



National
Rural Health
Alliance

Australian Cancer Plan consultation submission

March 2022



... healthy and
sustainable rural,
regional and remote
communities



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1. What would you like to see the Australian Cancer Plan achieve?

Think ahead to the next 10 years. What do you want the Australian Cancer Plan to achieve? Think big – what transformational change(s) should we be aiming to influence?

The National Rural Health Alliance (the Alliance) welcomes the opportunity to contribute to the development of the Australian Cancer Plan (the Plan). As the peak national body representing the regional, rural and remote (hereafter rural) health sector, we work towards a vision of healthy and sustainable rural communities.

Vision

Australians can access high-quality, comprehensive, and culturally safe cancer care across the full spectrum of care, in a timely manner and as close to home as possible, no matter where they live. This care is delivered within a sustainable system and enables equitable cancer outcomes to be achieved by rural and metropolitan Australians alike.

Long-term outcomes

Equity of outcomes for people living in all geographical regions of Australia

- Reduced incidence, mortality and improved survival for all cancers combined and specific cancers for which there is a notable disparity in outcomes by geography.
- Specific cancers requiring particular focus include: head and neck, cervical, unknown primary site, lung, liver, prostate and bladder cancers.
- Equity of outcomes for Aboriginal and Torres Strait Islander peoples in rural Australia must be addressed.

Cancer care services in rural Australia are sustainable

- The system is oriented to prevention and early intervention to manage growing demand over time.
- The cancer care (and primary care) workforce is developed and grown over time.
- Services are delivered via a suitable mix of models appropriate to rural communities to enable timely and affordable access to care.
- Funding enables services to be sustained, taking the challenges of the rural context into account.

Cancer care services in rural Australia are comprehensive and of high quality

- Training systems and pathways enable the development of a highly skilled cancer care and primary health care workforce who are retained in rural areas.
- Innovation contributes to equity of access to best-practice care despite geographical distance.
- Multidisciplinary teams of cancer care practitioners are accessible and available in rural Australia.

Cancer care services in rural Australia are culturally safe

- The needs of Aboriginal and Torres Strait Islander peoples are specifically and comprehensively addressed, in genuine partnership with relevant stakeholders and community members, by building the community-controlled sector and improving mainstream institutions.

Rural communities and individuals are supported to live healthier lives

- Communities are supported to address the modifiable risk factors for and causes of cancer and individuals at risk are supported with:
 - increased access to healthy eating choices and exercise opportunities through a systems approach
 - well-funded programs, delivered by a professional workforce, to support lifestyle behaviour change
 - improved health literacy on the prevention of cancer is addressed through education and awareness-raising activities.

Background

Cancer and other neoplasms were the leading cause of disease burden (by disease group) in all geographical regions of Australia in 2018.^{1,i} While overall cancer mortality has been reducing over time and survival rates have been increasing, the incidence of most common cancers has been increasing.² Given the incidence of cancer is greater in older people, as our population grows and ages the rate of new cancer diagnosis is predicted to grow.² There are notable disparities in cancer incidence and outcomes by geography.

According to data presented by the Australian Institute of Health and Welfare (AIHW) utilising the Australian Statistical Geography Standard – Remoteness Areas (ASGS-RA)ⁱⁱ, the age-standardised **incidence of all cancers combined** between 2012 and 2016 was highest in Inner Regional areas (512.7 cases per 100,000 population), followed by Outer Regional areas (511.7 cases per 100,000 population) and lowest in Very Remote areas (421.9 cases per 100,000 population).³

- The incidence of head and neck cancers and cervical cancer increased with remoteness.
- Cancers of unknown primary site and lung cancer were diagnosed more frequently in all rural areas than for Australia overall.
- Melanoma of the skin was diagnosed more frequently in regional areas than for Australia overall.
- The incidence of liver cancer in Very Remote areas was 60.5 per cent higher than for Australia overall.
- Uterine cancer in Very Remote areas was 18.9 per cent higher than for Australia overall.

