significantly lower.[2] These disparities across both priority groups areas are multifactorial, linked in part to historical, socioeconomic and cultural determinants, and are compounded for those who are part of both groups, with intersectionality increasing complexity and disparity to access equitable and appropriate care.

Expanding telehealth through increased bandwidth for video consultations, or expanding funding for phone consultations, encouraging rural placements, implementing culturally safe models of care, and embedding anti-racism frameworks within health services can help improve equity in access and outcomes.

1 Australian Government. Australian Cancer Plan – Action 5.2.1: Strengthen the cancer workforce. Canberra: Department of Health and Aged Care.
2 Cancer Australia. Submission to the National Nursing Workforce Strategy public consultation; 2023 Nov.

Future considerations to strengthen equity across the cancer workforce include:

- Co-designing and locally adapting cancer care models to embed culturally safe and responsive care into service delivery.
- Implementing community-led education to improve workforce readiness and retention, particularly in rural and Aboriginal and Torres Strait Islander communities, by aligning training with local service delivery, cultural context, and flexible learning needs.
- Embedding cultural safety in everyday practice, language, and organisational culture governance, workforce structures, and service delivery models to ensure accountability and sustained change.
- Adopting networked training models utilising regional partnerships to support training and supervision, and to address gaps in the cancer workforce.
- Building a clearer understanding of effective incentives for rural and remote placements to address cancer workforce maldistribution.

See Section *Topic 3 Summary: Equity* for further detail.

Summary of collective workshop discussions

Across all topics, the need for coordinated, data-driven cancer workforce planning and collaboration across jurisdictions, disciplines, and communities was identified as a priority. At present, data collection and cancer workforce modelling does not accurately reflect on-the-ground experiences for the cancer workforce, which can prevent meaningful change given its implications to both funding and resourcing. It was recognised that the available data is more comprehensive for regulated professions than self-regulated professions.

The workshop was a valuable step towards better understanding current and emerging cancer workforce undersupply and identifying collaborative policy opportunities aligned with strategic objectives of the Australian Cancer Plan. Moving forward, Cancer Australia and its partners are well-positioned to translate insights from the workshop into priority actions that will support a resilient, capable, and equitable cancer workforce for all Australians.

Workshop overview

Aligned to the strategic objectives of the Australian Cancer Plan, the *'Understanding the Cancer Workforce Workshop'* (the workshop) provided a forum for discussion and collaboration to identify critical challenges facing the cancer workforce and explore future collaborative opportunities to address them.

Following an overview of the Australian Cancer Plan's workforce aspirations and the national health workforce context, participants engaged in breakout discussions around three topics:

1. **Supply and demand:** The cancer workforce needing to respond to increasing demand for cancer services.
2. **Capability:** The capabilities required of the cancer workforce to deliver high quality cancer care are evolving.
3. **Equity:** Australia requires a cancer workforce that enables equitable care to improve cancer experiences and outcomes for all.

Each breakout included representatives with differing backgrounds and expertise to ensure discussions were reflective of the broad challenges and opportunities facing the cancer workforce.

These sessions surfaced a range of key issues facing both the current and future cancer workforce. The day concluded with a synthesis of insights and this summary report has identified opportunities for collaboration opportunities. See Appendix A for the workshop agenda.

The workshop commenced with presentations from Cancer Australia and the Department of Health, Disability and Aged Care

The workshop began with three presentations. One from Professor Dorothy Keefe PSM MD, CEO of Cancer Australia, and two from the Department of Health, Disability and Ageing (the Department). These presentations provided valuable context for the workshop, providing participants with insights into the Australian Cancer Plan, the national health workforce, and the current national reform agenda.

Cancer Australia's presentation highlighted strategic objectives of the Australian Cancer Plan and the importance of a well-prepared workforce for transforming cancer care delivery
Professor Keefe outlined the context for the workshop and highlighted the relevant strategic objectives from the Australian Cancer Plan. She reintroduced the six core strategic objectives, positioning the workshop as a foundational step toward advancing Action 5.2.1: *'Identify current and emerging workforce undersupply in line with cancer workforce modelling and other national health workforce strategies, and initiate planning with the sector towards building future workforce capacity and capability.'* The presentation acknowledged the broad alignment across national workforce strategies (such as those for nursing, nurse practitioners, and allied health) align with the Australian Cancer Plan, creating an opportunity for coordinated implementation.

The Department delivered presentations addressing the current and prospective national health workforce landscape to illustrate expected challenges and opportunities within the health workforce.

The first presentation focused on health workforce data in cancer-related professions. The data presented demonstrated a projected growth in the specialist healthcare workforce, with significant numbers of prevocational and hospital career medical officer (CMO) positions. It was noted that these data are not specific to the cancer workforce, and concerns remain around affordability and distribution of the specialist workforce. The presentation also emphasised a significant workforce gap (by 2035) in the nursing workforce and limited capacity in registrar positions despite increasing enrolments in medical schools.

The second presentation outlined the range of initiatives to address healthcare workforce challenges, including through workforce strategies such as the National Nursing Workforce Strategy, National Allied Health strategy and the Aboriginal and Torres Strait Islander Cancer Plan. Despite a steady growth in registered health practitioners over the last decade, there is still a distribution challenge with more generalists in the system than subspecialists, and poor workplace culture still effecting retention. The presentation outlined a need to enhance innovative models of care and preventive strategies to meet healthcare demands. Similarly, systemic reform and collaborative action across jurisdictions and disciplines is required to build a resilient and sustainable workforce.

The following sections provide a summary of each workshop topic, and includes information presented from the discussion paper and group discussions.

