



National
**Rural Health
Alliance**

SENATE STANDING COMMITTEES ON COMMUNITY AFFAIRS
COMMUNITY AFFAIRS REFERENCES COMMITTEE

**Inquiry into equitable access to diagnosis and
treatment for individuals with rare and less common
cancers, including neuroendocrine cancer**

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Healthy and
sustainable rural,
regional and remote
communities
across Australia.



National
Rural Health
Alliance

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SENATE STANDING COMMITTEES ON COMMUNITY AFFAIRS COMMUNITY AFFAIRS REFERENCES COMMITTEE

Inquiry into equitable access to diagnosis and treatment for individuals with rare and less common cancers, including neuroendocrine cancer

Terms of reference

Equitable access to diagnosis and treatment for individuals with rare and less common cancers, including neuroendocrine cancer, with particular reference to:

- a. **barriers to screening and diagnosis, including the impact of factors such as:**
 - i. **geographic location**
 - ii. **cost**
 - iii. **cultural and language barriers**
 - iv. **type of cancer**
 - v. **availability of treating practitioners**
- b. **barriers to accessing appropriate treatment**
- c. **the adequacy of support services after diagnosis**
- d. **the adequacy of Commonwealth funding for research into rare, less common and neuroendocrine cancer**
- e. any other related matters.

This submission will address the terms of reference highlighted in bold.

Recommendations

1. Increase participation in screening programs, especially in very remote Australia and for First Nations people:
 - a. This includes a specific focus on First Nation's health care.
 - b. Address health literacy issues that might influence participation in screening.
 - c. Address access barriers by maximising the provision of screening close to home for rural people, utilising innovative methods and models of care where appropriate.
2. Improve access to primary health care in rural Australia, particularly general practitioners (GPs) and other models of care that increase accessibility and affordability while maintaining quality and safety (such as nurse practitioner and nurse-led models of care).
 - a. This requires a focus on addressing the financial viability of primary health care in rural Australia, via consideration of alternate models of funding (including a component of block funding).
 - b. Support for place-based models of primary health care designed, implemented and led by local communities, based on local population health needs and gaps in existing service provision, such as the Primary care Rural Integrated Multidisciplinary – Health Service (PRIM–HS) model developed and advocated for by the National Rural Health Alliance (the Alliance). See Appendix A.

- c. Support entry-to-practice and professional training programs that allow students and practitioners to train and work rurally, such as end-to-end rural medical schools, extended placements within the Rural Health Multidisciplinary Training (RHMT) program, prevocational training in general practice via the John Flynn Prevocational Doctor Program, and single-employer models for rural generalist and GP trainees (Murrumbidgee Model).
 - d. Support for the Remote Vocational Training Scheme (RVTS), to assist the training of GP registrars when there is not a fellowed supervisor onsite, enabling these doctors to remain in their rural community while they complete their training.
3. Build balanced access to specialist cancer care services in rural Australia (including for diagnosis, treatment, rehabilitation, survivorship and palliative care):
 - a. Enhance the rural training pipeline for medical specialties to build a larger cohort of trainees who stay rural.
 - i. This requires development of rural training pathways by non-GP medical specialist colleges, accreditation of rural training places, and development of adequate supervisory capacity within these sites.
 - b. 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.
 - i. Where it is feasible to provide components of specialised cancer services outside of major cities and large regional centres, telehealth, visiting services and shared care arrangements can be used in innovative ways, in combination with upskilled local staff, to deliver high-quality care closer to home.
 - ii. Continuity and coordination of care, along with social and emotional support and culturally safety, should be prioritised within all models of care.
 4. Build the health workforce in rural Australia for nursing, pharmacy and allied health to maximise the contribution of these workforces to cancer care in primary and secondary care in rural areas.
 - a. Support entry-to-practice and professional training programs that allow students and practitioners to train and work rurally, such as end-to-end rural schools of health science, extended placements within the Rural Health Multidisciplinary Training (RHMT) program and rural generalist training programs such as the National Rural and Remote Nursing Generalist Framework and the Allied Health Rural Generalist Pathway.
 - b. Enable equitable access to workforce incentives across professions, outside of medical practitioners.
 - c. Address the financial viability of primary health care in rural Australia, via consideration of alternate models of funding (including a component of block funding).
 - d. Support for place-based models of primary health care such as the PRIM–HS model.
 5. Build cancer care skills in local generalist workforces – GPs, nurses, pharmacists and allied health practitioners – including for rare and less common cancers.
 - a. This will enable them to better contribute to the provision of high-quality, comprehensive, culturally safe care close to home for rural people, in combination and coordination with the skills and expertise of specialised teams located at a distance, as appropriate to the context.
 - b. This requires adequate funding, quarantined time and workforce support for professional development, across professions.
 - c. It also requires the development and provision of suitable training programs, supervision and mentoring opportunities.
 6. Ensure travel and accommodation assistance schemes are adequately funded and easy for consumers to navigate. The Alliance recently published an [updated fact sheet](#) on this issue.