ⁱ NRHA analysis of AIHW data

ⁱⁱ www.abs.gov.au/websitedbs/D3310114.nsf/home/geography

The **mortality** rate (age-standardised) due to *all cancers combined* between 2015 and 2019 was highest in Very Remote areas (190.7 deaths per 100,000 population) and lowest in Major Cities (150.7 deaths per 100,000 population).³ The rate in all other rural areas was similar, exceeding the Australian combined rate of 158.7.

- Deaths due to lung cancer, cancer of the head and neck and cancer of unknown primary site all increased with increasing remoteness.
- The mortality rates due to prostate and bladder cancer in all rural areas were higher than for Australia overall.
- The rate of death due to cervical cancer in Very Remote areas was 3.3 times that of Australia overall.
- Deaths due to liver cancer in Very Remote areas occurred at almost twice the rate of Australia overall.

Five-year observed survival for *all cancers combined* between 2012 and 2016 was lowest in Very Remote areas (55.1 per cent), increasing with reducing remoteness to its highest point in Major Cities (62.5 per cent).³ The percentage survival in all rural areas was significantly lower than for Australia overall. Survival for the following cancers reduced with remoteness: lung, head and neck, liver and cervical cancer.

Aboriginal and Torres Strait Islander peoples make up a larger proportion of the population with increasing remoteness⁴ and therefore contribute significantly to population health outcomes in more remote areas.

- The **incidence** rate (age-standardised) for *all cancers combined* was higher in Indigenous than non-Indigenous people across all remoteness areas between 2012 and 2016, though it was highest in Major Cities (538.1 per 100,000 population compared with 451.8 per 100,000 population).³
- Age-standardised **mortality** rates for *all cancers combined* between 2015 and 2019 were higher in Indigenous than non-Indigenous people when looking at Australia overall.
- **Five-year observed survival** for *all cancers combined* between 2007 and 2016 was lower in Indigenous than non-Indigenous people in all remoteness areas and reduced with increasing remoteness from 52.6 per cent (compared with 60.0 per cent in non-Indigenous people) in Major Cities to 37.5 per cent (compared with 60.9 per cent in non-Indigenous people) in Remote and Very Remote areas combined.³

The factors driving the differences in incidence and poorer cancer outcomes in rural Australia, include:

- the higher proportion of Aboriginal and Torres Strait Islander peoples (and therefore factors specific to this population group)
- higher levels of socioeconomic disadvantage
- higher prevalence of health, behavioural and biomedical risk factors
- reduced rates of participation in population-level screening
- delays in diagnosis or treatment
- prevention, treatment and recovery disparities.

Access to and timely utilisation of health care services are imperative when it comes to maximising cancer outcomes. The provision of high-quality, comprehensive, culturally safe services is intimately linked to the presence of an appropriately trained workforce and requires consideration and development of new models of care that utilise all members of the workforce effectively.

We will explore these factors and methods of addressing them in the subsequent questions.

Plan instruments essential to achieving these goals

Aboriginal and Torres Strait Islander peoples need focused attention to improve the disparities in their experiences and outcomes. While this must be included in the Plan, the complexity and body of work involved warrants an independent Indigenous Cancer Plan to ensure the holistic requirements of optimal care in this population group throughout Australia are addressed.

The Plan needs to include **specific, measurable targets** and require reporting on these targets at intervals. Such **monitoring** of performance against targets should sit alongside a requirement for rigorous **evaluation** at five and 10 years.

For the Plan to have the best chance of seeing success, higher-level strategic goals and objectives must be coupled to clear **implementation** actions, for whom responsibility is assigned. Energy must then be expended to advocate for government commitment to **funding** the essential activities included in the Plan, along with strategic, fiscal and human resource support for the implementation process itself.

2. What are the opportunities with the greatest potential to realise your vision?

Think about what you would like the Australian Cancer Plan to achieve. What priorities need national action? In what areas could national action drive or accelerate progress?

Introduction

Our response to the previous question clearly highlighted the differences in outcomes of cancer in rural Australia compared to major cities – most notably the negative relationship between remoteness and cancer survival, increased mortality outside of major cities and higher cancer incidence in regional areas.

