



**RURAL DOCTORS
ASSOCIATION
OF AUSTRALIA**
Caring for the Country

RURAL DOCTORS ASSOCIATION OF AUSTRALIA

**SUBMISSION TO THE SENATE
INQUIRY INTO SERVICES
AND TREATMENT OPTIONS
FOR PERSONS WITH CANCER**

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RURAL DOCTORS ASSOCIATION OF AUSTRALIA
SUBMISSION TO THE SENATE COMMUNITY AFFAIRS
REFERENCE COMMITTEE
INQUIRY INTO SERVICES AND TREATMENT OPTIONS FOR
PERSONS WITH CANCER

The Rural Doctors Association of Australia (RDAA) was formed in 1991 to give rural doctors a national voice.

The RDAA is a federal body with seven constituent members - the Rural Doctors Associations (RDAs) of all States and the Northern Territory. Every RDA is represented on the RDAA Committee of Management which meets monthly by teleconference. Each autonomous State/Territory association works and negotiates with relevant bodies in its own jurisdiction, while the RDAA Committee of Management, supported by a small national secretariat in Canberra, has overall responsibility for negotiations with the Commonwealth and working with national bodies and decision makers.

In keeping with the overall demographic profile of the rural medical workforce, most RDA members are general practitioners (GPs) and most are men. However, the Association takes steps to ensure that the interests and perspectives of smaller groups within the rural medical workforce are incorporated into its advocacy and negotiations. This has led to the establishment of special interest groups for female doctors and rural specialists, both of which meet regularly to discuss specific and generic rural workforce matters. RDAA also works closely with relevant agencies to support the interests of the Overseas Trained Doctors (OTDs) who now make up over 30% of the rural medical workforce.

The RDAA has a primary focus on industrial issues and seeks to promote the maintenance and expansion of a highly skilled and motivated medical workforce to provide quality care to the people of rural and remote Australia. Much of its work therefore concentrates on recruitment and retention issues and the viability of rural medical practice. However, it also works on particular health and health service issues including Indigenous health, rural obstetric care, small rural hospitals and rural and remote nursing practice.

As the only advocacy body with a specific mission to support the provision of medical services to rural and remote communities, RDAA has a particular responsibility to ensure that the needs and perspectives of people who live in the bush are heard by decision makers and incorporated into the design and implementation of national policies and programs.

RDAA is alarmed by research that shows people in country areas who are diagnosed with cancer are 35 per cent more likely to die within five years than cancer sufferers in the city. Recently published figures highlighting poor cancer outcomes for Australians living in rural and remote NSW serve as a timely reminder of the enormous inequalities embedded in our health care system.

The figures are even worse for gender-specific cancers like cervical or prostate cancer with death rates three times higher in the country compared with metropolitan areas.

Indigenous Australians experience much poorer health outcomes than others, but this disparity cannot be explained away by aboriginality alone. Approximately half the Indigenous population of Australia lives outside the major cities. Aboriginal and Torres Strait Islander peoples make up about 24% of the population in remote areas and 45% in very remote areas. However, given the very small proportion of Indigenous Australians in other areas, the contribution of Indigenous data to the demonstrated gap in cancer outcomes between urban and rural areas as a whole is not great.¹

The sad fact that rural Australians have poorer rates of survival after cancer diagnosis is at least partially due to more advanced conditions at diagnosis and poorer access to treatment subsequently.² Colorectal and lung cancers contribute about 6% to rural excess mortality. Lung cancer alone accounts for 6% of excess death in rural people under 65.³ Modifiable risk factors have been identified for both. They include smoking, poor diet and nutrition, physical inactivity and excess weight, all of which are associated with living in a rural area. Yet few public campaigns to promote behavioural change in these matters appear to be adjusted for relevance to the rural environment or to engage people of lower economic or educational status.

For example, there is strong evidence that population screening for bowel cancer can save lives and the Commonwealth is embarking on a national program to do this. This was properly preceded by a pilot that was reviewed positively in 2004. However, “for logistic reasons”, no sites in inland rural areas, and no small towns, were included in this trial on which the future program will be based. Hence it contains no provision to assist rural people who screen positive to access the colonoscopy which is the next stage in the process. This is in spite of the fact that a concurrent study suggests that there is already a lower probability of rural patients completing treatment when referred for rectal cancer.⁴

Another study of lung cancer patients in rural and metropolitan NSW suggests that the former *were less likely to have pathological confirmation of their lung cancer and less likely to undergo any treatment, especially radiotherapy and chemotherapy*. Commenting on survival rates, which were higher in the metropolitan health service district with the highest average incomes and education, it notes other studies that have found excess mortality and poorer survival rates in areas of relative deprivation.⁵

¹ AIHW (2004a) *op cit*; AIHW (2003) *Rural, regional and remote health: a study on mortality*. Canberra, AIHW [PHE 45]

² Jong KE, Vale PJ & Armstrong BK (2005) – Rural inequalities in cancer care and outcome. *Medical Journal of Australia (MJA)*182:1 p13

³ AIHW (2004a) *op cit*.

