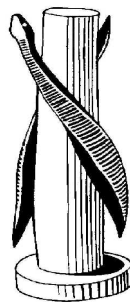
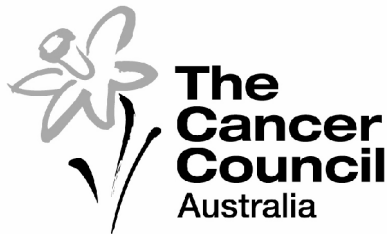


Cancer in the Bush

Optimising Clinical Services

Report and Recommendations

from a meeting held at the National Convention Centre, Canberra
8-9 March 2001



“Christmas was approaching and her parents wanted her home. Aged four, she had been away for several months having treatment and they felt it was time to return to the family. But they lived in the black soil country of Western Queensland at the end of a long, long dirt road. With the wet season it was likely they would be cut off, even from the nearest one-doctor town a hundred kilometres away. The mother took all the medications she might need and drove her daughter home. From time to time she would ring for advice. The child died peacefully at home, about a month after Christmas. She hadn’t been seen by a health professional in the interim. Her parents wrapped her small body, put her on the backseat and drove to the nearest doctor. People can be very brave about these issues and we have to be willing to help them. Dying at home was extremely important for this family and they accepted the compromises in technology and quantity of care knowing that for them, the quality of the experience would be improved.”

- Dr Will Cairns, Palliative Care Specialist

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Executive summary

A conference was held in Canberra in March bringing together professionals and consumers from regional and rural Australia. This was the first conference to address the disparity in cancer services between urban and regional areas.

Planned outcomes

1. To identify a level of service that rural cancer patients have a right to expect in the areas of surgical, medical, radiation oncology, palliative care and psychosocial support.
2. To identify areas in which deficiencies are perceived to occur.
3. To outline strategies to redress imbalances of equity and access.
4. To identify areas of knowledge such as epidemiology or world's best practice that are unavailable and commence research to address these.
5. To outline a defined clinical pathway to enhance cancer services.

Conference participants were cognisant of the importance of not disenfranchising primary health care providers in the bush. While they recognised the need to minimise the burden of providing high quality service by subsidising travel, providing appropriate accommodation and psychosocial support, they remained aware that quality of care should not be sacrificed for convenience.

In the recommendations a series of seven key issues that require attention for both regional and rural patients are addressed. There are also issues of national priority.

The key issues are:

- **Transport** and the need to remove inequities in the current IPTAAS arrangements.
- **Improved patient support** including the provision of breast cancer nurses nationally and the need for a cancer nurse demonstration project.
- **Training** and the need for it to be nationally coordinated and funded.
- **Workforce Planning** and the need to implement AWAC recommendations and develop workforce planning for disciplines covering the special needs of rural areas.
- **Networks** and the need to develop national accreditation commencing with chemotherapy services and trialing these standards in all disciplines and the need to develop a regional cancer demonstration project.

- **Epidemiology** and the need to study comparative outcomes in survival, access, psychosocial support and quality of life in rural and urban Australia.
- **Reimbursement** and the need for item numbers for rural services and teleoncology.
- **Issues of national priority** include the need to rapidly make specific cancer drugs available on the PBS, and action to be taken on the Radiation Oncology Strategic Plan and the NCCI utilisation strategy.

It is proposed that the best approach to planning the implementation of the recommendations is to fund taskforces. These groups would initially meet independently for three months and then meet together to finalise a comprehensive document. The model of the consensus guidelines in breast and colorectal cancer would be an excellent guide.

Recommendations

Transport

As patients in rural and regional Australia are currently disadvantaged by IPTAAS it was universally agreed that reform was required.

Recommendations:

- That funding be made available for a national review, using the NBCC model, to identify State differences.
- Following the review, the development of nationally consistent criteria for benefits, especially for prolonged treatment and for accommodation in all specialist centres that provide services.
- Issues of acceptable funding, such as airline sponsorship, should be addressed.

Support

There is a need to enhance patient support not only financially but also psychologically.