Topic 1 Summary: Supply and demand

Supply

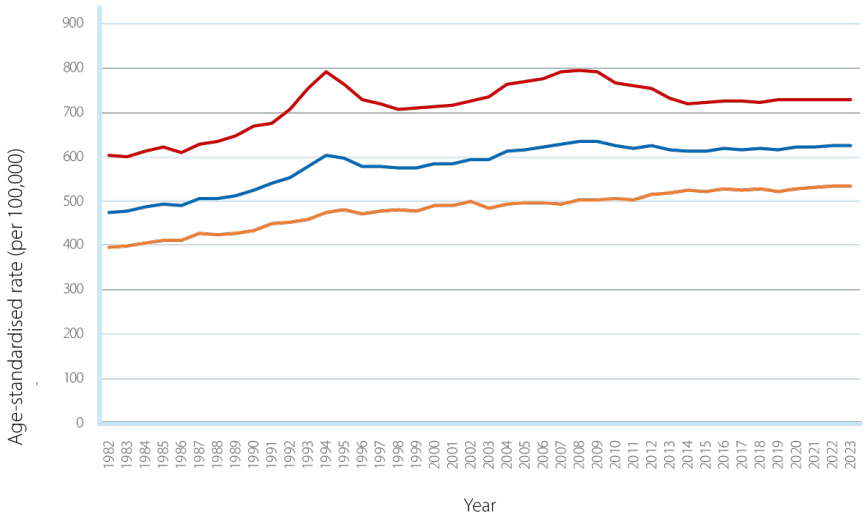
The supply of the cancer workforce is constrained by several systemic issues. A significant proportion are approaching retirement age, and two-thirds of cancer-specific sub-specialties are predicted to experience insufficient growth to meet future service demands.[3] Furthermore, an undersupply of nurses and registrar positions is expected by 2038.[4] While medical graduate numbers have increased, the availability of specialist training positions has not kept pace, creating a bottleneck that delays entry into oncology specialties and discourages potential candidates.[5] These findings outline the structural limitations caused by an ageing workforce, limited positions and reduced training capacity which are impeding workforce growth.[6]

Retention challenges compound supply issues with high workloads, limited career progression, and inadequate mentorship contributing to burnout and attrition. These factors are exacerbated by poor culture within the Australian healthcare system where bullying and systemic racism are common.[7] COSA in partnership with several national peak-bodies, the American Society of Clinical Oncology (ASCO) and the European Cancer Organisation (ECO) have developed a contemporary definition and principles for fostering healthy workplace culture.[8] This approach aims to enhance diversity and inclusion as part of team culture.

Demand

Australia's cancer workforce is under increasing pressure to meet the rising demand for cancer services, driven by demographic shifts, evolving models of care and persistent workforce challenges. Cancer incidence is projected to grow by 2.4 per cent annually, with an estimated 192,000 new diagnoses expected by 2030 (Figure 1).[9] This surge, coupled with improved cancer survival rates and the expansion of survivorship care, is intensifying the need for a robust, multidisciplinary workforce capable of delivering high-quality care across the cancer continuum.

Figure 1. Age standardised incidence rates, all cancers combined, Australia, 1982-2023[10]



Notes

1. Age-standardised rates are expressed per 100,000 population.
2. Age-standardised rates using the 2023 Australian Standard Population.
3. 2020–2023 data are estimated.

Source: Australian Institute of Health and Welfare 2023. Cancer data in Australia. Cat. No. CAN 122. Canberra: AIHW.

3 Australian Government Department of Health. Cancer care workforce modelling: Final executive report. 2022 Jun 22.
4 Department of Health, Ageing and Disability workshop presentation: Health Workforce. July 2025.
5 Department of Health and Aged Care. National Medical Workforce Strategy 2021-2031. Australian Government. 2021.
6 Department of Health, Ageing and Disability workshop presentation: Health Workforce. July 2025.
7 A Better Culture, Qualitative Research for Culture Change. August 2023.
8 Sabesan S, Levit LA, Ceelen W, Crul M, Garrett-Mayer E, Kirkwood MK, et al. Principles for advancing healthy work environments and cultures: an ASCO-COSA-ECO joint statement.
9 Australian Government Department of Health. Cancer care workforce modelling: Final executive report. 2022 Jun 22.
10 Australian Institute of Health and Welfare 2023. Cancer data in Australia. 2023.

Key measures such as innovative models of care, expanded scopes of practice and an improved workplace culture could help to resolve cancer workforce shortages.[11] To appropriately address supply and demand issues for the cancer workforce, sector partners need to strategically invest in initiatives that are supported by up-to-date, accurate data.

Thematic insights

Key thematic insights on the challenges regarding supply and demand in the cancer workforce are outlined below.

Measuring and responding to cancer workforce demand

- Demographic changes, including an ageing population, compounded with earlier detection of cancers increases the complexity and demand for care at every stage, especially for older patients with multiple comorbidities and health care needs.
- Increasing survival rates means many people require cancer care into stages of long-term follow-up and monitoring for recurrence or secondary cancers.
- Survivorship care is becoming more community-based, with general practitioners and primary care providers playing an increasingly critical role in delivering consistent, high-quality care, which increases workforce demand.
- Advancements in therapies and technologies are reshaping the nature of cancer care, influencing the type, duration, and frequency of services required.

Health workforce projections and on-the-ground realities

- Despite national workforce projections suggesting growth in specialist numbers, many workshop attendees from diverse settings reflected on their experiences of specialist shortages that limit comprehensive cancer care. This disconnect is particularly evident in rural and regional areas, where the loss of specialists can destabilise an entire cancer service. The reliance on fractional, specialist positions and the lack of redundancy in staffing models exacerbate this issue.
- Current workforce modelling and funding mechanisms are largely reliant on activity-based funding sources and registered professions, which may not be reflective of all workforce capacity.
- The lack of integrated data across jurisdictions hampers effective workforce planning, making it difficult to accurately identify and respond to current and future needs.

> "There's the even smaller sites where they're never going to be big enough to actually have a dedicated oncologist"
>
> Medical specialist college representative

11 Department of Health, Ageing and Disability workshop presentation: Health Workforce. July 2025.

Multidisciplinary training approaches

- Despite strong evidence for multidisciplinary cancer care, university students still experience fragmented training, particularly between medicine, nursing, and allied health. For example, allied health students, such as exercise physiologists, are often trained in isolation, despite the reality that cancer care requires coordinated input from diverse professionals. This lack of early exposure to team-based care can impact graduates' confidence and readiness to practice in clinical settings.
- Stronger dialogue is required between universities and health services to ensure curricula reflects the complexity and pace of modern cancer care. The mismatch between academic preparation and clinical expectations is a potential barrier to effective workforce integration, putting pressure on a system that is already experiencing shortages. For example, as cancer diagnoses and survivorship grow, collaborative, person-centred approaches that integrate physical and psychosocial care are likely to increase.