A global systematic review from 2018 that assessed research on cancer survival in rural dwellers in developed countries found a reduction in survival in rural dwellers around the globe, quantifying it via meta-analysis at five per cent. These authors presented a socioecological model to explain the factors contributing to this phenomenon, covering four broad domains: patient-level characteristics; institutions; community, culture and environment; and policy and service organisation.⁵

Many of the issues emphasised in their model are discussed below, grouped alternatively into the categories of prevention and early intervention/diagnosis, access to best-practice cancer care – both demand and supply-side concerns, followed by a discussion of workforce.

Prevention and early intervention/diagnosis

Despite the many upsides to living in rural Australia, rural Australian populations experience higher levels of unemployment, lower incomes and lower rates of educational attainment, all of which are important social and economic determinants of health which contribute to the complex picture of cancer burden in rural areas.⁶

About half of all cancer burden is attributable to personal and behavioural risk factors, with tobacco exposure resulting in the greatest burden.² At the population level, rural people experience greater rates of these risk factors including: smoking, overweight and obesity, risky alcohol consumption, poorer diet and lower levels of physical activity, all of which have a role to play in cancer aetiology.⁶ For example:

- age-standardised daily smoking rates in 2019 increased with remoteness from 9.8 per cent of the population in Major Cities to 19.2 per cent in Remote areas⁷
- in 2018–19, rates of daily smoking in Aboriginal and Torres Strait Islander peoples were considerably higher, increasing from 30.1 per cent in Major Cities to 52.3 per cent in Very Remote areas.⁸

Population-level cancer-screening programs aim to detect cancer early to enable early intervention and ultimately improve cancer outcomes. Participation rates across the three national screening programs (cervical cancer, breast cancer and bowel cancer) vary by remoteness.

- **Cervical cancer** screening participation rates in 2018 to 2020 reduced with remoteness and were lowest in Very Remote areas.⁹
- **Breast cancer** screening program participation rates in 2018–19 were lowest in Very Remote areas but highest in Inner and Outer Regional areas.¹⁰ Rates were lower in Indigenous compared with non-Indigenous women.
- **Bowel cancer** screening program participation rates in 2018–19 were lowest in Very Remote areas and highest in Inner Regional areas. Indigenous people had a lower participation rate than non-Indigenous people.¹¹

Given the likelihood of an increasing cancer burden over time due to population growth and ageing, current inequities in cancer incidence and outcomes in rural Australia, along with geographical differences in the socioeconomic determinants of health, health risk factors, and participation in screening programs, **prevention and early intervention must be a priority area of focus.**

Prevention activity at the primordial level (targeting the broader determinants of health, specifically support for lifestyle behaviour change) should be combined with efforts to address risk-factor prevalence, and sit alongside action to improve rates of early detection and intervention via screening. These things are key to improving rural health outcomes while managing the system in a sustainable way. The Plan would benefit from alignment with the *National Preventive Health Strategy 2021–2030*¹² in working towards these aims.

Access to best-practice cancer care

As mentioned in our response to the previous question, access to and timely utilisation of health care services are imperative when it comes to maximising cancer outcomes. Services required include: prevention activities, screening programs, primary health care, diagnostic imaging, treatments in primary, secondary and tertiary care (surgery, chemotherapy, radiotherapy, allied and psychosocial care), survivor care and palliative care.

Without access to and use of appropriate services, diagnosis and then subsequent treatment and recovery can be delayed, with a detrimental impact on outcomes. Poor access to the full complement of treatment options can result in disparities in the treatments received by rural people. Treatment disparities include:

- reduced utilisation of exercise-based therapy and other evidence-based non-pharmacological interventions for prevention, during and after treatment and to aid recovery from cancer
- lower rates of chemotherapy administration¹³
- lower likelihood of having surgical treatment at a high-volume specialist centre¹⁴ (which alters outcomes for some cancers) and
- reduced access to clinical trials.¹⁵

Research from the United States has found that when rural people have access to the standardised treatment protocols of clinical trials, their outcomes are not significantly different from their metropolitan counterparts.¹⁶