Recommendations:

- A pilot study, using the NBCC model, of the role of a cancer nurse as an advocate for rural patients be conducted.
- Quarantined funding be identified for the proven model of breast cancer nurse to be implemented in all regional centres of sufficient size.
- A trial of a 24-hour phone support service.
- Trials of individual and group psychological support.
- The role of teleoncology in the provision of both medical and psychosocial support be studied by commissioning pilots projects in all States.

Training

A key issue in ensuring better training was to have sufficient staff and funding to allow health professionals the opportunity to attend training courses.

Recommendations:

- A nationally coordinated program be developed to establish distance learning packages
- Multidisciplinary workshops
- Academically detailed guidelines
- Funding be made available for staff release, such as nursing positions to allow time away for training
- Funding for rural advanced trainee positions in medical and radiation oncology be identified.

Workforce planning

There are deficiencies in the availability of cancer specialists in regional Australia and strategies to encourage and retain them need to be implemented.

Recommendations:

- A cancer workforce analysis to focus on the implementation of the AMWAC recommendations in relation to radiation and medical oncology.
- Workforce planning for other disciplines that account for the special needs of rural areas such as surgical oncology, oncology nursing, palliative care, allied health and psycho-oncology.

Networks

The interaction between tertiary referral and outreach centres and local health professionals need to be improved. Several strategies were recommended to enhance interaction.

Recommendations:

- Develop national accreditation standards for chemotherapy services.
- Develop palliative community capacity building to increase domiciliary palliative support.
- Develop demonstration projects of a regional centre with outreach clinics, formal links to a tertiary institution, funding for travel in both directions, patient held records and teleoncology.
- Find additional sites in other States to test the shared care model developed in WA.
- Provide funds to create a national register of current cancer services in regional and remote Australia.
- Establish a demonstration multidisciplinary teleoncology clinic.

Epidemiology

It is recommended that a study of outcomes in regional versus urban Australia is commissioned focusing on:

- a comprehensive review of survival in each cancer type
- issues of access, psychosocial support and quality of life.

Reimbursement

Reimbursement is a particularly pertinent issue in dealing with the long distances between patients and their carers. It is recommended that Medicare item numbers be allocated for:

- excessive travel to make palliative care home visits
- teleoncology.

National priorities

On behalf of all cancer patients, rural and urban, the conference concluded there was an urgent need to:

- address the availability on the PBS of widely used palliative care drugs and evidence based chemotherapy
- action the radiation oncology proposals, identified in the National Radiation Strategy planning document and the NCCI's utilisation strategy.

“We should move away from the mantra that country care should be the same as city care – we need innovative models of care that suit residents of rural Australia and deliver for them, equitable services.”

- Professor David Wilkinson

Introduction

“If I were to become a cancer patient, the plain fact is that I would much rather be living in a capital city like Sydney than in some parts of regional Australia where no suitable infrastructure exists.”

- Dr David Goldstein, Medical Oncologist

The idea for the “Cancer in the Bush” conference was proposed by Dr David Goldstein, a Sydney-based medical oncologist who, for the past five years has been providing a weekly outreach clinic to the New England Health Area based at Tamworth Hospital in country NSW. At first hand he has seen the significant disparity between services available in the city and those available in the bush.

The concept was enthusiastically supported by both the president, Professor John Zalberg, and council of the Clinical Oncology Society of Australia (COSA). The conference was then also taken up as a joint activity with The Cancer Council Australia (formerly the Australian Cancer Society). The Cancer Council Australia declared it a priority issue and a steering committee was established. The Commonwealth Department of Aged and Health Care became involved, also made it a priority, and provided guidance and financial support. Macquarie Bank provided sponsorship while Telstra Countrywide and Integrated Vision provided facilities for a telemedicine demonstration.

While several new initiatives in improving service deliveries have begun (see appendix 6) the conference provided an opportunity to gain an overview, better understand the issues facing rural patients and set the agenda to guide future improvements. It was hoped this conference would initiate “a flood of change”. The first step in this process would be providing the Government with practical and constructive recommendations for its program on cancer care in rural and regional Australia.