⁴ Armstrong K, O’Connell D, Leong D, Spigelman A & Armstrong B (2004) – *The New South Wales Colorectal Cancer Care Survey Part I. Surgical management*. Sydney, Cancer Council of NSW

⁵ Vinod SK, Hui AC, Esmaili N, Hensley MJ & Barton MB (2004) – Comparison of patterns of care in lung cancer in three area health services in New South Wales, Australia. *Internal Medicine Journal* 34: 677-683

A recent editorial in *The Medical Journal of Australia* commented:

*In principle, tackling rural inequality in cancer care and outcomes requires a combination of improved primary healthcare, access to expert multidisciplinary services, and coordination of the two. Evidence that could guide investment decision-making is limited. Present rural health policy is underpinned by the principle that patients should have access to high quality services as close to their homes as is clinically and geographically possible. This policy should improve access to primary healthcare and aid in obtaining earlier diagnosis of cancer and quicker referral to expert care. That these factors will improve cancer outcomes is, however, more an article of faith than supported by evidence.*⁶

The authors of this editorial suggest that outreach specialist services in a shared care model with local healthcare professionals would appear to be a solution – but this approach, like the suggested system of well-defined pathways tailored to the needs of rural patients, also requires further evidence to back its general implementation. RDAA has recently proposed a framework to delineate core health service needs which would assist in the collection and application of relevant data.⁷

RDAA has therefore recommended that the National Health and Medical Research Council research program should include a specific focus on the socio-economic factors associated with cancer and other chronic diseases and their prevention, diagnosis and management in rural and remote Australia.

RDAA believes difficulties in accessing screening and diagnostic services are part of the reason for the imbalance between cancer outcomes for urban and rural Australia, but even when cancer is detected early, more country people are dying because of a service fragmentation and a lack of adequate treatment facilities in regional areas.

The coordination of specialist services is a major issue. Some research suggests that rural medical practitioners do not always have adequate information for appropriate referrals. Doctors in areas of workforce shortage have found it difficult to keep up to date with changing technology and the services and support available in urban areas. The use of a website to which they could refer for current information would be extremely helpful.

Some people diagnosed with cancer do not want to travel away from their family and friends to get treatment and they decide to stay in their own community, accepting levels of treatment that are not giving them the best chances of surviving. Others cannot manage the inconvenience and expense of the long distance travel to a metropolitan centre and choose options that enable them to stay at home. Many people undergoing chemotherapy will lose their hair and experience intense nausea. This makes the need to travel to distant centres for care almost inhumane, especially when patient support schemes do not all cover the full costs of travel and

⁶ Jong, Vale & Armstrong *op.cit*

⁷ RDAA (2005) – *Preventive healthcare and strengthening Australia's social and economic framework*: a submission to the National Health and Medical Research Council. Canberra, RDAA

accommodation. Consequently the need to travel becomes a major determinant of poor cancer outcome, as many people have to make their health care choices on the basis of financial and social cost, rather than optimum healthcare. RDA members and other rural healthcare providers face many examples of this.

Ideally, cancer screening is an integral part of quality GP care, but many rural areas have patient doctor ratios of 3000 to 5000 patients : 1 GP. Workforce shortages mean opportunistic screening rates are often comparatively low, and this delays the diagnosis of 'embarrassing' genital cancers in particular. For some patients, the rate of screening will also vary with the gender of the health professional. Rural Australians would benefit from standardized cancer detection programs following the very successful and well accepted national breast and cervical screening programs and initiatives. Models of mobile service units or outreach services like those addressing these women's health issues should be developed for other cancers.

The recent introduction of a Medicare item number to enable practice nurses to do Pap smears is a long over due recognition of the lack of Medicare support for screening in general practice. It should be followed by the creation of an item number for annual screening for population groups known to be at high risk of cancer.