> "All of our lab work [while studying] was really focused on our own roles, but in reality, [training should] involve multidisciplinary teams… [to help us] understand the scope of not only our own roles, but of the other professions [we will collaborate with]"

Allied health workshop participant

Balancing generalist and specialist skills for cancer care

- Certain cancer specialties are faced with significant challenges in terms of workforce quantity and distribution. For example, radiation oncologists that can deliver complex treatments like brachytherapy, are currently concentrated in only a limited number of centres across Australia.
- Some specialties could have their demand reduced by increasing generalist skills of other specialists. For example, limited training in adjacent fields has led to clinicians requesting consultation from stretched services, including pathology.
- Currently, there are various separate systems that contain health workforce data, and many fail to capture the diversity of roles involved in cancer care, impeding comprehensive cancer workforce planning.

Workplace culture and staff retention

- Workplace culture remains a key determinant of retention, with calls to address bullying, racism, and burnout across the sector.
- Career progression for many health professionals working in cancer care can be limited by a lack of structured mentorship and supervision. Healthcare professionals are further challenged by a lack of consistency in their training across jurisdictions and individual health services.
- Healthcare professionals, particularly GPs and nurses, are increasingly seeking part-time roles and more autonomy over their schedules.

Future considerations for supply and demand of the cancer workforce

Workshop discussions on supply and demand of the cancer workforce also identified future considerations to address key challenges. These are outlined below.

- Determining prospective cancer workforce demand needs to account for demographic shifts such as an ageing population and increasing survivorship, to determine the requirements for the cancer workforce of the future. Initiatives at all levels should seek to address these factors by investing in key, relevant care fields, such as community care and palliative care, to ensure that the workforce has enough supply to meet the prospective needs of the community.
- Fostering healthy workplace culture through a values- and purpose-aligned culture approach.[12, 13]
- Identifying gaps across disciplines, levels of remoteness and specialisation through leveraging broader national approaches to workforce planning.
- Promoting more multidisciplinary based models of tertiary training for medical, nursing and allied health students is an important aspect of preparing students to enter the cancer workforce and practice in multidisciplinary clinical settings.
- Cancer care specialists should be supported to meet increasing demand by enhancing the number of available positions for senior clinicians across disciplines. Simultaneously, the demand on specialists may be reduced by increasing generalist capabilities within the workforce. This can be achieved by increasing training for the workforce in specialist fields to prevent unnecessary referrals that increase the specialist workload.
- Creating a more integrated and transparent approach to workforce planning, supported by accurate and complete datasets, can help balance the allocation of generalists and specialists to meet the specific care needs patients across Australia by illustrating where there are significant gaps and consequently investing in resources to address them.
- Exploring and embedding innovative practices can be helpful in improving cultural safety and trust in the workplace. For example, "in house" psychological support programs and psychosocial risk assessments were identified as successful initiatives in improving staff wellbeing and job satisfaction.
- Providing flexible work arrangements and improving work-life balance can significantly improve retention by reducing burnout and fostering a more sustainable work environment. So too can adopting employment models that better accommodate career transitions, parental leave, and secondment opportunities.
- Supporting early career professionals through consistent, structured mentorship and supervision, including through statewide training programs and rural training networks, can also support career progression.

12 Clinical Oncology Society of Australia. Healthy workplace culture in health systems: A proposed National Framework. Clinical Oncology Society of Australia. March 2024.

13 Sabesan S, Levit LA, Ceelen W, Crul M, Garrett-Mayer E, Kirkwood MK, et al. Principles for advancing healthy work environments and cultures: an ASCO-COSA-ECO joint statement.

Topic 2 Summary: Capability

The capabilities of Australia's cancer workforce are evolving in response to increasing complexity in cancer care, rising demand for services, and significant shifts in models of care and technology. Given increased burden and shortages within the specialised cancer workforce, there is potential to focus on harnessing the existing skills and capabilities of staff across healthcare settings (noting many of these are also faced with undersupply) to ensure that they are working at the top of their scope of practice.

The cancer workforce is not a singular entity, but a broad and diverse system of professional groups. It includes those whose roles are entirely cancer-focused, such as oncologists and cancer nurses, as well as general practitioners, allied health professionals, Aboriginal and Torres Strait Islander Health Workers and Practitioners, and psychosocial support providers, for whom cancer care is a component of broader responsibilities. This diversity necessitates a system-wide approach to capability development that ensures all professionals, regardless of setting or specialty, are equipped to contribute effectively to cancer care. This is particularly significant in areas with known capability gaps such as palliative care, as well as emerging capabilities, like genomics.[14]

Capability development and training should also be aligned with new and innovative models of care. For example, studies have indicated that shared follow-up care by a nurse or nurse coordinator can be as effective as specialist follow-up care and so would need to be considered in training.[15]

A key capability challenge is enabling all health professionals to work at the top of their scope of practice. This requires addressing regulatory, funding, and training barriers that may limit full utilisation of skills while introducing innovative models of care and using digital innovation as an enabler of workforce capability. Additionally, digital technology can be leveraged to support the cancer workforce to work at the top of their scope of practice.

Thematic insights

The key thematic insights on the challenges regarding capabilities of the cancer workforce are outlined below.

Cancer workforce capacity constraints

- Australia's cancer workforce is under strain from staff shortages and rising demand, leaving many professionals overburdened. Without sufficient staffing, professionals are often forced to assume responsibilities outside their core competencies, reducing efficiency and compromising care quality.
- There is a need for clear delineation of professional role responsibilities and increased investment in administrative support to enable health professionals in cancer services to focus on patient care.