In officially opening the conference, Dr Michael Wooldridge, Minister for Health and Aged Care, talked of the challenge of distance and the dispersion of Australia’s remote communities. Dr Wooldridge said he firmly believed that so long as the quality of care was not compromised, cancer should be treated and managed in local communities, to avoid dislocation from family, friends and familiar surroundings at what could be an enormously difficult time. “I also believe in the power of such familiar surroundings to assist the recovery process and improve quality of life as treatment progresses,” he said.

The Conference

The two-day conference had three stated aims:

- to gain a more informed understanding of the issues facing rural cancer patients
- to develop proposals aimed at overcoming barriers to equity of access for both clinical and supportive care services outside metropolitan areas
- to identify pathways to better health outcomes for people living in the bush who are diagnosed with cancer.

The organising committee was headed by Dr David Goldstein (convenor) and included broad representation from medical and radiation oncology, nurses, consumers and cancer organisations. More than 120 people, including doctors, nurses, patients, health professionals, administrators and Government representatives attended this tightly organised conference to hear 25 speakers deliver short papers identifying key issues on seven topics:

- epidemiological differences between urban and rural Australia
- the rural perspective
- medical oncology
- radiation oncology
- surgical oncology
- palliative oncology
- Government policy

These were followed by five workshops in which participants helped to draft practical recommendations for medical, surgical, radiation, palliative and psychosocial oncology. These recommendations formed the blueprint for the conference writing committee to prepare a working set of proposals to be discussed at the final conference session.

The next day, the workshop facilitators reported back to the conference and open, lively discussion followed. While participants watched a telemedicine demonstration, the consensus panel finalised recommendations, which were put to the conference in its closing session.

Participants expressed a strong desire to be able to keep in touch with each other and regroup with the aim of maintaining the momentum generated at the conference. To facilitate this, each participant was provided with contact details of all those present. A wish was expressed to reconvene in two years to assess progress and plot future directions.

Senator Grant Tambling, Parliamentary Secretary to the Minister for Health and Aged Care, officially closed the conference saying the Government was committed to improving health services in rural Australia. As a Senator for the Northern Territory, he was familiar with the concerns and needs of people living in rural Australia.

Topic Summaries

Epidemiology: Differences between urban and rural Australia

Little information is available on this subject. Two speakers provided some preliminary data from their studies in South Australia and NSW. There were no comparisons available on morbidity or quality of life, only crude mortality figures.

Survival

Professor David Wilkinson, from the Centre for Rural and Remote Health in Whyalla (SA), provided some evidence for variation in survival. In the South Australian data, country men had consistently lower survival for prostate cancer, there was lower survival for chronic lymphocytic leukaemia and multiple myeloma and a trend to lower survival for acute lymphocytic leukaemia and Hodgkins Lymphoma. There was trend to higher survival for women with cervical and ovarian cancer.

David Smith, of the Cancer Epidemiology Research Unit of The Cancer Council NSW, showed that in NSW there was no significant difference in incidence or mortality between highly accessible or remote populations for all cancers considered together. However, the incidence of lung cancer in women, and prostate, head and neck cancers in men, were significantly higher in the bush.

All cancer patients from the bush had about a 30 per cent excess risk of death at five years compared to all patients from urban NSW. At five years, men in the bush who had pancreatic, head and neck, prostate and rectal cancer had higher relative risks of death compared to their urban counterparts. The same was true for women with cervical cancer in the NSW bush.

Access

Professor Wilkinson noted a grossly inequitable distribution of general practitioner services and said there was a three-fold difference in access to these services between rural and urban areas.

Dr Liz Kenny, from the Queensland Radium Institute, said infrastructure requirements meant radiation oncology services were principally city or regionally based. The minimum population base to support a two machine department was approximately 250,000. From NSW data, it was evident that the utilisation of radiation treatment was region dependent but this was mainly influenced by availability of radiation oncology consultations rather than proximity to linear accelerators. Access was a problem whether the patient was rural or urban based and rural patients in NSW did not appear to be disadvantaged in their use of radiation oncology services.

