Submission to the Senate Community Affairs Committees regarding the factors affecting the supply of health services and medical professionals in rural areas.

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The Clinical Oncological Society of Australia (COSA) is Australia's peak multidisciplinary society for health professionals working in cancer research, treatment, rehabilitation and palliative care with over 1600 members. COSA is recognised as an activist organisation whose views are valued in all aspects of cancer care. We are allied with, and provide high-level clinical advice to Cancer Council Australia.

Cancer Council Australia is the nation's peak non-government cancer control organisation. Cancer Council Australia advises the Australian Government and other bodies on practices and policies to help prevent, detect and treat cancer and also advocates for the rights of cancer patients for best treatment and supportive care.

Overview

The Clinical Oncological Society of Australia (COSA) and Cancer Council Australia (CCA) welcome the opportunity to provide comment on the factors affecting the supply of health services and medical professionals in rural areas. We are concerned about the poorer cancer outcomes experienced by people living in rural communities in Australia compared to those living in metropolitan centres. Lack of access to appropriate services and difficulties in recruiting professionals to rural areas is a major contributor to this disparity in outcomes. Although a more coordinated approach to cancer care for rural areas has begun with the establishment of a program to build infrastructure for regional cancer centres, the issue yet to be addressed is that of human infrastructure to cater for the cancer care needs of rural Australians.

Summary of Recommendations

- The capacity of regional cancer centres must include sufficient staff to service the cancer care needs of the surrounding areas in a coordinated manner.
- All Medicare Locals are required to monitor the cancer care needs of their community and interact with the closest regional cancer centre to ensure these needs are met.
- Focus incentive schemes on increased training and personal and professional support to retain doctors in smaller rural communities.
- Relate incentives for health professionals to move to rural areas to the health care needs of the community and not population density or location.
- Increase the human resources, educational facilities, and coordination of care in the 24 regional cancer centres around Australia to a level that allows them to service the cancer care needs of the surrounding area without compromising the standard of care for the region.
- Equip all regional cancer centres with the staff and facilities to take advantage of the opportunities available in telehealth.

- Perform a comprehensive evaluation of rural health initiatives so that projects that are proven to improve cancer outcomes in this population can be funded in a sustainable manner.
- Training in oncology must be included in programs such as the Rural Generalist Training Pathway.
- Nominate a training coordinator for each regional cancer centre so that appropriate goals can be put in place for the ongoing training of staff.
- Cancer care is coordinated in a multidisciplinary manner at regional cancer centres and between the centre and the outlying rural areas.
- We recommend that an outreach care co-ordinator be appointed to each regional cancer centre to facilitate appropriate supervision of care at remote sites.
- Commonwealth to show leadership on improving/unifying standards, streamlining administration and increasing subsidies for remote patient travel and accommodation assistance.

Cancer in rural areas

Cancer incidence statistics highlight a pressing need to improve the supply of health services and medical professionals to Australians living in rural areas;

- People living in regional and remote regions diagnosed with cancer experience a decreased survival rate relative to Australians living in major cities.[1]
- While death rates from all cancers are decreasing the decrease in death rates in regional areas is lower than that for major capitals.[2]
- People living in remote areas of NSW have a 35% excess risk of dying from any cancer within 5 years of diagnosis compared to those living in accessible areas. [3]

Cancer services and medical, nursing and allied health professionals in rural areas

The disparity in cancer outcomes in rural areas is due to inadequate delivery of cancer services and health professionals to these areas. Optimal cancer care requires the coordination of multiple areas of specialty including screening, pathology, surgery, chemotherapy, radiotherapy, follow-up and palliative care. An additional challenge is the bulky, expensive equipment that is required for screening and radiotherapy.

The first mapping of rural and regional oncology services in Australia showed that the availability of oncology services diminishes as geographical isolation increased.[4] In addition it is estimated that there are close to half the number of medical practitioners per capita in rural areas compared to the numbers of practitioners in major cities.[5] Choice of health professionals and opportunities for a second opinion is limited or non-existent in some regional areas.

The challenge of providing cancer care in rural areas is reflected in the patterns of chemotherapy administration in regional areas. Only 21% of regional hospitals administering chemotherapy have a resident medical oncology service. Those without a resident service have access to a visiting service (41%) or administer chemotherapy independently (38%). Of further concern is the high number of nurses administering chemotherapy without a recognised certificate.[4]

Factors limiting the supply of health services and professionals to small regional communities: distance and funding, infrastructure and support.

COSA and CCA have identified a number of factors limiting the supply of health services and professionals to small regional communities including distance and funding, infrastructure and the level of professional and personal support available.