Supply-side concerns

For most people, the cancer journey begins in primary health care, with many touchpoints over time. To prevent development of and manage risk factors, enable early diagnosis and intervention, timely and affordable access to primary health care is essential. It is also essential for the delivery of shared care with cancer care specialists who might be located at a distance, and filling the various gaps in more specialised care in rural areas that will be illustrated below. Yet almost 43,000 Australians cannot access primary health care within an hour's drive of their home, with 65,000 Australians being unable to access a general practitioner (GP) in this drive time.⁶ Access to allied health services is poorer in remote areas.⁶

Even if primary health care services are available within a reasonable distance, access is often reduced by wait times and out-of-pocket costs. If these services are not readily accessible, rural people are missing the bedrock of their cancer care journey.

If the Plan is serious about improving cancer outcomes for rural people, it must include action to improve access to primary health care in rural Australia. Access to GPs is a priority, as is consideration of implementing and bolstering alternative models of primary health care such as block-funded nurse practitioner (NP) and other nurse-led clinics. Access to allied health services must also be considered. To this end, alignment with the Australian Government's *Primary Health Care 10 Year Plan* would be beneficial.

Mapping of rural oncology services performed in 2006 provides evidence of a reduction in cancer services with increasing remoteness.¹⁴

- This survey of regional hospitals administering chemotherapy (RHAC) highlighted reduced access to specialist oncology services – both medical and surgical – in rural areas, resulting in an increased load on general physicians, GPs, other doctors and non-chemotherapy-trained nurses.
- Although allied health care was available in many locations, accessibility was compromised by long wait times, high cost (including out-of-pocket costs) and restrictions to service eligibility.
- Psychosocial support services were lacking, as was access to multidisciplinary clinics.

While we acknowledge investment in the infrastructure of regional cancer centres (RCCs) as a significant initiative to improve access to cancer care in rural Australia, it is important to note that 52 per cent of these centres are located in Inner Regional areas¹⁵ and at a significant distance from many patients living rurally.

- A report from the Clinical Oncological Society of Australia in 2012 suggested that, despite the roll out of RCCs, limited access to diagnostic imaging – particularly MRI – and radiotherapy outside Inner Regional areas persisted.¹⁵
- Another cross-sectional survey completed in 2016, after the commencement of the RCC project, found respondents from remote regions were significantly more likely to report a lack of specialist medical practitioners.¹⁷

The 2019 announcement by the Australian Government, of \$63 million in funding to set up radiation therapy treatment facilities in 13 additional rural sites is very welcome and we look forward with anticipation to the delivery of these radiation therapy services to more rural people, closer to home, in the near future. It is imperative that these facilities receive appropriate ongoing funding and are supported to recruit and retain the workforce required to be fully functional.¹⁸

It has been estimated that Australia has half the palliative medicine specialists it needs to adequately care for the population at large¹⁵, with this discrepancy amplified in rural areas.

- Only 24 per cent of RHAC reported having a palliative care specialist.¹⁴
- GPs were found to provide most palliative care in 34 per cent of these hospitals – their access to specialist support via outreach reducing with remoteness.¹⁴
- A workforce of palliative-care-trained nurses supported by doctors and professional development contribute significantly to the provision of palliative care in rural areas.¹⁵

As has been illustrated, there are significant deficiencies in access to both primary health care and specialised cancer care services in rural areas across the spectrum of care; from medical and surgical oncology to diagnostic radiology, radiation therapy, psychosocial support, multidisciplinary team-based care and palliative care. This results in an increased burden on primary health care practitioners, negatively affects a patient's experience of care and ultimately influences their outcomes.

Demand-side concerns

Access to health care services in rural populations is also influenced by demand for these services. Demand is modified by attitudinal factors common in rural people (such as stoicism, self-reliance, concerns about privacy and reduced help-seeking), health literacy, the need to travel vast distances and financial burden (in the context of a lower socioeconomic profile).