> "From a nursing perspective… working to top of scope is often hampered by a lack of recognition of… non-clinical roles in cancer care [particularly]… administrative support. [Despite being] one of the cheapest roles in a health service, [it is] often first to be cut."

Cancer peak organisation workshop participant

14 Cancer Australia. Cancer Australia submission to the unleashing the potential of our health workforce – scope of practice review. 2023 Oct.

15 Cancer Australia. Cancer Australia submission to the unleashing the potential of our health workforce – scope of practice review. 2023 Oct.

Harnessing technology to promote professionals working at the top of their scope of practice

- Digital systems to support cancer care are often fragmented, outdated, and not interoperable across jurisdictions. For example, it was noted that some clinicians were recently still using outdated systems, like Windows XP, impeding key clinical activities such as accessing patient information. Similarly, the lack of interoperability of electronic medical records (EMRs) across jurisdictions requires patients to retell their medical history and places additional time burden on clinicians. These inefficiencies contribute to burnout and reduce the workforce's ability to focus on complex cancer care.
- Further research and analysis are required to ensure that artificial intelligence (AI) tools have appropriate governance and ethical oversight.
- Further funding is needed to support the integration of digital health solutions. Without adequate funding, these technologies cannot be fully leveraged to support the workforce in working at the top of their scope.

The role of funding models in supporting the cancer workforce

- Current funding models like activity-based and episodic funding don't align with the complexities of modern cancer care. They limit flexibility by preventing the integration of funding streams, hindering innovation and adequate resourcing. They further restrict the ability of health services to support staff in working to their full scope, particularly in multidisciplinary and community-based settings.

Future considerations for the capability of the cancer workforce

Workshop discussions on capability of the cancer workforce also identified future considerations to address key challenges. These are outlined below.

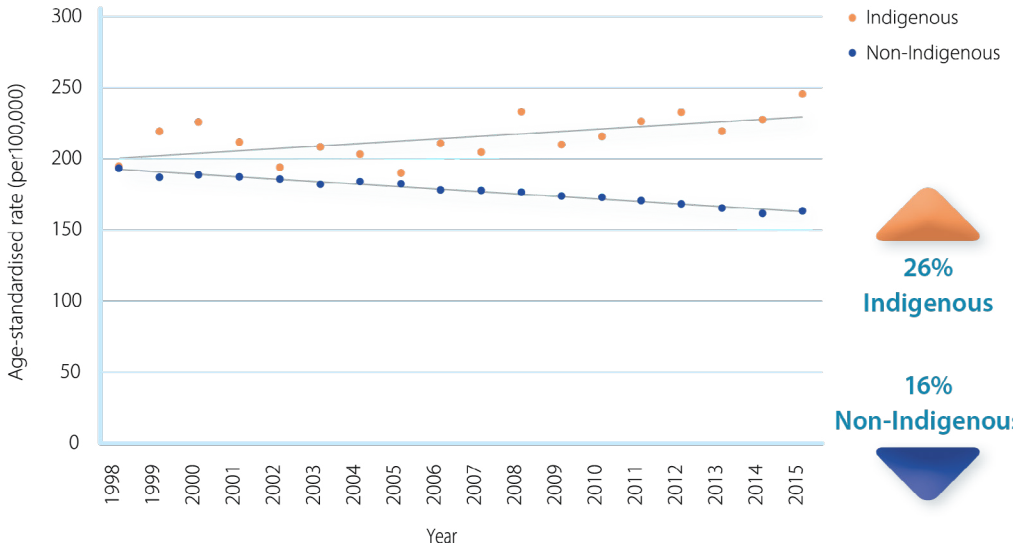
- The sector should consider initiatives that integrate relevant graduates, such as science graduates, into clinical trial teams that can alleviate the load on clinical staff. Such models demonstrate how effective workforce design can enhance capability without increasing clinical headcount.
- Investment in enhancing digital platforms and increasing digital literacy across the cancer workforce is essential to enabling professionals to work at the top of their scope.
- Given the rise in technology and digital innovation, opportunities exist to ensure the cancer workforce is digitally trained and upskilling. For example, micro-credentialing and targeted training in emerging technologies can serve as a mechanism to keep the workforce up to date with rapid advancements in technology.
- Adopting AI tools like medical scribes and automated scheduling can significantly reduce administrative burden and enhance clinical decision-making, but their adoption requires upfront investment and training. AI-powered medical scribe software, for instance, can automate clinical documentation, enabling clinicians to focus on patient care.
- Expanding innovative nurse-led and allied health-led models of care can support the non-pharmacological aspects of cancer care and alleviate pressure on medical specialists. For example, a nurse-led clinic can provide assessment, education, and treatment for patients to support cancer treatment and care. These models not only improve continuity of care but also offer career progression opportunities for nurses and allied health professionals.
- Implementing innovative models of care, such as primary care-led survivorship models, can shift survivorship care from specialist-led to general practice-led. This can be more cost-effective, while delivering the same value as specialist-led care.
- Implementing a blended model combining Medicare, state, and private funding could better support holistic, team-based care, particularly where traditional models fall short.

Topic 3 Summary: Equity

Significant disparities in cancer outcomes and experiences exist for many priority population groups. The workshop focused on two of these priority population groups, Aboriginal and Torres Strait Islander people and those living in rural, regional and remote areas of Australia. Disparities experienced by both populations are compounded for those who are part of both communities, as the proportion of the population who are Aboriginal and/or Torres Strait Islander is generally higher in more remote areas.[16] This intersectionality increases complexity and disparity to access equitable and appropriate care.

Cancer is the leading cause of death for Aboriginal and Torres Strait Islander people, with a widening survival gap compared to non-Indigenous Australians, as illustrated in Figure 2. Most contributing factors to these gaps such as intergenerational trauma, socioeconomic risk factors, and systemic racism within the Australian healthcare system, require collaboration from sector partners and input from Aboriginal and Torres Strait Islander people to appropriately address them.[17] National and jurisdictional strategies, including the Australian Cancer Plan and the National Aboriginal Community Controlled Organisation's (NACCHO) Aboriginal and Torres Strait Islander Cancer Plan, reflect a commitment to bridge this gap and enhance access to effective and culturally safe care, including through increased representation of Aboriginal and Torres Strait Islander staff within the cancer workforce. Mandatory cultural safety training for non-Indigenous staff, aligned with the Australian Health Practitioner Regulation Agency's standards, is also critical to reducing bias and improving care quality.