7. Include a specific focus on First Nations service provision:
 - a. ensure the Aboriginal community-controlled health sector is core to this aim.
 - b. build the Aboriginal and Torres Strait Islander health workforce.
 - c. improve the cultural safety of health services.
 - d. work to enhance cancer health literacy in this population.
8. Increase funding for research into rare and less common cancers, with a population-proportionate amount targeted to rural researchers and projects.

Background

The Alliance welcomes the opportunity to make a submission to the Community Affairs References Committee's Inquiry into equitable access to diagnosis and treatment for individuals with rare and less common cancers, including neuroendocrine cancer. The Alliance is the peak body for rural health in Australia. We comprise 47 national organisations⁹ and our vision is for healthy and sustainable rural, regional and remote (herein rural) communities across Australia. The Alliance is focused on advancing rural health reform to achieve equitable health outcomes for rural communities – the 7 million people residing outside our major cities. Our Members include healthcare and medical professionals, service and support providers, health and medical educators, healthcare students, and the Aboriginal and Torres Strait Islander health sector.

Rare cancers are those with an incidence of less than six per 100,000 population and *less common cancers* are those with an incidence rate of six to 12 per 100,000 population (inclusive).^{1,2} Other features of this group of cancers – which individually affect few people, but collectively add up to around 52,000 diagnoses per year – include affecting children, being diagnosed in a person much older or younger than usual, originating or being found in an unexpected site, being diagnosed later than usual, or being a small subtype of a common cancer.³ These cancers can occur anywhere in the body and examples include brain cancers, thyroid cancers, stomach cancers, pancreatic cancers, liver cancers, gynaecological cancers and osteosarcoma, among others.³ Rare and less common cancers comprise 30 per cent of all cancer diagnoses and result in half of all cancer deaths.⁴

Given their rarity, research on this group of cancers is challenging and scarce.⁵ As a result, clinical management guidelines and treatment options are limited and outcomes are worse than for more common types of cancer.⁵

A recent study, which performed spatial analysis of rare cancer data in Australia, found evidence of substantial differences in incidence and survival from rare cancers by geographic location and socioeconomic status – with more rural and remote areas, along with the most disadvantaged areas, having increased incidence and reduced survival.⁵

When looking at cancer more generally, there are notable disparities in cancer incidence and outcomes by geography. The incidence of all cancers combined is highest for people living in regional areas.⁶ People living in rural Australia are more likely to die from cancer than their metropolitan counterparts, with the highest mortality rate for all cancers combined found in very remote areas.⁶ Rural people also have poorer survival rates after a cancer diagnosis.⁶

⁹ Please see www.ruralhealth.org.au/about/memberbodies for details.

Statements addressing the terms of reference

a. barriers to screening and diagnosis, including the impact of factors such as:

i. geographic location

The Alliance's remit is to develop policies and advocate for improved health outcomes for people living outside of Australia's major cities. Rural Australia includes regional centres, rural towns of varying sizes, remote areas and very remote areas. These locations are defined using either the Modified Monash Model^b or the Australian Statistical Geography Standard – Remoteness Areas.^c

Most of Australia's population is concentrated in major cities and these cities are centres for specialised service provision. Rural areas are, by definition, located at varying degrees of distance from major cities. Dispersal of population over vast distances means that many rural people do not have ready access to health services, due to the lack of physical presence of a service within a reasonable drive time of their location of residence. This may be true to varying degrees – from the lack of access to even the most basic of primary healthcare services, to a lack of access to more specialised services.