However, for the country patient, travel and accommodation were major issues. Patients were often away from their homes for up to seven weeks. In some States patients could only get travel and accommodation assistance if they lived more than 200kms from their treatment centre. This was a great burden for country patients. The inequity between States required urgent review.

The rural perspective

While there are numerous disadvantages being a cancer patient in the bush compared to the city, there are some relative advantages. In this segment, speakers described both and offered innovative solutions to overcome disadvantages.

Advantages

A high quality of emotional and social support exists in rural communities, according to Helen Snodgrass, a palliative care and oncology nurse from the Mid Western Area Health Service (NSW). She noted that people volunteered readily and spontaneous cancer support services had often been established in small towns by those who had experienced cancer themselves or had a loved one with the disease.

This had to be seen, however, against the background of changing social demographics in rural communities. Kate White, associate professor of Cancer and Palliative Care at Edith Cowan University (WA), said as rural communities aged and families moved away, fewer people were left to fill voluntary roles. Ms Snodgrass said doctors and nurses in the bush were more proactive in getting things done and tended to be more resourceful.

Results from a national survey of women diagnosed with early breast cancer showed that in many respects the experience of women living in rural areas was similar to that of women in urban areas. Professor Sally Redman, director of the National Breast Cancer Centre, told the conference both rural and urban women with breast cancer are being told their diagnoses over the telephone.

Disadvantages

Jane Redmond made a highly memorable point about rebates for prostheses when she reached inside her blouse, pulled out her breast prosthesis and displayed it to the conference.

"Medicare will give on-going rebates for cosmetic prostheses, like glass eyes, but will not give the same for a breast prosthesis which is far more than cosmetic - it is essential for balance and posture."

- Jane Redmond, Cancer patient and clinical nurse consultant

Just as the smallness and closeness of rural communities makes them more supportive, so it also can make privacy an issue, said Professor White. She noted that special needs of paediatric patients were difficult to meet in the bush and that generally one of the key problems in rural Australia was access to after-hours health care.

Jane Redmond, a cancer patient and a clinical nurse consultant in women's health in Cooma (NSW) said the absence of multidisciplinary teams in the bush meant patients were entirely dependent on the GP. Their journey was determined by the GP they saw on the day, by his or her network, understanding and psychosocial skills, particularly in breaking bad news. Many country GPs did not bulk bill and it was not unusual for patients to wait a week or two for an appointment.

Breast Care nurses did not exist in the bush, Ms Redmond said. Through screening programs women had access to such nurses but as soon as they return to their country homes, they no longer have support on the ground.

The lack of an on-going Medicare rebate for breast prostheses also was a problem. A prosthesis was necessary for balance and posture and being unable to afford one, she said, some country women were improvising with football socks or pouches of birdseed.

Oncology nurses are the unsung heroes of the rural cancer service and usually carry an excessive burden. Ms Snodgrass described how nurses had to be simultaneously “social worker, counsellor, dietician, occupational therapist, VMO’s registrar, health professional’s information source, GP’s sounding board, patient or carer’s best friend and, on a bad day, everybody’s frustrated target as they tried to get what they needed from the wasted brain of the poorly supported oncology nurse”.

Solutions

Ms Sandi McCarthy, nurse, of Toowoomba Hospital (Qld), suggested solutions to isolation and lack of professional support might be found in improved distance education for health professionals in their own communities; specialist outreach services and telemedicine.

Later in the conference, Dr Robert North, a surgeon from Dubbo Base Hospital (NSW), suggested another way of reducing this problem through “inreach” – with a surgeon at a regional hospital bringing in a more remote doctor to assist in an operation on a rural patient. This builds valuable links back to the rural community. At the regional centre there was a need for increased medical and radiation oncology visits, the re-creation of a position for a specialist breast cancer nurse and a palliative care specialist, Dr North said.

Professor White said a palliative care model that could work in a rural setting and could be sustainable long term was the “Pop Up Service” which was based on using existing health care resources in a new and coordinated way when a cancer or palliative patient required it, as opposed to creating a specified cancer palliative care service in each town. Work was underway on this model in WA.