Long distances and the lack of funding are major factors limiting the supply of health services to small regional communities. Both factors are linked to the sparseness of the population outside metropolitan centres, and neither can be surmounted without a major shift in population to rural areas. Health professionals are unlikely to move to regional and rural areas that are not supported by infrastructure such as schools, telecommunication, community services and leisure activities. The decision to move out of major capitals in Australia will depend on the relative cost of living and transport as well as available employment for partners. Individuals may also consider the sustainability of funding for the position and the availability of support staff.

The lack of access to continuing professional development is also of concern for health professionals considering a move to regional Australia. They may be discouraged by the lack of peer support due to lack of peers. The volume and complexity of work may be too low to keep some cancer health professionals engaged. Sparsely distributed populations reduce the opportunity for involvement of health professional in research. Health professionals living in rural Australia may also need to call on a wider variety of skills than their city counterparts. This may be a disincentive to some professionals who prefer to specialise in one particular area or procedure and may be accompanied by challenges in updating procedures and practices due to isolation and inferior education networks.

The levels of stress associated with working in rural and remote regions may also be a deterrent for health professionals. Increased demand to be on call or to work more night shifts than professionals in major cities is a reality of rural and regional employment. It could also be perceived that moving outside major cities may lead to cultural and personal isolation. The increased risks involved in living in rural communities (such as road traffic accidents) may also be a deterrent.

Considering the challenge of providing funding, infrastructure and support to rural areas we recommend that the capacity of regional cancer centres include sufficient staff to service the cancer care needs of the surrounding areas in a coordinated manner. This way cancer care will be delivered to rural areas while medical professionals can find the infrastructure, education and support they need in regional centres.

Medicare Locals and the provision of medical services in rural areas

To date it is unclear if Medicare Locals will improve the provision of medical services in rural areas. The establishment of Medicare Locals for a number of areas is ongoing as there are challenges in forming Medicare Locals in areas with little existing support. The success of Medicare Locals is also limited by the shortage of General Practitioners in rural and regional areas.

Medicare Locals, many of which were previously Divisions of General Practice, may not be equipped to provide support for cancer care. However, they will be ideally placed to measure the need for primary cancer care within the community. We recommend that all Medicare Locals be required to monitor the cancer care needs of their community and interact with the closest regional cancer centre to ensure these needs are met.

Incentive programs for recruitment and retention of doctors in smaller rural communities.

Current incentive programs to recruit doctors to smaller rural communities are primarily financial and are ineffective. Remuneration may not be sufficient to attract people to rural areas. The factors that discourage people are generally cultural and associated with isolation and lack of infrastructure in smaller rural communities.

Currently small rural communities rely on medical professionals with little support who often work long hours and travel long distances to provide health care. This situation attracts a transitory workforce of younger doctors, often immigrants who experience challenges both professionally and culturally. There is little incentive or time for these health care professionals to improve their training in oncology practice.

We recommend a focus on increased training and support to retain doctors in smaller rural communities. South Australia offers the most generous level of locum relief in Australia, allowing doctors six weeks for continuing education and another six weeks' holidays each year. This enables health professionals to seek the training they require and reduces workplace fatigue. Establishment of networks with regional centres and support from allied health professionals is also necessary.

Australian Standard Geographical Classification

The Rural Doctors Association of Australia has recently publicised the mounting evidence that the new Australian Standard Geographical Classification – Remoteness Areas (ASGC-RA) system is making it significantly more difficult for small rural towns to attract doctors.[6] This system has placed many smaller rural towns in the same category as larger regional centres. This reduces the incentive for doctors to relocate to or remain in these smaller towns, as they receive the same incentive payments for living in regional centres. We recommend that incentives for health professionals to move to rural areas be related to the health care needs of the community and not population density or location.

The solution – a hub and spoke model of regional, rural and remote health care

The focus for cancer care in rural and remote Australia must shift away from specialist recruitment to optimising service delivery from a regional cancer centre that is appropriately staffed with medical subspecialists and other health professionals, each of whom provide relevant support to outlying sites.

It is evident that the recruitment and retention of oncology health professionals to rural and remote regions of Australia is problematic due to the sparseness of the population and infrastructure available in these areas. Under current schemes it is almost impossible to provide optimal cancer care to rural communities due to the economics and logistics of employing oncology health professionals in these areas. Attracting health professionals to regional centres may be easier as these centres are more likely to have the amenities and support these individuals require.

To date 24 regional cancer centres have been endorsed and funded by the Department of Health and Aging through the Health and Hospitals Fund. This funding focuses on the provision of cancer services at regional centres and is primarily for equipment, treatment facilities and accommodation.[7] Regional cancer centres will not be valuable to the outlying rural communities unless they are resourced with the appropriate numbers of cancer health professionals with the required expertise in cancer care.