When health services are not available close to home, accessing these services requires the utilisation of alternative models of care, such as telehealth, or travel to another location. Travel has many consequences for consumers and their carers and families including the need to take time off work, the inability to meet caring responsibilities for children or others, and the cost of the travel itself and associated accommodation. Travel also takes people away from their support networks and into potentially culturally unsafe environments. Hence, travel is associated with personal and financial burdens⁷ and these are felt disproportionately by rural people.

Cancer screening and diagnosis require access to screening programs and primary healthcare services, at a minimum. Diagnostic imaging is also likely to be required, along with referral to more specialised services.

Population-level cancer screening programs aim to detect cancer early to enable timely intervention and ultimately improve cancer outcomes. Participation rates across the three national screening programs (cervical, bowel and breast cancer) are all lowest in very remote areas.^{8,9,10} Rates of participation in screening are also lower in Indigenous peoples.^{8,9,10} Geographical distance is likely to play an important role in these statistics.

Contemporary Australian research suggests that 44,930 people living in remote and very remote Australia do not have access to any primary healthcare services within a 60-minute drive time of their home.¹¹ People living in outer regional, remote and very remote areas utilise Medicare (such as for GP visits) up to 50 per cent less than those in major cities and inner regional areas.¹² These same people also experience longer waiting periods to see a GP.¹³ Yet, access to primary health care is essential to prevent development of cancer, manage risk factors and enable early diagnosis and intervention. It is also important for the delivery of shared care with cancer care specialists who might be located at a distance and filling various gaps in more specialised care in rural areas.

Diagnostic imaging services are vital to cancer diagnosis and treatment. A 2019 government inquiry found geographic disparities in access to these services, with submitters concerned about the limited access to various modalities and a case study from New South Wales highlighting the fact that most positron emission tomography (PET) scan facilities are in major cities.¹⁴

A comprehensive national, cross-sectional survey completed in 2016 examined the coverage of cancer services in Australia and ascertained providers' views on service gaps.¹⁵ The survey aimed to identify dedicated cancer services, in both the public and private sector, addressing the needs of adults, adolescents and children. Services were provided in hospitals (as both inpatient and outpatient) and community-based organisations. Their geographic location was recorded and categorised. Regional analysis found that significantly more respondents from remote areas reported gaps in specialist oncology services than in other geographic regions.

^b [Modified Monash Model](#)

^c [Australian Statistical Geography Standard – Remoteness Areas](#)

Hence, geographic location is a significant barrier to timely diagnosis of any cancer, let alone rare or less common cancers.

ii. cost

People living in rural Australia have on average, lower incomes than those living in major cities.¹⁶ The provision of health care in rural areas is more costly due to numerous factors, including higher labor costs and travel costs.¹⁷ Due to small, dispersed populations, rural primary healthcare practices are often unable to generate adequate patient through-put to make their practices financially viable utilising a predominantly fee-for-service model. This can make it difficult for them to bulk bill their clients, putting them in the position of trading off their financial viability against costs to consumers.

Rural people are also disproportionately burdened by the costs associated with travel to receive health care at a distance – both the cost of the travel itself and the associated costs of time off work, accommodation, and the need for alternative childcare or other caring arrangements.

In the context of reduced ability to pay, the additional financial costs borne by rural people are significant and, in combination with the challenges posed by the need to travel, can contribute to delayed presentation for care and alteration to treatment choices.

iii. cultural and language barriers

First Nations peoples

First Nations peoples make up a larger proportion of the population with increasing remoteness¹⁸ and therefore factors affecting them significantly impact population health outcomes in more geographically remote areas. Cancer incidence and mortality rates are higher in Indigenous people overall, while survival rates are lower.⁶ Participation rates in population-level screening programs are also lower.^{8,9,10}

For many First Nations people living in remote communities, English may not be their first language. The lack of access to resources and healthcare services in language provides a significant barrier to screening, diagnosis and treatment of cancer, along with its prevention, for First Nations peoples.