- Outer Regional and Remote residentsⁱⁱⁱ were found to have the greatest travel burden to receive cancer treatment – 61 per cent travelled at least two hours one way and 49 per cent lived away from home.¹⁹
- Those who travelled more than two hours, or lived away from home, faced significantly greater financial difficulties.
- Travelling and living away from home increases costs; might require a patient or their family to take time off work or pose challenges to caring responsibilities, including for children; and removes people from their families, communities and broader support networks – with an associated financial and personal burden.

Workforce

The provision of cancer services relies on the presence of an appropriately trained workforce. However, we know attracting and retaining a well-distributed health workforce in rural Australia is difficult across many professions.

The full time equivalent (FTE) rate of GPs per 100,000 population is highest in Major Cities (119.0), lower in regional areas (109.6) and lowest in remote areas (73.3), according to 2020 data.^{6,iv} This is despite the fact that rural GPs are required in greater numbers due to their broader scope and the higher burden of disease in rural populations.

Comprehensive cancer care requires access to the services of a suite of health professionals, including nurses, pharmacists and allied health professionals. Yet rural communities have fewer pharmacists, psychologists, physiotherapists, occupational therapists and other registered allied health workers based on 2020 data.⁶ They also have fewer dietitians, speech pathologists, audiologists and social workers based on 2016 data.²⁰

Workforce inadequacies are amplified when specialised skills are considered – for example, only 19 of 7,000 accredited exercise physiologists (AEPs) in Australia work predominantly in oncology exercise treatment as part of a multidisciplinary team, therefore this specific workforce in rural Australia is likely exceedingly small.^v

After initial diagnosis, many people with cancer will require the services of non-GP medical specialists. The FTE of these specialists decreases from 178.9 per 100,000 population in major cities to 9.7 per 100,000 population in small rural towns and 26.3 per 100,000 population in very remote communities.^{6,vi}

- Radiation oncologists and medical oncologists are predominantly located in major cities, regional centres and large rural towns.^{21,vii}
- Palliative medicine specialists are in very short supply in large, medium and small rural towns.^{21,vii}

ⁱⁱⁱ Utilising the ASGS-RA classification system

^{iv} Based on the Modified Monash Model (MMM) geographical classification system.

^v Data provided directly by Exercise & Sports Science Australia, Feb 2022. www.essa.org.au

^{vi} Based on the Modified Monash Model (MMM) geographical classification system.

^{vii} NRHA analysis of 2020 National Health Workforce Dataset data utilising population data from 2020 by MMM obtained directly from the Australian Government Department of Health

- Although there is no agreed staffing mix for RCCs to date²², the Clinical Oncological Society of Australia reported that there were inadequate staffing levels within RCCs across many professional disciplines.¹⁵

Solutions to improve access and address workforce disparities

The Alliance acknowledges that some cancer care is highly specialised and might always need to be provided in high-volume centres in major cities. In addition, we acknowledge that it would be very difficult to provide face-to-face diagnostic, oncology and palliative care services in all areas of Australia due to vast distances and small populations. Yet we stress the need to decentralise specialised cancer care wherever it is feasible, using innovative models and technological advances where necessary, to ensure equitable access to high-quality, safe, comprehensive care by rural populations.

Outreach services are an important mechanism to take high-quality care to cancer patients in rural areas after the initial phase. These services might be provided via digital means, shared-care arrangements, fly-in fly-out or other visiting services, or include virtual multidisciplinary teams.²³ Access to high-quality digital health care requires investment in the infrastructure to support it, as well as training for health professionals and an adequate ongoing funding mechanism. Continuity of relationship with visiting services is also an important consideration.

A focus on multidisciplinary, supportive care is imperative in the management of many cancers and requires development, given the current state of services in rural Australia – where access to allied health, psychosocial support, specialist palliative care and multidisciplinary teams is poor. Strong but flexible referral pathways^{15,24} and cancer care networks^{15,25,24} are proposed by several authors as a way of facilitating delivery of best-practice care between major cities and rural areas, including engagement of multidisciplinary team members.

Utilisation of the primary health care workforce to provide ongoing cancer care closer to home, perhaps as part of shared-care arrangements with more specialised teams, is also a possibility but requires that GPs, nurses and allied health professionals have support and training to ensure care is safe and effective.

