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

COLLEGE SUBMISSION

Australian Cancer Plan

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College Details

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Initial Comments

ACRRM welcomes the opportunity to comment on the Australian Cancer Plan, to ensure that key national cancer priorities and action areas are set for the next 10 years, and those priorities and action areas address the specific needs of rural and remote Australians, and our most vulnerable communities.

A person-centred approach which strives for equitable cancer outcomes across all population groups is a commendable vision for the Plan. 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 scope of practice. In the rural and remote context, if primary care is to ensure provision of all patients' essential health care needs, this will often involve provision of services extending from general practice clinic based care to contribution to, and facilitation of as much as practicable of people's secondary and tertiary needs in the most accessible possible way. This involves a 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.

We have focused our feedback on the ***"identified opportunities"*** for an Australian Cancer Plan to deliver the greatest impact on cancer outcomes in Australia. College feedback is very general, in anticipation of further detailed consultation and collaboration on policy and implementation when the Plan is finalised.

Response to Survey Questions

Question 1: What would you like to see the Australian Cancer Plan achieve? Think ahead to the next ten years. Think big – what transformational change(s) should we be aiming to influence?

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.[1] 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.[2]

"The further from a major city patients with cancer live, the more likely they are to die within five years of diagnosis"[3]

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.

"Continue to increase cancer screening rates nationally particularly in populations and areas where cancer screening participation is low or where disparities exist"

Improved access to diagnostic and treatment services - people living in rural and remote areas have difficulty in accessing cancer screening services, such as breast screening services, where there is an insufficient critical mass to sustainably support a full range of diagnostic 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.

Aboriginal and Torres Strait Islander health - the relationship of rurality to morbidity from cancer has particular implications for Aboriginal and Torres Strait Islander people, who represent significant portions of rural and remote communities. The Plan must ensure it addresses these health disparities by taking immediate action to improve health outcomes for this population group.

Funding support - funding for rural and remote diagnostic and treatment services for cancer needs to reflect the additional cost of service delivery in these areas.

"Support the role of primary care providers in investigating suspected cancer early and referring appropriately; adopt new and more accurate diagnostic tests and risk modified screening to pick up cancer earlier"

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

[2] 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

[3] 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

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 an 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.

"Build the cancer literacy of all Australians to improve understanding of personal cancer risk factors and to empower behaviour change that reduces risk of cancer"

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.

Question 2 : What are the opportunities with the greatest potential to realise your vision? What priorities need action? In what areas could national action drive or accelerate progress?

"Plan future workforce capacity and capability requirements by identifying national trends, addressing current and future skills shortages and planning for future care needs; consider the need for a national cancer workforce strategy"

By virtually all indicators, remote Australians are grossly underserved, and this underservice occurs in tandem with this sector of the population recording greater disadvantage by health, mortality, and morbidity measures as well as by most measures of social determinants of health. This equity gap is spiralling as rural health workforce shortages are reinforced by diminishing funding for rurally based practice and services.

The disparities in the health status of Indigenous Australians and those of remote Australians are intertwined, and it is 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.

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.

"Expand implementation of virtual cancer care including telehealth, remote diagnosis and virtual consultation"

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.

Question 3: What examples and learnings can we build on as we develop the Australian Cancer Plan? Think about great examples of work within or outside the cancer sector in Australia and internationally. How can we learn from these examples and build on them to improve cancer outcomes and experience for <u>all</u> Australians?

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.

Rural and remote cancer treatment and care should be person-centred while being cognisant of the needs and circumstances of families, carers, and the wider community. It should be culturally appropriate and tailored to meet the specific needs of a diverse population, including Aboriginal and Torres Strait Islander people and those from culturally and linguistically diverse backgrounds

"Consider sustainability of specialist palliative care community services to ensure they are available to all who want or need them"

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.

Summary of ACRRM Recommendations

- There must be improved access to diagnostic services and cancer treatment for rural and remote Australians
- The Plan must aim to immediately address the health equity gap for rural and remote Australians and reduce morbidity rates, particularly for Aboriginal and Torres Strait Islander people
- Health promotion, education and preventive measures must be tailored to rural and remote audiences, with a specific focus on programs for high risk groups
- Rural and remote cancer treatment and care should be person-centred while being cognisant of the needs and circumstances of families, carers, and the wider community.
- Cancer treatment and care should be culturally appropriate and tailored to meet the specific needs of a diverse population, including Aboriginal and Torres Strait Islander people and those from culturally and linguistically diverse backgrounds
- 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.
- The Plan should make provision for innovative models of care and service delivery which give patients choices about their cancer-care and treatment, with the option to elect to have some treatment delivered at home.

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 progresses this through the provision of quality vocational training; professional development education programs; setting and upholding practice standards; and through the provision of 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 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.