A specific focus on First Nations 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 investment¹⁹, prioritising the provision of care *to* First Nations peoples *by* First Nations peoples (including workforce development).²⁰ This also includes 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.²¹ Work might also focus on enhancing the cancer health literacy of First Nations peoples.²¹

Culturally and linguistically diverse people

The need for health services that are tailored to the specific requirements of culturally and linguistically diverse (CALD) people and groups, including the provision of resources and care in the appropriate language, is well recognised. As absolute numbers of people from a CALD background are smaller outside of major cities, provision of specialised services is less likely, with a concomitant impact on access to screening, diagnosis, treatment and supportive care.

iv. type of cancer

Issues faced by people living in rural Australia are likely amplified in the case of rare or less common cancers, due to the lower incidence and therefore reduced likelihood of health practitioners being abreast of the most up-to-date research regarding clinical care, and reduced likelihood of access to specialised services close to home.

Reduced access to healthcare practitioners with experience in rare cancers can result in diagnostic delays and reduced survival.⁵

There is evidence for improved outcomes from rare cancers when diagnosis and treatment occur in a specialised setting with access to multidisciplinary expertise.⁵ Yet for rural people, this means a patient needs to travel, with resultant challenges and financial costs (as previously discussed).

v. availability of treating practitioners

Comprehensive cancer care requires access to the services of a suite of health practitioners, across the spectrum of care (from prevention to early intervention and diagnosis, treatment, rehabilitation and palliative care) and traversing different parts of the health system (primary, secondary and tertiary care). The provision of high-quality, culturally safe 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 most professions. This is true of both primary healthcare practitioners and those providing more specialised care upon referral or within secondary and tertiary care settings.

There is a persistent, ongoing maldistribution of health professionals in Australia – major cities have an ample workforce supply, while rural and remote areas face a crisis. Small rural towns have almost 60 per cent fewer health professionals than major cities.²² The prevalence of **non-GP medical specialists** and their trainees, as a FTE per 100,000 population, in medium and small rural towns and remote and very remote areas, is much smaller than in major cities, regional areas and large rural towns.²² Similarly, most **allied health professions** reduce in prevalence as a FTE per 100,000 population with geographic remoteness, with lowest numbers in either small rural towns or very remote areas.²² Health professionals in remote and very remote areas also **work longer hours** on average than those in other areas.²³

Nurses are the largest component of the health workforce – registered nurses (RNs) have a similar prevalence, as a FTE per 100,000 population, in all geographic areas except for medium-sized and small rural towns, where they are in short supply.²⁴ Enrolled nurses (ENs), on the other hand, contribute more to the workforce in regional centres, rural towns and remote areas, than in major cities or very remote areas.²⁴

The largest prevalence of **Aboriginal and Torres Strait Islander health practitioners** as a FTE per 100,000 population is found in remote and very remote areas.²²

Major cities have more **GPs providing primary care** per 100,000 population compared to regional centres, small rural towns, remote areas and very remote areas, which have the lowest prevalence.²⁵ The highest prevalence is found in large and medium-sized rural towns.²⁵ The prevalence of GPs providing primary care has been reducing over recent years in remote areas and in the Northern Territory (NT).²⁵ The NT has the lowest rate of GPs by FTE of any state or territory.²⁵ Rural GPs require a broader skill set and are needed in greater numbers to serve communities with higher burdens of disease or where populations are dispersed over vast distances.²⁶

So, while nurses and midwives are collectively the largest health workforce and more well distributed across the country than most other professions – sitting alongside Aboriginal and Torres Strait Islander health practitioners who are more prevalent with geographic remoteness – there are challenges with recruiting and retaining health practitioners with the right skills and expertise and maintaining continuity of workforce across the nation in rural Australia. When specialised skills are considered, inadequacies are amplified. For example, radiation and medical oncologists are predominantly located in major cities, regional centres and large rural towns, and palliative medicine specialists are in very short supply in rural towns of all sizes.²⁷ This is intrinsically linked to the lack of training capacity for these medical specialties in rural areas.

A suite of policy measures is required to help develop the rural health workforce as it relates to cancer care and, more specifically, the screening and diagnosis of rare and less common cancers.

b. barriers to accessing appropriate treatment

Access to and timely use of healthcare services is imperative when it comes to maximising cancer outcomes. Treatment services required include GP care, imaging and associated technologies, non-GP medical specialist care, as well as allied, psychosocial, survivor and palliative care. Poor access to the full complement of options can result in delayed presentation for care and disparities in the interventions undertaken by rural people.