To help rural patients receive treatment in their own communities, planning of pathways of service must be done at a senior level, according to Dr Hayden Baillie, general practitioner of Port Lincoln (SA). Pathways should link tertiary and rural centres making use of new technologies such as telemedicine, on-line pathology, digital email and teleradiology. Time needed to be allocated for teleconferences at which fee-for-service doctors could attend.

Kim Hardwick, the coordinator of the Cancer Shared Care Project at Sir Charles Gairdner Hospital (WA), described another solution, a model of care, shared between general practitioners and specialists in haematology, that encouraged the patient to be an active participant in decision making. One of the key outcomes of this project was the development of a patient held record.

Rather than impose a “hub and spoke” model or introduce breast care nurses, Dr Sue Robertson, a country general practitioner from Hamilton (Vic) made a case for building on local services. She suggested better use of communication technology and a travel allowance to cover expenses of doctors and district nurses needing to travel out of town particularly to deliver palliative care. Dr Robertson also supported the establishment of single machine radiation oncology centres in small towns because of the ease of access, particularly in the case of palliative radiation.

Clinical Services

Medical Oncology Services

The vast majority of medical oncologists are based in metropolitan or major regional centres. In 1999, 85 per cent of medical oncologists had their practices located in a capital city, with a further 10 per cent in metropolitan cities and large rural centres and four per cent in small rural or remote areas. Outreach clinics from major metropolitan or rural centres provided services in some other areas.

Optimal medical oncology practice requires careful assessment of patients before, during and after cytotoxic drug treatment. Where an outreach service is provided to a rural area, the visiting medical oncologist normally prescribes the chemotherapy regime and reviews the patients on subsequent visits, but the responsibility for the administration of these drugs is delegated to local medical practitioners and nurses who provide a part time service. In many cases, such a medical oncology outreach service is motivated by individual enthusiasm and is conducted in an ad hoc manner.

Dr Geoffrey Beadle, medical oncologist at the Royal Brisbane Hospital (Qld) and Dr Craig Underhill, a medical oncologist at Border Medical Oncology, Albury Base Hospital (NSW) compared the advantages and problems of outreach and regional cancer centres.

Describing the advantages of properly performed outreach, Dr Beadle said it could provide a more convenient service for patients and the possibility of regular attendance, and bring skills and technology to the community.

The disadvantages included: the prescribing medical oncologist was not at the treatment interface, there was no possibility of holistic care, extra time and effort were spent in communication, an increased likelihood of errors in cytotoxic drug delivery, increased legal exposure and a lack of remuneration for the extra effort required.

A systematic approach was necessary to optimise a high quality service. He said Government policy should recognise and finance outreach services as an area of need for the rural community.

Dr Underhill described the benefits of moving from an outreach clinic at Albury-Wodonga to a regional cancer centre. The benefits were a substantial increase in the number of new patients able to be treated, from 150 a year to 750; an eight-fold increase in chemotherapy day treatments; the establishment of a clinical trials unit; and the availability of dedicated oncology pharmacists and a two machine radiotherapy service. He said certain tumour types and surgical oncological procedures were not treated on site but referred to specialist units in the city. He cautioned that technology should not be viewed as a cheap solution to avoid the establishment of regional cancer centres that would provide a better service than outreach clinics. Metropolitan centres should support regional centres rather than attempt to replace them. Barriers to progress included lack of funding, access to training, access to allied health services, access to psychosocial support and locum relief.

Radiation Oncology Services

“Some country women just can’t afford to be away from their farms and families for six or seven weeks to have radiotherapy so they forgo a lumpectomy. A mastectomy is simply more manageable.”

- Dr Sue Roberston, General Practitioner

Earlier in the conference Dr Liz Kenny noted there was a well-documented national crisis in the provision of radiation oncology services that affected rural and non-rural Australians alike. Waiting lists were commonplace in most public departments, with some patients waiting up to six weeks. In some this could compromise cure.

Dr Craig MacLeod, Radiation Oncologist, Murray Valley Radiotherapy, Albury-Wodonga and Dr Christopher Milross, radiation oncologist at the Prince of Wales Hospital (NSW), discussed the role of regional radiation oncology and outreach service provision from major centres.