Figure 2. Age-standardised mortality rate, all cancers combined, Aboriginal and Torres Strait Islander Australians and non-Indigenous Australians, 1998 to 2015[18]



Source: Australian Institute of Health and Welfare 2018. Cancer data in Aboriginal and Torres Strait Islander people of Australia. Cat. No. CAN 109. Canberra: AIHW.

Additionally, Australians living in rural and remote areas face poorer cancer outcomes compared to people living in cities.[19] People in remote areas of Australia face poorer cancer outcomes, with a 1.3 times higher mortality rate and lower 5-year survival rate compared to people living in major cities. They also face significant difficulties accessing specialised cancer care, which negatively impacts their treatment and consequently contributes to health disparities. The barriers to accessing quality cancer care in rural areas are multifaceted. This is partly linked to cancer workforce shortages and a maldistribution of health professionals, who are concentrated in metropolitan areas. Specialty training programs with greater number of rural placements, enhancing virtual supervision for cancer workforce trainees, and implementing effective telehealth practices can help to address equity in cancer care.

16 Australian Institute of Health and Welfare. Profile of First Nations people. 2024.
17 Australian Institute of Health and Welfare. Closing the Gap targets: key findings and implications. 2025.
18 Australian Institute of Health and Welfare. Cancer data in Aboriginal and Torres Strait Islander people of Australia. 2018.
19 Cancer Australia. Submission to the National Nursing Workforce Strategy public consultation; 2023 Nov.

Thematic insights

The key thematic insights involving challenges and future considerations for enhancing equity in the cancer workforce are outlined below.

Aboriginal and Torres Strait Islander people and the cancer workforce

Specific challenges regarding Aboriginal and Torres Strait Islander people and the cancer workforce discussed in the workshop are outlined below.

Enhancing Aboriginal and Torres Strait Islander representation in the cancer workforce

- Aboriginal and Torres Strait Islander medical, nursing and allied health students often lack exposure to cancer specialties. Targeted, culturally safe engagements and visible role modelling are deeply needed to foster a sense of interest to join the cancer workforce.

> "You can't be what you can't see."
>
> Workshop participant from an Aboriginal and Torres Strait Islander-focused organisation

Barriers to a more equitable cancer workforce

- Aboriginal and Torres Strait Islander health professionals often lack access to mentorship, supervision, and career progression pathways. This contributes to attrition and prevents long-term retention in cancer care roles.
- While national frameworks like the Aboriginal and Torres Strait Islander Cancer Plan and the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework exist, participants repeatedly noted that these are not adequately funded to be implemented.
- Identifying Aboriginal and Torres Strait Islander professionals within workforce datasets is difficult, which makes it challenging to plan, resource, and advocate for increased representation.

Enhancing cultural safety across cancer care

- Tokenistic approaches fail to address systemic racism and inequity. Superficial gestures or one-off cultural training sessions do not dismantle entrenched racism or improve care.
- There is a clear gap in the inclusion of cultural safety in core curricula and professional development. This needs to be enhanced for the benefit of both Aboriginal and Torres Strait Islander health professionals and patients and be aligned with the priorities within the Australian Cancer Plan.
- All health professionals must be trained, supported, and held accountable for delivering culturally safe care. However, current training for non-Aboriginal and Torres Strait Islander health professionals is not consistently implemented or evaluated.

> "In some states they have [helped to embed cultural safety] by making it mandatory for liaison officers to get qualifications as an Aboriginal Health Worker."
>
> Workshop participant from an Aboriginal and Torres Strait Islander-focused organisation

Models of care for Aboriginal and Torres Strait Islander people

- Many Aboriginal and Torres Strait Islander patients feel lost in the healthcare system after a cancer diagnosis due to fragmented care pathways and lack of follow-up. This delay in treatment can lead to poorer outcomes and necessitates more place-based models of cancer care led by community.
- Volunteers and community champions are underutilised assets to provide or support the delivery of care for Aboriginal and Torres Strait Islander populations.

Future considerations for equity for Aboriginal and Torres Strait Islander people

Workshop discussions on equity and the cancer workforce, specific to Aboriginal and Torres Strait Islander people, also identified future considerations to address key challenges. These are outlined below.

- Leveraging the lived experience of Aboriginal and Torres Strait Islander health professionals offers a unique opportunity to embed culturally safe, community-aligned care across the cancer continuum. Formal partnerships have been established to enhance this representation, including Cancer Australia's partnership with the Australian Indigenous Doctors Association – this involves funding provided over three years to co-design and deliver a program to build their specialist cancer medical workforce.
- Opportunities exist to strengthen the representation and impact that Aboriginal and Torres Strait Islander Health Workers and Practitioners have on patient experience and outcomes. Aboriginal Liaison Officers, for example, play a vital role in continuity of care through their respective connections to community and their presence has been linked to reduced 'did not attend' rates. This is particularly relevant for service providers in rural and remote areas.
- There is a need for flexible, culturally safe training pathways that allow and support Aboriginal and Torres Strait Islander students to train on Country.
- Adopting community-led education presents a powerful opportunity to improve workforce readiness and retention, particularly in rural and Aboriginal communities, by aligning training with local service delivery, cultural context, and flexible learning needs. These models were seen as being more effective than traditional university-based pathways.
- Anti-racism frameworks should be community-led and implemented widely. This means shifting from "lip service" to visible, accountable equity practices, including anti-racism frameworks, and promoting courageous conversations among non-Aboriginal and Torres Strait Islander staff.
- Cultural safety must be embedded in everyday practice, language, and organisational culture governance, workforce structures, and service delivery models to ensure accountability and sustained change.
- Cultural safety must be built into professional standards and training. Embedding cultural safety across education settings helps to ensure that the cancer workforce is equipped to deliver respectful, responsive care.
- A cancer hub model, either in tertiary or primary care, was suggested to centralise coordination and ensure Aboriginal and Torres Strait Islander patients remain "on the books" across all teams, preventing them from being lost in siloed systems. This model ensures that patients receive timely, seamless care and are not lost in the complex healthcare system through elements like a single point of entry to store all patient data, dedicated care coordinators, and multidisciplinary teams that share all relevant updates regarding cancer treatment.
- Opportunities exist to adopt community-led and culturally embedded models as they are seen as more effective and best placed to deliver culturally safe care. Organisations such as Aboriginal Community Controlled Health Organisations (ACCHOs) already use multidisciplinary, wraparound models that should be scaled and funded for cancer care. Embedding Aboriginal and Torres Strait Islander Healthcare Workers and Practitioners more consistently into these teams would improve culturally responsive care and support Closing the Gap objectives.