Treatment disparities for rural people 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 administration²⁸
- longer travel times to access specialised surgical care
- reduced access to clinical trials.²⁰

Access to primary health care is essential to enable early diagnosis and intervention. It is also important for the delivery of shared care with cancer care specialists who might be located at a distance and filling various gaps in more specialised care in rural areas.

Diagnostic imaging services and associated technologies are vital to cancer diagnosis and treatment. A 2019 government inquiry found geographic disparities in access to these services, with submitters concerned about the limited access to various modalities and a case study from New South Wales highlighting the fact that most PET facilities are located in major cities.¹⁴

A comprehensive national, cross-sectional survey completed in 2016 examined the coverage of cancer services in Australia and ascertained providers' views on service gaps.¹⁵ The survey aimed to identify dedicated cancer services.

Survivorship and supportive care services (including allied health, complementary medicine, psychosocial care, survivorship, rehabilitation and wellness services) were rated as the most critical service gap across all geographic regions. When looking at Australia overall, deficiencies in this area were listed significantly more often than those in general cancer service resources (need for nursing staff, hospital beds, improvements in integration and coordination of care), palliative care services (physicians, hospital and hospice services and home-based care) or specialist oncology services (oncologists, chemotherapy, radiotherapy and surgery).

Regional analysis found that significantly more respondents from remote areas reported gaps in specialist oncology services than in other geographic regions. While not statistically significant, the highest proportion of respondents reporting their most significant gap was in palliative and hospice care were in regional areas. Investment in the infrastructure of regional cancer centres (RCCs) is a significant initiative to improve access to cancer care in rural Australia; however, 52 per cent of these centres are in inner regional areas and at a significant distance from many patients living rurally.²⁰

Barriers to accessing specialist cancer services include financial viability for practitioners due to thin rural markets and lack of healthcare infrastructure, including access to theatres and day surgery. Attracting and retaining medical and healthcare staff is also a major challenge. Difficulty accessing professional development is integral to this, particularly due to the lack of quarantined time, funding and staff backfill. The low number of accredited training positions in medical specialist college programs are also a major barrier to the development of the rural cancer care workforce.

From a consumer perspective, barriers include the need to travel if services are not available close to home and the associated personal, social and financial challenges associated with this.

General physicians and general surgeons have an important role to play in the provision of medical care for people with rare cancers in rural Australia. Their role should be acknowledged and supported, in line with the recommendations (more broadly) of the *National Medical Workforce Strategy 2021–2031*.²⁹

It is evident that there are significant disparities for rural people in access to the healthcare services required during a cancer journey. Yet research from the United States 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.³⁰ Hence, if we are to drive equity of cancer outcomes in rural people, we must improve rural people's access to high-quality services across the spectrum of cancer care and ensure this care is provided as close to home as possible.

c. the adequacy of support services after diagnosis

A comprehensive national, cross-sectional survey completed in 2016 examined the coverage of cancer services in Australia and ascertained providers' views on service gaps.¹⁵ Survivorship and supportive care services (including allied health, complementary medicine, psychosocial care, survivorship, rehabilitation and wellness services) were rated as the most critical service gap across all geographic regions. When looking at Australia overall, deficiencies in this area were listed significantly more often than those in general cancer service resources (need for nursing staff, hospital beds, improvements in integration and coordination of care), palliative care services (physicians, hospital and hospice services and home-based care) or specialist oncology services (oncologists, chemotherapy, radiotherapy and surgery).

The McGrath Breast Care Nurse model of care, supported by the Royal Flying Doctor Service, provides good support for people living in remote areas. Our membership suggests this model be enhanced in rural Australia, with similar models explored for other cancers.