We recommend increasing the human resources, educational facilities, and coordination of care in the 24 regional cancer centres around Australia to a level that allows them to service the cancer care needs of the surrounding area without compromising the standard of care for the region. This would involve the recruitment of additional cancer specialists, allied health professionals and care coordinators as well as providing comprehensive training in oncology at these centres. This will involve additional costs but inclusion of rural and remote communities in business plans for regional centres will enable leveraging of funds for the area.

An oncology care workforce based at regional cancer centres will be able to provide cancer care to outlying regions by teleconferencing, rotational visits and coordinated clinics. The success of this approach is demonstrated by a number of cancer care programs already established to deal with the challenge of cancer care in rural communities;

> The Townsville Cancer Centre has provided routine and urgent medical oncology services to rural and remote communities through videoconferencing since 2007. Satisfaction with this model of care has proven to be high among both patients and health workers.[8] Medicare rebates and guidelines are now available for telehealth services provided to patients in remote, regional and outer metropolitan areas. [9] We recommend all regional cancer centres

are equipped with the staff and facilities to take advantage of the opportunities available in telehealth.

E-health programs that have improved cancer care in regional and rural Australia require commitment from the government to ensure their ongoing success. Non-government initiatives such as the "Enhancing palliation in patients with advanced cancer in rural areas of Australia" e-learning program must compete for limited funding and are often unfunded after the initial stage of the project.[10] We recommend that a comprehensive evaluation of rural health initiatives be completed so that projects that are proven to improve cancer outcomes in this population can be funded in a sustainable manner.

Training programs are needed to provide all rural GPs with the skills required to work across primary cancer care and hospital settings. Programs such as the Rural Generalist Training Pathway, announced recently by the NSW Government[11] and already in place in Queensland[12] are essential to support general practitioners from graduation to the completion of their training. We recommend that training in oncology is included in these programs. GPs may also be better supported by a dedicated schedule of calls from specialists.

Training of existing staff at regional and rural centres to deliver cancer therapy with the support of specialists is essential for delivering care to remote communities. Educational workshop programs for delivery of systemic adjuvant therapy[13] or comprehensive palliative care,[14] are a successful tool for delivering evidence-based information, improve knowledge and facilitate networking. Chemo-competent nurses can supervise nurses in remote areas but more nurses need to have access to training. Psychosocial service delivery by a trained cancer psychologist via remote supervision of local health professionals can leverage a scarce resource.[15,16,17,18] We recommend that a training coordinator be nominated for each regional cancer centre and that appropriate goals be put in place for the ongoing training of all staff.

Programs such as the Cancer Services Network National Demonstration Program (CanNET), designed to establish clinical networks and multidisciplinary teams, has led to enhanced service delivery, improved consumer knowledge and increased the skills and knowledge of staff working in cancer care.[19] The success of the project in Western Australia has demonstrated the value of locally provided coordinated cancer care for rural people.[20] Coordination of sub-specialists (cardiology, cancer, respiratory disease and diabetes) in rural clinics would also be good use of resources. We recommend that cancer care is coordinated in a multidisciplinary manner at regional cancer centres and between the centre and the outlying rural areas. We recommend that an outreach care co-ordinator be appointed to each regional cancer centre to facilitate appropriate supervision of care at remote sites.

Related – patient travel and accommodation assistance

Patients in regional areas, particularly those in remote locations, are likely to continue experiencing reduced access to cancer care unless they have improved access to tertiary treatment centres.

Therefore, while improving services according to our recommendations against the explicit terms of reference would in our view reduce regional disparities, isolated patients will continue to experience (and in some cases accept) substandard treatment outcomes unless patient travel and accommodation support is also improved.

It is now more than four years since the Senate Community Affairs References Committee published a report calling for a number of improvements in patient travel and accommodation assistance schemes. In the interim, there have been one-off marginal improvements in subsidies funded by individual jurisdictions; however, the committee's structural reform recommendations have been

largely ignored. Support for the recommendations remains as urgent now as it was in September 2007:

http://www.aph.gov.au/Senate/committee/clac_ctte/completed_inquiries/2004-07/pats/report/b01.htm

We call on the committee to reinvigorate the discussion on patient travel and accommodation support as a key to reducing inequities in cancer care outcomes between patients in rural and metropolitan settings.

The current schemes are likely to continue being underfunded, incur cross-border inconsistencies and impose unnecessary administrative burden on patients and clinicians unless there is Commonwealth leadership on improving/unifying standards, streamlining administration and increasing subsidies for remote patient travel and accommodation assistance, as recommended by this Committee in September 2007.

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