Australian College of Rural & Remote Medicine
WORLD LEADERS IN RURAL PRACTICE

**College Submission**
December 2022

# Feedback on the Draft Australian Cancer Plan

## About the Australian College of Rural and Remote Medicine (ACRRM)

ACRRM's vision is ***the right doctors, in the right places, with the right skills, providing rural and remote people with excellent health care.*** It provides a quality Fellowship program including training, professional development, and clinical practice standards; and support and advocacy services for rural doctors and the communities they serve.

ACRRM is accredited by the Australian Medical Council to set standards for the specialty of general practice. The College's programs are specifically designed to provide Fellows with the extended skills required to deliver the highest quality Rural Generalist model of care in rural and remote communities, which often experience a shortage of face-to-face specialist and allied health services.

ACRRM has more than 5000 rural doctor members with1000 doctors in training, who live and work in rural, remote, and indigenous communities across Australia. Our members provide expert front line medical care in a diverse range of settings including general practices, hospitals, emergency departments, Aboriginal Medical Services, and other remote settings such as RFDS and Australian Antarctic Division.

## Initial Comments

ACRRM welcomes the opportunity to comment on the consultation draft Australian Cancer Plan (the Plan), to ensure that cancer outcomes are improved for all Australians, particularly for those groups whose health outcomes are poorer, including people living in rural and remote areas, and our most vulnerable communities.

The Plan's focus on priority population groups[1] and ambitions for a system that delivers optimal and equitable outcomes irrespective of culture, age, gender, sexual orientation, health status and education level is commendable, as are the guiding principles, particularly the person centred, equity and future focused and strengths-based approach.

[1] Australian Cancer Plan Public Consultation Draft, pages 14-29

ACRRM is pleased to note that the plan has been co-designed with Aboriginal and Torres Strait Islander leadership and will be implemented and evaluated with further significant involvement. Collaboration with NACCHO on the separate Aboriginal and Torres Strait Islander Cancer Plan will be important to ensure the strategic vision of both plans aligns.

The College would stress the importance of the Plan recognising that primary healthcare, including cancer care and treatment, in rural and remote areas requires a broad, outcomes-focused definition which incorporates the Rural Generalist[2] scope of practice.

# General Comments

Meeting patient needs with respect to cancer treatment within the rural and remote context will often involve an extension of primary care and general practice services. It is important that the rural and remote context is understood by everyone involved in the patient journey, and that this considered with respect to access and coordination with secondary and tertiary care.

The delivery of health care in rural and remote settings blurring of the distinctions between private and public health services, hospital, and private clinics, and between the traditional roles of medical, nursing, and allied health professionals. This is the Rural Generalist scope of practice which is provided by thousands of general practice doctors across rural and remote Australia.

All doctors that attain ACRRM Fellowship (FACRRM) are trained to be Rural Generalists. They will have trained to provide essential general practice care particularly in rural and remote communities recognising that these commonly include many Aboriginal and/or Torres Strait Islander peoples. They will have also completed training in hospital in-patient and emergency care and retrievals, and some Fellows will have also opted to complete an additional year of advanced specialised training in Palliative Care. These can be important contributors to cancer care for people living in rural and remote Australia, including Aboriginal and Torres Strait Islander people.

# Response to Strategic Objectives

**Strategic Objective 1: Maximising Cancer Prevention and Early Detection**

Remote Australians record greater disadvantage by health, mortality, and morbidity measures as well as most measures of social determinants of health. Whilst awareness, education, and support to address these determinants are important, access to cancer prevention and early detection programs must be increased for rural and remote Australians.

***Screening -*** people living in rural and remote areas have difficulty in accessing diagnostic and screening services, such as breast screening services, where there is an insufficient critical mass to sustainably support a full range of such services. It is imperative that the Plan addresses access to diagnostic services, with studies showing that diagnostic delays are common with increased rurality, and this in turn impacts on mortality.

Our members working with Aboriginal and Torres Strait Islander patients in this space in rural and remote area report that in providing quality care they key issues have been:

- Excessive patient wait times and time delays in their acceptance for referral
- Barriers to patient access to transport and accommodation

[2] https://www.acrrm.org.au/about-us/about-the-college/rural-generalist-medicine

Funding for rural and remote diagnostic and treatment services for cancer needs to reflect the additional cost of service delivery in these areas and must be culturally safe and appropriate. We have provided further commentary in our response to Strategic Objective 6.

***Literacy -*** supporting Australians to be physically well is no longer restricted to those experiencing ill-health, but also encompasses education, preventive measures, and early intervention to promote wellbeing, taking a proactive role in your own healthcare and assisting people at risk.

Literacy and consumer engagement initiatives must be designed to ensure they can be easily adapted to the rural and remote context. Health promotion and education activities need to be tailored to the specific needs of each community, particularly high-risk communities, and need to be culturally responsive and safe for those from Aboriginal and Torres Strait Islander or culturally and linguistically diverse backgrounds. The role of rural General Practitioners and Rural Generalists as leaders in rural and remote communities should be leveraged to ensure effective engagement.