Policies and initiatives to build the GP, nursing, pharmacy and allied health practitioner workforce and improve their distribution across rural Australia is essential to improving cancer outcomes. Allied health practitioners often do not have access to the same workforce incentives as their medical colleagues. The presence of these professionals in local communities makes timely, affordable access to cancer care in primary and secondary health care more likely. Building and sustaining a specialist workforce and improving cancer care skills in the generalist workforce is also essential to improving rural cancer outcomes.

The Clinical Oncological Society of Australia has proposed a number of recommendations to develop the oncology workforce in rural Australia including:

- increased availability of vocational trainee positions in oncology in rural areas, to bolster the rural training pipeline for doctors working towards fellowship
- enhancing the regional oncology experience of medical trainees from all disciplines
- increasing options for oncology training in the existing rural workforce (for nursing, allied health and non-clinical staff) and increasing access to Indigenous liaison officers at RCCs.¹⁵

Development of a staffing profile for rural oncology units has been proposed, to guide delivery of equitable care in rural areas²², alongside a specific staffing matrix for RCCs.¹⁵ These policies warrant inclusion in the Plan.

Travel and accommodation assistance schemes are an important component of holistic cancer care for rural people. Travel and accommodation support is required for those who must travel to receive appropriate care – to reduce the inequity of the financial burden this presents for rural people. Schemes must be funded adequately on an ongoing basis, patients should be made aware they exist and they must be easy for patients and their families to access and navigate.

The Plan would also do well to address the attitudinal factors that are prevalent in rural populations and levels of general and cancer-specific health literacy, if it is to increase the likelihood of rural people accessing care for cancer in a timely manner.

Aboriginal and Torres Strait Islander cancer care

A specific focus on Aboriginal and Torres Strait Islander service provision is key to changing outcomes and the experience of cancer for patients in rural Australia. This includes building the community-controlled sector via sustained capacity development and investment²⁶, prioritising the provision of care to Aboriginal and Torres Strait Islander peoples by Aboriginal and Torres Strait Islander peoples (including workforce development)¹⁵ and improving the quality and experience of care in mainstream institutions by working in genuine partnership with communities to co-design services where racism is eliminated and cultural safety is embedded.^{25,26}

Summary of recommendations

- Prevention and early intervention:
 - Prioritise action at the primordial level on the broader determinants of health.
 - Act to reduce the differential risk factor burden in rural Australia.
 - Increase participation in screening programs, especially in Very Remote Australia.
- Improve access to primary health care in rural Australia, particularly GPs and other models of care that increase accessibility and affordability while maintaining quality and safety (such as NP and nurse-led models of care).
- Build balanced access to specialist cancer care services in rural Australia:
 - Enhance the rural training pipeline for medical specialties to build a larger cohort of trainees who stay rural.
 - Decentralise specialised cancer care wherever it is feasible, using innovative models where necessary, to ensure equitable access to high-quality, comprehensive care by rural populations.
- Build the health workforce in rural Australia for nursing, pharmacy and allied health – including equitable application of workforce incentives – to maximise the contribution of these workforces to cancer care in primary and secondary care in rural areas.
- Build cancer care skills in local generalist workforces – GPs, nurses, pharmacists and allied health practitioners.

- Act on the attitudinal factors and health literacy of rural populations to increase the likelihood of individuals accessing behavioural lifestyle change services as preventive care and seeking clinical care in a timely manner.
- Ensure travel and accommodation assistance schemes are adequately funded and easy for consumers to navigate.
- Include a specific focus on Indigenous service provision, building the Aboriginal and Torres Strait Islander health workforce, improving the cultural safety of health services and working to enhance cancer health literacy in this population.

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 all Australians?

Models of non-pharmacotherapeutic care

Clinical guidelines recommend health professionals involved in cancer care discuss the role of exercise in cancer recovery with their patients, encourage their adherence to exercise guidelines and refer them to a health professional who specialises in exercise prescription and delivery (for example, an accredited exercise physiologist (AEP) or cancer physiotherapist).²⁷ Multiple models illustrate effective exercise interventions delivered during and after cancer treatment, worth considering for further roll out across the country. Below are two examples.