Overall, there is little research into regional and rural models of cancer and palliative care, although there is considerable information and local experience that delineates relevant issues. These include lack of easily accessible specialist services, fragmented service delivery, poor pain and symptom management, low levels of professional and public awareness of options and information to facilitate decision making, barriers to continuity and coordination of care and lack of respite services.

The Australian Cancer Council is heavily involved in rural and remote oncology and palliative care services across the States and Territories and is multi-dimensional in its orientation. There is a particularly strong rural network of care in South Australia in which nurses play a major role. The National Palliative Care Strategy endorsed by the Australian Health Ministers Advisory Council (AHMAC) in 2000 highlights the multi-dimensional nature of palliative care and provides a broad framework for action including issues specific to rural and remote areas. RDAA agrees that life expectancy for rural patients could be improved through work in several basic areas.

Rural people are more likely to smoke, to drink to excess, to eat poorly (high animal fat/low fibre diets) and to have unsafe sexual encounters. They are also exposed to occupational risks including chemical pollution and sun exposure. Yet rural people have less exposure to health education both through the media (less variety of TV stations, less exposure to print media) and through schools (lower average levels of education). There are substantially few rural public health units and workforce shortages limit the capacity of allied and other health professionals to deliver preventive care advice. Their capacity to encourage preventive health measures should be enhanced to counter the high level of risk factors and risk behaviour experienced in the bush.

In rural areas, health professionals of all disciplines report difficulties in accessing education specific to the health needs of their communities. The costs of obtaining the education then become a barrier both to acquiring and maintaining skills.

Additionally, there is a general lack of the type of education most suited to a multidisciplinary team in rural areas where professional boundaries are blurred by the availability (or lack thereof) of particular providers. Two specific areas where this becomes of particular concern, given the recognized and understandable reluctance of patients to leave their communities, are treatment and palliation.

It is essential that standards of quality are not compromised in the interests of local service availability. However, there are a number of successful models where guidelines have established key requirements by detailing the type of component needed in a service, rather than the classification of the hospital where it should be delivered. For cancer patients, this approach could enable more flexibility for the local delivery of chemotherapy, for example by access to an oncologist by video link and the delivery of medication by advanced nursing practitioners using national protocols under the guidance of GPs.

It is impractical to assume we can fund the infrastructure for multiple radiotherapy units in rural areas or recruit enough rural specialists from the limited pool of radiation oncologists. However there are already sufficient bunkers in place in urban areas to allow a political and planning commitment that any new units should be established in regional centres. It is essential that adequate family accommodation and counselling services are attached to all radiation units.

For palliative care, rural people lack local access to pain clinics and other forms of specialist care. Shared Care multidisciplinary models are possible utilizing TeleHealth and Medical Specialist Outreach Assistance Programs (MSOAP), but there is a need for a standardized training program. One model being developed is a 6 month Diploma involving ACRRM, RACGP, RACP Chapter of Palliative Medicine, the College of Radiation Medicine, and RANZSPM delivered through James Cook University. The specialist colleges are completing curricula that could be adapted to meet this need if funding was available for development and implementation.

Paediatric oncology and palliative care trained staff are in particular shortage in rural areas. Distance education and supports should be coordinated by a rurally based national office.

In Central Australia, there is half a doctor and 2 non-Indigenous nurses to meet the palliative care needs of 45,000 people across 900,000 sq km. There is one dedicated Indigenous palliative care worker in Australia. There is an urgent need for training and travel funds to build on the trust which these dedicated professionals have established.

RECOMMENDATIONS

- The capacity of health and education services to deliver preventive care to rural Australians should be enhanced to counteract the higher level of risk factors and behaviour associated with living in the bush.
- Up to date information on service and treatment options should be available to the rural primary care workforce to enhance its ability to offer appropriate choices of referrals and advice to patients.

- Financial support to enable a family to accompany a rural patient and affordable, easily accessible accommodation for their use while having assessment and treatment in the city would make a significant difference.
- Strategies to increase public awareness of cancer help lines and resources for information and support would assist rural patients and families in decision making about treatment options.
- Domiciled oncology services should be established in larger regional areas and provide outreach services to rural and remote areas through a “hub and spoke model”.
- Funding through new and existing programs, including MSOAP, should be directed to increase rural patient access to specialist services.
- Strategies to recruit appropriate specialists to provincial areas should be directed by data on the incidence and prevalence of cancer and the current level of service provision in rural and remote Australia.
- Immediate funding is required for the implementation of the results of research into cancer and palliative care services, models and outcomes in rural areas. While the need for further research is acknowledged, this need should not be used to justify procrastination in implementing accepted good practice models.