Dr MacLeod said it was not yet clear which model was optimal for providing radiotherapy to the bush. The three main options were: having all patients brought to capital cities, having large regional centres with two or three linear accelerators providing service to smaller towns or having many small country centres.

“Establishing a regional radiotherapy centre has additional benefits not only for cancer patients, but for the local community as well. It provides jobs, training, investment opportunities and builds community spirit.”

- Dr Craig MacLeod, Radiation Oncologist

Single machine units were the most expensive to build and run. By contrast, optimal utilisation of radiotherapy could be achieved in the country by regular outreach clinics from either well-resourced city hospitals or large regional centres such those in as Geelong and Townsville. Both models required access to an outreach clinic.

The problems of rural radiation included higher delivery costs, staff acquisition, ensuring long-term quality, the potential clash with current outreach services and community expectations.

Dr Milross suggested a centralised system of radiotherapy together with an organised satellite clinic program could provide equitable service delivery and improved survival for cancer patients. There was a need to be concerned not only with providing acceptable access but also with providing the best possible radiotherapy.

Palliative Care Services

Each year, small numbers of cancer patients die in rural communities. While local doctors have too many responsibilities to make palliative care their only priority, there often are strong local community support networks.

Issues

Dr Will Cairns, Director of Palliative Care Services, Townsville General Hospital and President of the Australian and NZ Society of Palliation Medicine, believes people like to die in their home community, if not actually at home. Compared to those in the city, country people have different attitudes to death and dying. They were more accepting of the reality of limitations of cure, less likely to pursue futile treatment, and appeared more accepting of death and dying. This could be because they were exposed to the whims of nature and death in day to day life, and had fewer illusions of control.

Dr John Troller, Director of Palliative Care, New England Health Area Service (Tamworth, NSW), noted that problem areas for palliative care in the bush included distance, smallness, isolation, sole practitioners, shared roles, home services, after hours care, respite in the home, bereavement support, fixed palliative care funding and old time attitudes.

Solutions

To help rural people die in their communities, Dr Cairns said a realistic assessment of the probability of this happening was needed, followed by early, open discussions with the patient and family. Planning and collaboration was needed between oncologists, palliative care specialists, rural health workers and the family.

Through early referral to palliative care services in a tertiary centres there could be an assessment of the level of support required and arrangements made for necessary equipment. Symptom management and psychosocial issues could be addressed and liaison established with the home community. There was a need for networks of palliative care, with tertiary oncology centres having in-house palliative care service and formal relationships with their referral catchments.

Surgical Oncology Services

Ten percent of Australians could currently be classed as living in rural and remote, as opposed to regional and metropolitan, areas of Australia. The old problems associated with “tyranny of distance” have not changed and while many accept the need to travel for an assessment of their cancer and for some treatment, they would prefer to have as much as possible near home.

In this program segment issues of general, specialised and super-specialised cancer surgery were examined.

Two general surgeons describe a “hub and spoke” model where it is possible to perform general cancer surgery in a regional centre or hub providing there is good medical, radiation and nursing oncology support and providing there is outreach to remote communities. Some tumours and surgical procedures had to be referred to urban centres.

A specialist breast cancer surgeon described how it was equally possible for him to operate in a regional hub providing all the support infrastructure was in place. However, super-specialised surgery, such as gynaecological oncology, had to be performed in a major urban centre where a full and specialised multidisciplinary team was available.

Issues

In rural and remote areas, multidisciplinary care requires a high level of communication and collaboration. While the general practitioner often has a key role in supporting the patient and coordinating care, there is also a role for a designated care coordinator to act as a patient advocate and confidant. This might be a local oncology nurse, the GP or the primary surgeon.

Dr Tony Green, Chairman, DG Rural Surgeons of the Royal Australian College of Surgeons Atherton Specialist Medical Centre (Qld) described the “hub and spoke” model used by Atherton Hospital for the delivery of multidisciplinary assessment and care.