Cancer Council WA: Life Now

Life Now²⁸ was established in 2007 and is based on research which links regular exercise programs to reduced treatment-related side effects and improved general wellbeing for people with cancer. Life Now exercise includes a one-hour class twice a week for twelve weeks. Each class is facilitated by an AEP. Life Now exercise is offered to Western Australians who have been diagnosed with cancer in the last two years, are currently undergoing cancer treatment or who have completed cancer treatment in the last two years. Life Now is offered across seven sites in Perth as well as regional Western Australia. Life Now is funded entirely by the Cancer Council WA and there is no cost to the participants. The program continues to be viable and well-attended after 15 years, with classes filling quickly and participants often having to be placed on waitlists.

Cancer Council Victoria: Cancer Wellness and Exercise program

Cancer Wellness and Exercise²⁹ was piloted in 2016 and took place at five health services in rural Victoria. Held over eight weeks, each participant engaged in one hour of supervised group exercise and a one-hour education session via telehealth per week. The group education and exercise were led by trained health professional facilitators. One-third of participants increased their physical activity levels by 86 per cent over the course of the program. Since the pilot, the program has been expanded to 70 health services across Victoria and 200 Cancer Education Program facilitators have been trained.

Digital health care: improving access to specialised cancer care services in rural Australia

Advances in technology have been transforming the way health care is delivered for many years, with the use of digital modalities exploding as a result of the COVID-19 pandemic. A body of evidence has been building over the past decade to support the use of telehealth broadly and in the context of cancer care in rural areas. Recent Australian research supports the use of telehealth models of care in rural areas across the spectrum of cancer care, from diagnostic radiology to chemotherapy, radiation oncology and to increase access to clinical trials.

Chemotherapy

A collaboration in north Queensland has developed a model to enhance access to high-quality, safe chemotherapy services outside of large rural centres – the Queensland Remote Chemotherapy Supervision (QReCS) model.³⁰ In this model, rural generalist nurses administer chemotherapy under the supervision of chemotherapy-proficient nurses from larger primary centres via videoconference. The model also utilises telehealth to enable medical oncologists and oncology pharmacists from larger primary centres to provide guidance to local rural generalist doctors and pharmacists.

A retrospective study of the implementation of the QReCS model was undertaken to assess its feasibility for scaling up safely.

- The researchers reported that the model was implemented at six sites between 2014 and 2016, enabling treatment of 62 patients (including 12.9 per cent who were Indigenous).
- Treatment delays, adverse events and hospital admissions occurred at similar rates to those receiving standard care (and there were no differences between Indigenous and non-Indigenous patients).
- Implementation was enabled by good leadership, support for the model by health service executives, funding from government (including for shared medical records and telehealth infrastructure), Australian Government incentives for doctors to participate in telehealth, and utilisation of a government-endorsed guide to the model.
- Barriers included the turnover of management and clinical staff and interruption to internet connectivity.
- Many hospitals and health services in Queensland are now providing chemotherapy services utilising this model and there is scope for it to be implemented more broadly, taking the learnings from this study into account.

Radiation oncology

As was discussed in our answer to the previous question, access to radiation oncology services for rural people is often limited to regional centres, requiring significant travel and with the potential to impact treatment decisions.

Hamilton, Van Veldhuizen and Brown et al. reported on the use of telehealth in radiation oncology in north Queensland.³¹ While patients were still required to travel to a RCC for radiation therapy treatment, 'initial' and 'review' medical consultations were available via telehealth. While uptake of this model was low, those who participated were satisfied with the care provided and travel savings were rated as the top advantage by patients. The model was deemed applicable to Aboriginal and Torres Strait Islander peoples who comprised 7.1 per cent of the cohort. While this descriptive study did not assess the impact of teleradiology consultations on patient outcomes, the results are promising and encourage further development in this area.

Diagnostic radiology

Telehealth is also being used to facilitate access to diagnostic radiology services in rural areas.

