New South Wales

Special Commission of Inquiry into Healthcare Funding

Submission Number: 101

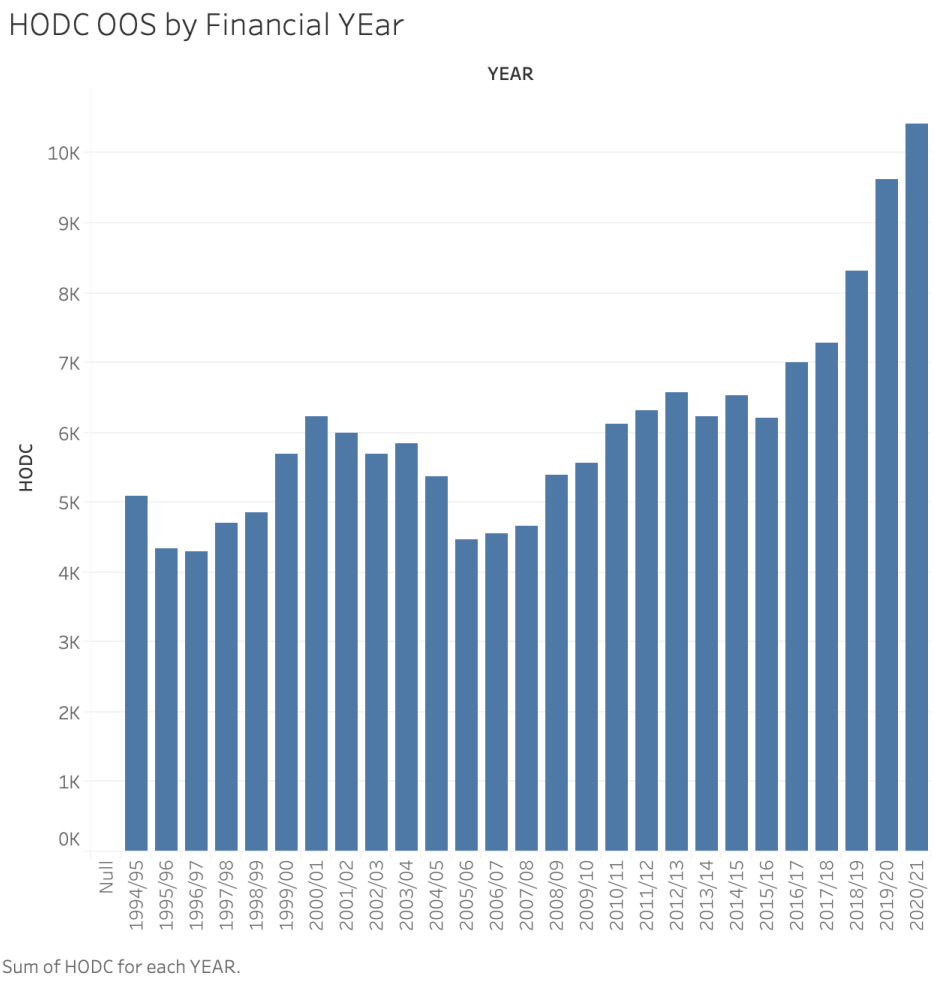
Name: Associate Professor Winston Liauw

Date Received: 31/10/2023

Re: The Special Commission of Inquiry into Healthcare Funding

1. I write in relation to the funding and operations of cancer services in NSW. Cancer services incorporates in most facilities and LHDs medical oncology, haematology, radiation oncology and palliative care. Governance structures many vary with these groups clustering with 'divisions' of medicine or they may be separately clustered as their own division/department.

My main base of work is St George Hospital. Our cancer service has seen a an almost exponential growth in activity through our treatment room (Haematology oncology Day Centre). There has been a 10% growth per annum in occasions of service (i.e., treatments) for over a decade. As illustrated below.



The reasons for this growth in activity is not due to increasing incidence of cancer or changes in local population. There has been a lot of progress in cancer treatment in the last two decades such that all cancer types including many rare cancers have multiple lines of therapy and the consequence is that patients are living much longer and receiving treatment during that extended time. Many of the treatments continue to require intravenous infusions and in the case of immunotherapy and other targeted treatments patients may be receiving infusions fortnightly or monthly for years. This is the main reason for the increase in activity. This is replicated at every cancer centre across the state.

This increase in activity has human resource implications, i.e., the need for more nursing, medical, pharmacy and allied health staff to deliver the treatments. In addition, the physical infrastructure is no longer adequate at many centres. The units reach capacity, and this translates into prolongation of waiting times to commence treatment, potentially to the detriment of the patient, and to difficulties rescheduling patients. Public holidays, especially 4-day weekends, can substantially degrade waiting times. A limited number of centres have created extended trading hours and/or weekend/7-day

operations. Many centres don't have the staff to support these measures, particularly as many centres have vacancies in nursing FTE.