**Strategic Objective 2: Enhanced Consumer Experience**

There needs to be clear recognition that provision of medical primary health care in the rural and remote context commonly involves an integrated model of care involving hospitals, GP surgeries and other work settings. Rural Generalists typically provide primary care across a range of settings.

In aiming to create a person-centred system which takes a holistic approach to health and wellbeing, the Plan needs to be cognisant that the delivery of support and treatment and who is best placed to deliver it, can be different in the rural and remote context.

Rural Generalist doctors are a vital part of the continuum of care for those living in rural and remote areas, and as such, they should receive appropriate training, recognition, resources, and support to enable them to meet the needs of patients with cancer in rural and remote areas.

These doctors are well-placed to deliver holistic care across the illness spectrum and the lifespan. It is therefore important that that their training and capacity is recognised in the Plan.

**Strategic Objective 3: World Class Health Systems for Optimal Care**

On average, Australians living in rural and remote areas have shorter lives, higher levels of disease and injury and poorer access to and use of health services.[3] The Australian Institute of Health and Welfare reports that cancer is responsible for Australia's largest disease burden, and that one third of people affected by cancer live in regional and rural areas. The burden of cancer is disproportionately heavy in rural and remote areas, with people living with cancer having poorer survival rates than those living in major cities.

Factors which contribute to lower survival rates for people with cancer in rural areas include availability of diagnostic and treatment services and delayed or late diagnosis. The Medical Journal of Australia reports that cancer outcomes are particularly poor for Aboriginal and Torres Strait Islander people living in regional and remote communities, with cancer being underreported in this group and death rates being 45% higher than in the non-Indigenous population.[4]

[3] AIHW Report Rural and Remote Health, Web report updated 22 October 2019

[4] Medical Journal of Australia mja.com.au "Cancer health inequality persist in regional and remote Australia" quoting Adams P, Hardwick J, Embree V, et al. Literature review: models of cancer services for rural and remote communities. Sydney: Cancer Institute NSW, 2009. http://www.cancerinstitute.org.au/media/70218/web09-83-02_literature_review_models_cancer_services_rural_and_remote_communities.pdf

***"The further from a major city patients with cancer live, the more***

***likely they are to die within five years of diagnosis"[5]***

People living in rural and remote communities should have equitable access to high quality, safe and sustainable healthcare services, including cancer treatment and care. This requires a structured, systematic, and person-centred and team-based approach to service delivery which properly reflects the distinctions of the rural and remote clinical context.

Rural Generalist doctors are involved in the full spectrum of patient care – through general practice-based primary care, home visits, secondary care in the local hospital, coordination of team-based care and referrals, support for family and carers, and palliative care.

***Palliative care -*** ACRRM views the optimum model of care as enabling patients to continue to live within their community where they can be supported by family and their wider networks and receive ongoing, coordinated, and collaborative care from a well-trained, skilled, and supported health care team led by their local medical practitioner. Patients benefit the most from a lifelong relationship with a "usual GP".

In recognition of the desire of most people to remain in their homes and communities, service models should be based on meeting as many of the needs of clients as close to home as possible. This will require flexibility in service delivery models, utilising team-based care and providing additional support for facilities and carers. Innovative service delivery models such as the National Ambulance Service model in New South Wales, which utilises paramedics to treat patients in their own homes (with medications per doctors prescribed plans) should be explored as a rural and remote home treatment option.

Funding models should recognise the important leadership role GP's can play in providing not only in treating direct clinical needs, but in assisting with strategies to improve overall health and wellbeing.

**Strategic Objective 4: Strong and Dynamic Foundations**

ACRRM welcomes the increasing role of data and digital technologies to value-add primary care provision particularly toward improved access to services in rural and remote areas. ACRRM views it as critical to assert the importance of continuity of care and human relationships in the delivery of primary care.

New technologies have the potential to greatly enhance care but should also support rather than replace human-driven, continuous care relationships. There is a risk of information technologies driving a trend toward low value, high convenience primary care. There is also risk that the interpersonal human relationships that are at the centre of effective primary care may be lost to the efficiencies of easy-to-access care.

The College sees value in further exploration of options for appropriately financing other potentially valuable telehealth/digital health models of care that can enhance primary cancer care especially in the remote home setting. Empowering patients through providing them with the option to access treatment from home via telehealth, with the support of a local practitioner would allow them to access specialist care and exercise greater control over their own treatment journey. These should be supported by appropriate funding mechanisms.