A study from 2020 reported on the implementation of a remote radiology assessment model at four BreastScreen services across three Australian states or territories, three of which were outside of major cities. In this model, teleradiology was used for diagnostic assessment of mammograms by a radiologist at a remote site and could also incorporate asynchronous or synchronous teleconsultation. Communication between the various health professionals and the client at the local site and remote site was enabled via telehealth. Service providers from implementation sites were interviewed and while the study did not report on patient outcomes, service providers were satisfied with the remote radiology assessment model and felt it provided improved access to high-quality assessment services.

Key components of safe implementation included: strong support for clinical governance with the flexibility to adapt to the local context, the ability to adapt the model over time, well-functioning teams, and appropriate equipment and adequate technological support. This model, while narrow in its scope, has the potential to improve the timeliness of diagnosis of cancer for rural people. Assessment of its use in the diagnosis of other forms of cancer and in a broader array of settings is warranted.

Clinical trials

Support for clinical trials in regional centres and rural areas has the potential to increase access to novel treatments for rural people, with flow-on effects for outcomes.

The Clinical Oncological Society has been instrumental in the development of the Australasian Teletrial Model to increase access to cancer clinical trials in rural populations, in collaboration with industry, government and research bodies. The teletrial model aims to decentralise clinical trial processes via the use of telehealth to connect primary and satellite trial sites. Satellite sites include smaller regional or rural sites who would otherwise not have the capability to provide clinical trial access to patients.

A lack of access to clinical trials close to home is a barrier to participation for rural people. Sabesan, Brown and Poxton et al. reported on the implementation of a teletrial in north Queensland across four sites from 2017 in a case study, focusing on enablers and challenges.³² This is a promising development for rural people worthy of support in the Plan.

These examples illustrate the potential for telehealth to enhance access to specialist cancer care services in rural Australia, in a way that is safe and effective, and acceptable to patients and clinicians. The Plan should focus on enabling expansion of these models so their benefits can be realised by a broader section of the rural Australian population. Further funding for health systems and policy research is required to evaluate the success of measures aimed at reducing the city–country divide in cancer outcomes.²³ Ongoing research in this area and evaluation of programs that are implemented will ensure continuous quality improvement and development of the body of knowledge about how we can better serve rural Australians who experience cancer.

NP- and nurse-led models of care

NP- and nurse-led models of care have the potential to increase access to high-quality, affordable primary health care that improves patient outcomes.³³ They can supplement the traditional medical model of primary health care – helping to solve workforce issues, providing care where it might not otherwise be available or accessible, and providing patients with choice. Examples of such models have been implemented in both metropolitan and rural areas with good effect and show potential for further scaling.³⁴ Similar models could be developed for oncology-specific purposes, involving NPs and advanced practice nurses, supported by medical specialists and GPs.

Rural Area Community Controlled Health Organisations

The Alliance has proposed Rural Area Community Controlled Health Organisations (RACCHOs) as a model to improve rural health outcomes by addressing the barriers to attracting and retaining a rural health workforce.

The model, which is described in our *2022–23 Pre-Budget Submission*³⁵, seeks block funding – as well as being able to utilise the Medicare Benefits Schedule – from the Australian government, to set up not-for-profit organisations in rural areas in need, to help them address gaps in local health care services. RACCHOs, broadly modelled on the successful Aboriginal Community Controlled Health Organisation (ACCHO), will provide comprehensive primary health care services via multidisciplinary teams, with their services tailored to and co-designed with each rural community. These organisations will have strong local governance and leadership, along with flexible and adaptable organisational structures and employment mechanisms, enabling them to provide appealing roles to health professionals with attractive employment conditions and ongoing financial security.

RACCHOs will provide an opportunity to employ health practitioners such as GPs, nurses and midwives, allied health, pharmacists, dentists and paramedics. They will have the ability to incorporate NP- and nurse-led models of care and work closely with residential aged-care facilities and community pharmacies to design solutions appropriate for the needs of the local community.

RACCHOs have the potential to significantly improve access to comprehensive primary health care services, which are an essential component of the cancer care journey, and action to this end is imperative (as noted in our recommendations in the previous question).

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