- In settings where Aboriginal and Torres Strait Islander Healthcare Workers are not funded, there is a clear opportunity to formalise and scale volunteer-led models of care, drawing on the lived experience of cancer survivors and the cultural authority of community Elders. These trusted figures already provide vital, culturally safe support that formal systems often lack, such as accompanying patients to appointments and helping them navigate care pathways. Recognising and resourcing these models can strengthen continuity of care, build trust, and improve outcomes for Aboriginal and Torres Strait Islander patients.
- Co-designing and locally adapting cancer care models offers a critical opportunity to embed cultural safety and responsiveness into service delivery. This is vital as cultural practices and challenges in health and wellbeing differ between Aboriginal and Torres Strait Islander populations.

Regional and remote areas and the cancer workforce

Specific challenges regarding rural and remote areas and the cancer workforce discussed in the workshop are outlined below.

Funding to address health inequity in rural and remote communities

- Current funding models are misaligned with the realities of rural and remote cancer care delivery, given they do not support innovative or flexible models of care. For example, small rural cancer services often operate under block funding arrangements, which restricts their ability to scale or adapt services. This model does not support the nuanced needs of telechemotherapy or outreach oncology services, making sustainability difficult. Similarly, cancer patients in rural areas often rely on GP Management Plans for allied health access, which only provide five subsidised visits per year. This makes it financially unviable for providers to operate in remote communities.
- Telehealth funding is limited, with certain Medicare items only available for video consultations. In remote areas, bandwidth constraints make video consultation impractical, yet telephone consultations are not adequately funded.
- While postgraduate oncology trainees are expected to complete rural rotations, there is insufficient investment in sustained rural training programs for other disciplines. This limits the development of a permanent rural cancer workforce.

Enhancing partnerships to cover gaps in the rural and remote cancer workforce

- Poor bandwidth and incompatible platforms in rural and remote areas reinforce silos and limit collaboration.
- GPs in rural and remote areas can currently face delays and rejected referrals, which disrupts treatment and isolates primary care from the broader cancer system.
- Rural cancer coordinators often work in isolation without supervision or leave relief.

Recruitment and retention of the cancer workforce in rural and remote locations

- Rural workforce losses have a disproportionate impact on cancer care. For example, losing a single nurse practitioner in a rural town can collapse an entire cancer unit, whereas the same loss in a metropolitan centre has minimal impact. This highlights the fragility of rural services and the need for redundancy and investment in workforce buffers.
- Metropolitan students face financial barriers to rural and remote placements due to the cost of relocation. This may result in students opting out of placements, preventing needed exposure and ultimately leading to a reduction in the rural and remote workforce.

- Trainees often lack exposure to generalist oncology roles during rural and remote placements, which limits their preparedness and willingness to work outside metropolitan centres.
- A lack of supervision in rural and remote locations limits teaching and guided exposure to the rural and remote workforce students. Fragile staffing structures further mean that supervision can collapse with unplanned leave.

> "Understanding incentive for health workers to work in rural and remote areas goes well beyond just providing a job and housing."

Cancer peak organisation workshop participant

Future considerations for equity for rural and remote locations

Workshop discussions on equity and the cancer workforce, specific to rural and remote locations, also identified future considerations to address key challenges. These are outlined below.

- Adopting innovative networked models utilising regional partnerships can support training and supervision. For example, Queensland's success with statewide oncology training rotations, which improved rural workforce retention, can be expanded to across other states. Bringing cancer staff, such as nurses, from regional sites into metropolitan centres for training also strengthens relationships and team cohesion.
- Implementing appropriate digital platforms can support regional integration to prevent silos. For example, there is a need for interoperable digital systems and bandwidth access to enable shared care across geographic regions.
- Embedding primary care into regional partnerships presents a critical opportunity to strengthen and ensure direct lines of communication between GPs and tertiary centres.
- Regional partnerships can support workforce wellbeing and build redundancy. There is an opportunity for rural and remote cancer services to provide peer support, case discussions, and shared resources to reduce burnout and improve retention.
- Increasing understanding of incentives for rural and remote placements can enhance the cancer workforce in these locations. Services should consider crucial, influential factors including childcare access and travel subsidies that can help to overcome logistical barriers that deter the cancer workforce for relocating.

Concluding discussion

At the workshop's conclusion, participants reflected on their key takeaway from the day (see Appendix B). These responses are summarised against the workshop's topics below.

Supply and demand

Participants emphasised the importance of aligning cancer workforce strategies with community and population needs, rather than institutional priorities, and recognised the importance of demand-driven workforce models. Additionally, there were calls to better leverage investments in existing programs, such as Commonwealth cancer screening programs and rural and remote service delivery programs and better integration of health technologies as ways to meet growing demands on the workforce. Participants also highlighted the need for prioritising efforts to strengthen the cancer workforce training pipeline (for key clinical and non-clinical roles), the urgency of practical, supply-building efforts across the sector, and the need to foster a healthy workplace culture.