[5] National Rural Health Alliance Inc Factsheet 8: Cancer in Rural Australia
https://ruralhealth.org.au/sites/default/files/publications/fact-sheet-08-cancer-rural-australia.pdf

**Strategic Objective 5: Workforce to Transform Delivery of Cancer Care**

The current health workforce crisis faced by rural and remote communities has been well documented. The maldistribution of the medical workforce, both in terms of location and skills, continues to result in pervasive rural workforce shortages. While long term planning is important, this does not obviate the need for significant, immediate action to address the disparities in access to healthcare services for rural and remote communities across Australia.

Therefore, the success of the 10-year Plan will be contingent on its interaction the *National Medical Workforce Strategy*, *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031,* the *Primary Healthcare 10 Year Plan* and the *National Preventive Health Strategy*, coupled with adequate funding for services in rural and remote areas, and the extent to which focus is centred on substantive, immediate intervention in support of rural healthcare.

***Workforce shortages -*** the maldistribution of the medical workforce, both in terms of location and skills, continues to result in pervasive rural workforce shortages. The skills maldistribution particularly relates to the increased numbers of non-GP specialists and sub-specialists. These doctors do not provide the range of services required in rural and remote communities, which require a more generalist model of care to enable them to access as many services as possible, as close to home as possible, and in a way which is economically sustainable.

***Securing a Skilled and Sustainable Workforce -*** the College believes that a key strategy in improving rural cancer outcomes involves providing as many services as possible, as close to home as possible. Urgent and priority action should be taken to improve access to a skilled and sustainable rural and remote primary healthcare workforce, acknowledging the specific challenges facing clinicians working in rural and remote communities.

The importance of the Rural Generalist approach should be recognised, and strategic work is required to support this as an enabler to innovative workforce models and workforce capacity building. Priority should be given to supporting local services and training and growing a local health workforce wherever possible.

The Plan should be developed, implemented, and evaluated in detailed consultation with representatives from rural practitioners, community representatives and stakeholders, and should include a 'rural proofing' protocol.

**Strategic Objective 6: Achieving Equity in Cancer Outcomes for Aboriginal and Torres Strait Islander People**

ACRRM notes that equity in cancer outcomes is central to the ACP, and the commitment to "shifting the dial" for those whose outcomes are poorer through concerted and collaborative effort is welcomed.

ACRRM is pleased to note the Plans' intention to align with the *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-203*1 to address the ongoing safety of all cancer services to ensure they are free of racism, discrimination and supportive of Aboriginal and Torres Strait Islander health professionals, and to complement and leverage existing plans and strategies for Aboriginal and Torres Strait Islander people

It is important for the Plan to recognise that the disparities in the health status of Indigenous Australians and those of remote Australians are intertwined, and therefore imperative that in addressing rural access that this includes providing access to culturally safe and responsive health care for Aboriginal and Torres Strait Islander peoples.

Some important investments in improving the efficacy and quality of this care should include funding and or expanding all the following:

- Culturally appropriate cancer counselling
- Culturally appropriate, accessible screening
- Culturally appropriate literacy resources
- Health worker and/or case worker assignment to attend the multitude of appointments associated with cancer care
- Providing cultural activities for patients undergoing treatment
- Providing patient access to traditional healers

The Rural Generalist model can make an important contribution to care of Aboriginal and Torres Strait Islander peoples in rural and remote areas where Rural Generalist doctors work in ACCHSs and other Aboriginal Medical Services and GP clinics and provide services in hospitals. The Rural Generalist builds relationships of trust in their community based, continuous care practice and by being part of the hospital system - help patients to have confidence in hospitals as a culturally safe space in which they can receive needed care. Many ACRRM doctors and especially our Aboriginal and Torres Strait Islander doctors work in Aboriginal Medical Services and are also available to provide services to their Aboriginal and Torres Strait Islander patients in their hospital Emergency Departments, and during their in-patient stays.

The plan should emphasise establishing innovative fit-for-purpose models for Aboriginal and Torres Strait Islander people in rural and remote areas. They models emphasise integrated care, centred-around the local professionals providing primary care and be appropriate for the realities of their location.

ACRRM views case conference with Rural Generalists as a key tool for managing Aboriginal and Torres Strait Islander Peoples cancer care *on-country.* These doctors should be included in the multidisciplinary discussions regarding care and should paid for the time the give to contribute to this care. This model of care should be utilised more extensively than is currently the case. This would reduce the burden of transport and treatment. This should present a cost saving and some of these savings should be directed to the Rural Generalists and other locally based health workers and health practitioners who are providing the continuing care.

An example is in Port Lincoln where there is a dialysis unit combined with chemotherapy services. Patients have access to specialist consultants via telehealth (who are usually based in tertiary centres in cities). However, they undertake these telehealth consultations with their local Rural Generalist/General Practitioner and/or nurse to link these in to their accessible, local continuing care. This service is appreciated by patients as they can remain close to home while receiving treatment.

# College Details



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***ACRRM acknowledges Australian Aboriginal People and Torres Strait Islander People as the first inhabitants of the nation. We respect the Traditional Owners of lands across Australia in which our members and staff work and live and pay respect to their Elders past present and future.***