These resource considerations are not taken into consideration through regulators such as the PBAC and MSAC.

Over the timeframe illustrated above there has been the expectation that several modern practices are instituted as standard. These include care coordinators, care navigators, multidisciplinary care via multidisciplinary teams/tumour boards, early incorporation of supportive/palliative care as part of treatment, survivorship care and the use of patient reported outcome measures. The implementation of these activities through the employment of relevant staff has been very variable between facilities and even within facilities. In my facility, e.g., we do not have a funded position for care coordinators for patients with genitourinary cancer or melanoma. Our survivorship clinic has no funding for relevant staff and the exercise physiologists are funded from special purpose trust funds. Traditional (and current) funding of outpatient cancer departments did not consider these models of care and therefore there are inadequate FTE provisions in budget. FTE allocations are inadequate for the models of care and the volume of activity. This impacts all classes of health care workers including nursing, pharmacy, allied health, medical and administrative staff. These capacity issues are reflected internationally: Int J Health Policy Manag. 2022;11(7):1024–1034. Service planning has not factored in the modern models of care and changes in survival outcomes of our patient population. Palliative Care Australia has done work force planning that includes all of the workforce not just palliative care medical officers.

Some staff are employed through grant funds e.g., via arrangements with Cancer Institute NSW. These translate into short-term contracts which are difficult to recruit to and staff retention can be poor. This can also be an issue with staff employed via funds from NGOs like Glenn McGrath Foundation and Prostate Cancer Australia.

2. There needs to be uptake of nurse practitioners into cancer services. Nurse practitioners have been shown to reduce health resource utilization (e.g., admissions) through better care provision. There are barriers for nurses to pursue training including financial barriers. In my unit we have subsidized training costs through trust funds.

3. There is a shortfall of clinical trial coordinator staff. A substantial reason for this is the lack of a structured career pathway and lack of an award structure or a dual grading approach. Some coordinators have a nursing background and others are employed under a hospital science award.

4. Central and Eastern Sydney PHN is partnering with Sydney LHD, South Eastern Sydney LHD and St Vincent's Healthcare to establish a model of shared care between cancer services and primary care. This program is called GP CanShare and is funded by the Commonwealth. Programs such as this facilitate reduction of visit burden on the cancer centres and improve communication with patient' general practitioners. Funding will expire in 2025 and there will be a need to find further funding to sustain this care coordination, with the major cost being staff.

5. The situation with medical oncology medical specialist workforce is complicated. A recent Victorian report identified a shortfall in medical oncologists based on the number of new patients medical oncologists are expected to see. The number of patients on active treatment, which has been increasing, arguably increases the need for specialists. In NSW, prior to the pandemic, approximately 30 advanced trainees attained College Fellowship each year. The medical oncology workforce is relatively young with few clinicians at retirement age. Very few new positions have been created overall and each year there is likely < 5 FTE of medical oncology position advertised each year. The new Fellows spend time doing post-graduate degrees, local or overseas clinical or research fellowships, undertaking locum roles, or private practice. There has been a sudden shift in advanced trainee recruitment outcomes in 2022 and 2023. Normally all positions across NSW are fillable but for the 2024 intake fewer than half of the 37 positions were filled. Effectively no regional centres will have advanced trainees and the metropolitan sites will all have vacancies. This will translate into an even greater need for nurse practitioners, care coordinators and consultant FTE.

6. I draw attention to the Oncology Information System Strategy jointly developed by eHealth and Cancer Institute NSW. This highlights opportunities that will influence procurement particularly in view of the implementation of the Single Digital Patient Record.

7. The pandemic has created significant changes in expectations of both junior and senior medical officers with respect to work commitments. Flexible arrangements e.g., work from home and virtual care, should be endorsed where appropriate. New models for the working week e.g., 4 day working week, should be explored to come in line with other industries. This needs to be done in conjunction with a review of how more service can by provided on weekends so to reduce the bottleneck effects on access and flow.

8. The provision of affordable housing near hospitals would facilitate attraction of staff, particularly to inner metropolitan facilities.

9. Performance measures for outpatient activities should be considered as important as performance measures such as the 4-hour rule and surgical waiting time breaches.

10. Environmental sustainability programs should be established with cost savings in mind. E.g., AI powered environmental control systems to manage energy costs, etc.

11. Funding models to support treatments at home need to be established.