Capability

There was strong support for recognising lived experience, patient coordination and peer support roles as legitimate components of the workforce, which can enhance service delivery and support others to work at the top of their professional scope of practice. The need for greater balance of generalist and subspecialist roles in cancer care was identified as a key concern, as was ensuring that efforts to support appropriate scope of practice for the cancer workforce are targeted to avoid both underutilisation and overextension. Education and training initiatives, such as place-based learning pathways, were noted by participants as essential for building cancer workforce capability. Greater health system integration and more seamless cancer service delivery were also identified as part of the solution, by breaking down siloed systems and improving overall effectiveness and efficiency of the cancer workforce.

Equity

Strengthening the cultural responsiveness of the cancer workforce, with an emphasis on enabling Aboriginal and Torres Strait Islander Healthcare Workers and Practitioners, was seen as core to more equitable cancer outcomes. Participants also emphasised the need to learn from effective rural programs and applying those lessons to metropolitan areas, fostering interprofessional collaboration and community engagement. The need for greater medical oncology training rotations in rural and remote settings and a stronger understanding of incentives for workforce retention were also identified an important. Incentives should address not just remuneration and career progression, but also lifestyle and wellbeing considerations for cancer care professionals.

Across all topics, a consistent theme emerged: the need for coordinated, data-driven cancer workforce planning and collaboration across jurisdictions, disciplines, and communities. The workshop laid the groundwork for future partnerships and policy development, aligning with the strategic objectives of the Australian Cancer Plan. Moving forward, Cancer Australia and its partners are well-positioned to translate these insights into actions, ensuring a resilient, capable, and equitable cancer workforce for all Australians.

Appendix A Workshop agenda and attendees

Appendix A outlines the high-level workshop agenda and a summary of the organisations that were represented at the workshop.

Table 1. Cancer Australia Workshop Agenda

Time	Session	Lead
10:00-10:10	Welcome and introductions	Cancer Australia & Nous Group
10:10-10:25	Cancer workforce aspirations of the Australian Cancer Plan	Cancer Australia
10:25-10:55	The national health workforce context	Department of Health, Disability and Ageing
10:55-11:55	Supply and demand	Nous Group
11:55-12:40	*Lunch*	
12:40-13:40	Capability	Nous Group
13:40-14:40	Equity	Nous Group
14:40-14:55	Synthesise insights and identify future cancer workforce policy priorities	Nous Group
14:55-15:00	Close	Cancer Australia

Table 2. Cancer Australia Workshop Attendees

Organisation	Attendees
Australian & New Zealand Children's Haematology/Oncology Group	1
Australian College of Nursing	1
Australian Indigenous Doctors Association	1
Australian Society of Cytology/Clinipath Pathology	2
Australian Society of Medical Imaging and Radiation Therapy	2
Cancer Australia (observers)	11
Cancer Council Australia (CCA)	1
Cancer Nurses Society of Australia	2
Cancer Voices South Australia	1
Chris O'Brien Lifehouse	1
Clinical Oncology Society of Australia	1
Congress of Aboriginal and Torres Strait Islander Nurses and Midwives	1
Consumer representative	1
Council of Presidents of Medical Colleges	1
Department of Health, Disability and Ageing	8
Department of Health, Tasmania	2
Department of Health, Western Australia	4

Organisation	Attendees
Exercise & Sports Science Australia/Allied Health Professions Australia	1
Fiona Stanley Hospital, Western Australia	1
Genomics Australia	2
Indigenous Allied Health Australia	1
Metro North Hospital and Health Service, QLD Health	1
Medical Oncology Group of Australia	2
National Aboriginal Community Controlled Health Organisation	1
National Association of Aboriginal & Torres Strait Islander Health Workers & Practitioners	1
Nous Group	5
NSW Health	4
Peter MacCallum Cancer Centre	1
Royal Australasian College of Physicians	1
Royal Australasian College of Surgeons	2
Royal Australian and New Zealand College of Obstetricians and Gynaecologists	1
Royal Australian and New Zealand College of Psychiatrists	1
Royal Australian and New Zealand College of Radiologists	2
Royal Australian College of General Practitioners	2
Royal College of Pathologists of Australasia	1
Royal Darwin Hospital	1
Royal Prince Alfred Hospital	1
SA Health	2
The Australasian College of Physical Scientists and Engineers in Medicine	1
VCCC Alliance	1

Appendix B Participant responses to key questions

Appendix B outlines participant responses to a *Slido* question and request for participant takeaways from the workshop.

Following the two presentations from the Department, workshop participants were asked to consider the following question: *"In light of all the work that has been done in national health workforce modelling and policy, what are some of the barriers to change and action in the cancer workforce?"*. Table 3 outlines the responses to this question across five, key themes.

Table 3. Responses to Slido question

Theme	Responses
Funding, financial modelling and policy	• "Need financial modelling to support nurse led models of care. We have evidence they make a difference to patients and outcomes but nothing that shows the impact on the system." • "Funding models that don't take into account benefits of nurse-led models of care." • "Funding model leaves much of our work without remuneration." • "Seems to be many workforce strategies however their implementation doesn't seem to be funded even though they have been supported by all jurisdictions." • "Promising strategies remain unfunded, making translations into action difficult." • "Current funding models like activity-based and episodic funding don't align with the complexities of modern cancer care." • "Blended funding models and incubator-style grants can enable local innovation and support multidisciplinary teams in regional settings." • "Funding misalignment prevents the development of an effective rural and remote cancer workforce." • "Telehealth funding is limited, with certain Medicare items only available for video consultations." • "Funding for ongoing professional development is also critical to ensuring the cancer workforce remains equipped with the latest knowledge and skills." • "Employment policies that are implemented without an understanding of the prior research done on workforce modelling."
Workforce capability and scope of practice	• "Interdisciplinary supervision models." • "Training opportunities and changing scope of practice. Need to also consider radiology, surgery, nuclear medicine and pathology and trial workforce interactions." • "Extended scope of practice." • "Lack of clinically led solutions and involvement." • "Medical models of care." • "Allied health still feels like an afterthought and not embedded as part of core, critical care at a systems level." • "Capacity constraints can intensify capability challenges, limiting the cancer workforce's ability to operate at the top of their scope of practice." • "Micro-credentialing and targeted training in emerging technologies serve as a mechanism to keep the workforce up to date."