A group from La Trobe University in Victoria was recently funded by Cancer Council Victoria to co-design and co-develop a 'peer-support online psychosocial intervention program' for rural people diagnosed with rare cancers, to try and bridge this gap in the provision of survivorship and supportive care services and improve the experience of cancer and outcomes for these patients.³¹

Anecdotal evidence from within our membership suggests that palliative care services outside metropolitan areas are also in need of attention. Enhanced access to high-quality training in palliative medicine should be provided to medical practitioners, along with funding to complete it. An example of this would be the Palliative Medicine special skills module of Rural Generalist Training via the Australian College of Rural and Remote Medicine or the Royal Australian College of General Practitioners.

d. the adequacy of Commonwealth funding for research into rare, less common and neuroendocrine cancer

Here we face a double dilemma: research funding directed to rural areas and rural researchers is not equitable given the 30 per cent of the population residing outside of major cities, and research into rare and less common cancers is difficult and limited.⁵ In order to reduce the inequities experienced by rural people with rare and less common cancers, not only does funding for research into these cancers need to increase, but some of this research must be targeted to rural areas and rurally designed projects in order for the benefits to be felt by rural people. This will help contribute to a reduction in the geographic maldistribution of health and medical research funds.

Appendix A: What are PRIM-HS?

PRIM-HS is a model of care and funding for primary health care in rural areas advocated by the National Rural Health Alliance and supported by a wide diversity of organisations. When funded, PRIM-HS will be community-based organisations that offer a comprehensive and affordable range of primary healthcare services. They should be not-for-profit organisations funded by government, designed, and established by local communities to meet their primary healthcare needs in flexible and responsive ways.

PRIM-HS will employ a range of primary healthcare providers including rural generalists, nurses, nurse practitioners and midwives, dentists and allied health professionals. The mix of practitioners employed will depend on the needs and circumstances of individual communities, with consideration of existing healthcare providers. Health practitioners will be supported by administrative staff (including practice managers), to ensure that clinical staff can focus on clinical practice. The PRIM-HS paradigm supports medical and allied health rural generalist models and pathways, including opportunities for structured supervision and support.

PRIM-HS would help overcome the barriers to attracting and retaining a rural health workforce. They would provide secure, ongoing employment with a single or primary employer, attractive conditions including leave provisions (holiday, personal, parental and long service leave) and certainty of employment and income.

Most importantly, PRIM-HS are not urban-based corporate entities, cherry picking the profit out of rural communities. The Alliance believes that Australia has a social and economic contract to build regions, not just to take the best from them. This requires support to determine need and investment at the grassroots – in local people, local services and regions.

PRIM-HS do not rely on health practitioners committing to establish their own practice, with the attendant responsibilities of operating a financially viable, standalone business (managing staff, administration and compliance) in what are generally thin markets. This employment model makes it easier for health practitioners to take up a rural position, knowing they can focus on their professional practice without the stress of establishing, purchasing or running a practice in a thin or failed market.

PRIM-HS support work–life balance, minimising social and professional isolation through peer support from a multidisciplinary team and overcoming related negative perceptions of rural practice. Employment conditions recognise and support continuous professional development and specific accreditation requirements and can provide the opportunity for training and research collaborations. PRIM-HS provide ready connection to the local community, with support and advice available regarding accommodation, employment opportunities for partners, education options for children, and social and recreational activities.

The health workforce shortage in rural Australia often means that older people or people with disabilities cannot access the support and interventions they need and are eligible for, including medical, nursing, allied health, dental and pharmacy services, across a range of settings: residential aged care facilities (RACF), National Disability Insurance Scheme (NDIS) benefits and support through the Department of Veteran's Affairs (DVA). PRIM-HS has the potential to provide in-reach services for RACF, NDIS and DVA recipients, as well as for rural people with chronic disease, including those with chronic disease management or other similar care plans.

PRIM-HS are not intended to compete with Aboriginal Community Controlled Health Organisations (ACCHOs). Where appropriate, PRIM-HS will work collaboratively to ensure that all primary healthcare services, serving the full spectrum of community members, can thrive. PRIM-HS acknowledge the holistic, comprehensive, and culturally appropriate health services provided by these distinct organisations.

PRIM-HS are also not intended to compete with existing health professionals in a community or threaten the viability of existing services. PRIM-HS are aimed at supporting communities where there is a lack of primary health care and would be implemented to ensure existing services are enhanced. Hence, PRIM-HS will be co-designed with local health consumers, providers and organisations to address local needs, offering a range of services that are better integrated across all sectors.

Further details can be found at www.ruralhealth.org.au/primary-care-rural-integrated-multidisciplinary-health-services

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