Theme	Responses
Workforce distribution, retention and culture	• "Workforce preferences to work in metro vs rural/regional areas." • "Increasing workforce preference for part time and casual work vs full time." • "Increasing complexity of care. Workforce fatigue." • "Culture, culture, culture. Declare workforce issue as a chronic issue and review the balance of what is important." • "Limited time for planning in an operational environment due to patient care." • "Fostering a positive culture, supporting wellbeing, and offering clear development opportunities helps to retain staff." • "Supporting early career professionals through structured mentorship and supervision is essential for retention." • "Flexible work arrangements and work-life balance are seen to be significant retention enablers." • "Rural workforce losses have a disproportionate impact on cancer care." • "Metropolitan students face financial barriers to rural and remote placements." • "Trainees often lack exposure to generalist oncology roles through rural and remote placements." • "Cultural barriers: systemic reluctance to change practice models/ways of working."
Equity and inclusion	• "Embedding antiracism and cultural safety practice into health care environments and cultures." • "Specifically for Aboriginal and Torres Strait Islander workforce, there is stigma about cancer in general and other barriers are not being able to deliver culturally appropriate care in community." • "There needs to be a focus on the workforce that does the following: service rural, helps implement effective screening programs, connects people to systems that have barriers to access, ensures follow-up." • "Inequity in health distribution: Higher financial and social costs in rural and regional areas. No longer a cheap option. Over reliance on visiting clinicians." • "Aboriginal and Torres Strait Islander health professionals are members of their respective communities and require greater representation in the workforce." • "Community-led and culturally embedded models are more effective and best placed to deliver culturally safe care." • "Volunteers and community champions are underutilised assets to provide or support the delivery of care for Aboriginal and Torres Strait Islander populations." • "Cultural safety must be built into professional standards and training."

Theme	Responses
System integration and data-driven planning	• "Siloed approaches within the health workforce." • "Barriers is workforce data, private vs public and patients pathways that cross over both sectors and ability to be agile/take action." • "Too many regulatory bodies not communicating to each other." • "Definition of cancer demand and alignment of workforce demand with service demand (modelling isn't cancer specific)." • "Demand is not accounting for workload and instead the data reflects positions which are determined mainly on finances." • "The lack of integrated data across jurisdictions hampers effective workforce planning." • "Digital platforms must support regional integration to prevent silos." • "Regional partnerships must include primary care to ensure direct lines of communication between GPs and tertiary centres." • "Digital systems are fragmented, outdated, and often not interoperable across jurisdictions." • "AI-powered medical scribe software can automate clinical documentation." • "Artificial intelligence will have big impact. Not sure how it will play out." • "Current systems are not helpful with regards to productive use of time. E.g. multiple IT systems not integrated." • "Implementation science and health services research to ensure it's appropriate prior to implementation."

At the end of the workshop, participants were asked to reflect on their most valued insight from the workshop.

Table 4. Workshop attendees' most valued insight from the workshop

Theme	Responses
Community-centred and patient-focused care	• "Thinking about community needs to then frame thinking about workforce demand and supply." • "Acknowledging the entire patient journey, where are the resources needed. Focus on the patient, not the current system and its needs." • "Cancer treatment is very patient centred, but it is very much controlled by systems and institutions whose priorities are not always well aligned to the needs of the patients." • "Move to a more co-ordination of patients with cancer, moving away from the siloed systems that currently are in place." • "Working with already established networks within communities rather than reinventing the wheel." • "Navigation, team-based care linked with community. Get students/trainees in rural and remote areas early in training." • "Responding to needs of the community with increased technology & diagnostics." • "Maximise the use of the current government screening programs to enhance equity. Look at alternative models such as having retirees mentor and support our new generation of professionals. Bring everyone on the journey together collaboratively. Healthcare is going to look very different in the next 5-10 years. AI is already amazing (being used as a counsellor), imagine having a robot treat you."
Rural and remote workforce development	• "Try to establish medical oncology training rotations in regional setting." • "Understanding incentives for health workers to work in rural and remote areas goes well beyond just providing a job and housing." • "Each healthcare professional is a human, with their own needs (work/life balance, accommodation and lifestyle needs in rural/remote areas) – these need to be considered." • "Look at what we can learn from effective rural programs – innovative practice that can translate to other areas – this can also provide lessons for metro areas on meeting patient needs and interprofessional collaboration." • "While lack of adequate health workforce in rural and remote areas is a significant contributor to poorer health outcomes in these areas – it is not the only contributor. Health and wellbeing seems not to be prioritised as highly by rural and remote communities as they seem to be in metro areas."
Workforce capability and scope of practice	• "Lived experience consumer representatives and supporters – peer support should be considered part of the workforce – assist in increasing others to work at top of scope need support & training." • "Balancing generalist vs subspecialist roles." • "Better targeting scope of practice on both sides (over scope and under scope)." • "Think about multidisciplinary approaches (incl. consumers as educators) to undergraduate training, specialised training and post graduate education. Given we ask them to work as a team." • "Potential innovation for access to education (resources related to Apprenticeship Degrees) and place-based + pathway approaches."

Theme	Responses
System integration and innovation	• "Break down the firewalls. Systems need to talk to each other." • "Embed implementation science models to ensure MOC are evidence based and iteratively improved as they are embedded." • "Establish more opportunities for trying new/"innovative" models of care and evaluating impact/learn from these experiences." • "Need to share more what is being tried locally/ put some evaluation opportunities around local service delivery models that are providing great care to people so we don't just keep these learnings locally and can scale." • "Gather what is happening at a local innovation and expand so we optimise the great work."
Culture, collaboration and action	• "Enough talking – must start doing. So many good ideas to progress these discussions into projects." • "Adopt healthy workplace culture as the foundation for wellbeing, productivity, health equity etc. then we can address the gaps through proper co-design." • "Investment across the health workforce pipeline (including non clinical roles), cultural responsiveness and safety." • "Cancer systems can strengthen the role of Aboriginal & Torres Strait Islander Health Workers & Practitioners aligned into Cancer Care teams."

Appendix C References

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