In the hub, diagnostic tests and staging of the cancer occurred and some aspects of treatment, particularly radiation therapy were performed. The spokes were the outreach services to nearby centres, providing ongoing follow-up of patients by the primary care physician (GP) or the treating surgeon. Such a model had the potential to promote education and upskilling of the medical staff on the ground and could provide an ongoing back up advice service whenever necessary. Dr Green said the rural or remote centre could provide most initial treatment, usually surgery or chemotherapy and even adjuvant post-operative chemotherapy if there was appropriate hub support.

Dr Bob North, a general surgeon at Dubbo Base Hospital (NSW) since 1968, gave the conference a detailed description of the logistics, frustrations and difficulties of providing oncology services in the bush, from the lack of secretarial help to the conflict in funding that existed between the State and Commonwealth and between the State and the base hospital and a private hospital. He provided a similar model of Dubbo as a hub and flagged the new concept of “inreach”, where doctors are brought from the bush to assist in the operations on their patients at regional centres.

“This person really created a revolution for me in my practice, and I was amazed at the response of patients to her and the problems that she solved.”

- Dr Robert North, Surgeon (on the loss of the specialist breast cancer nurse in the area)

Specialist breast surgeon, Dr Frank Sardelic from Tamworth (NSW), described a model for specialising in an area of cancer surgery in a regional setting. This required the support and help of colleagues. For breast cancer surgery it meant access to a screening program, diagnostic mammography and ultrasound, adequate pathological and cytological services and multidisciplinary care. Given the smaller caseload, subspecialisation in breast cancer surgery was only practical in a major regional centre. Voluntary division of labour with regards to the local surgical community was vital to allow greater concentration of cases for the interested surgeons. Appropriate supportive services and surgical supports were critical.

Dr Greg Robertson, a gynaecological oncologist at the Royal Hospital for Women in Sydney, said this branch of gynaecology had been recognised as an area of sub-specialisation within the Royal Australian and New Zealand College of Obstetricians since the late 1980s and most women were referred to one of the 25 gynaecological oncologists working in the 11 major city-based centres. Improved overall and disease-free survival statistics supported this. A recent prospective study conducted in Scotland showed that among women with Stage III ovarian cancer, survival was longest among those whose surgery was performed by a gynaecological oncologist rather than other gynaecologists or surgeons.

Dr Robertson said the current model of care for rural patients was based on geographical lines of referral underpinned by communication at a tertiary level between the referring gynaecologist and the gynaecological cancer centre. All patients were discussed at a multidisciplinary peer review forum then referred back to their home town for ongoing management such as chemotherapy or to a regional radiotherapy centre if required. Post-surgical patients were managed by the referring gynaecologist on discharge.

Difficulties encountered by such rural patients included dislocation from community support, difficulties with care of dependents and costs of travel. All were recognised and limited as much as possible. On site accommodation was increasingly available and allowed relatives to be close at hand.

Government policy overview

Socio-economic status has a significant impact on cancer in Australia. Most mortality gains are due to protective behaviours, which are invariably taken up more readily by the better educated and better off. The impact of socio-economic inequality is particularly apparent in rural Australia.

Professor Bruce Armstrong, Chair of the Cancer Strategies Group, told the conference that cancer control planning remains firmly on the national agenda in Australia. The approach being taken is not comprehensive but selective, based on priorities. It is supported by the recent experience of the plan developed by the National Cancer Control Initiative (NCCI) – *Cancer Control towards 2002* – that recommended 13 priority actions after a process that was open to all comers. Just four years later, substantial new action has been taken in 10 of these 13 areas. It's too early to tell what the health outcomes will be, but things look promising, Dr Armstrong told the conference.

In developing *Priorities for action in cancer control 2001-2003*, the Commonwealth's Cancer Strategies Group took a similar approach and sent 13 recommended priorities for action out for public comment. These priorities were developed from high priority items considered by the NCCI but not included in the top 13 and others advanced in a national stakeholder workshop conducted in 1999. Briefly, they are:

- Continuing national tobacco media campaigns
- A national Sun Smart campaign
- Increasing intake of fruit and vegetables through a national campaign
- Introducing a national FOBT screening program for colorectal cancer
- Increasing cervical screening efficiency by increasing interval from 2 to 3 years
- Increasing the efficiency of skin cancer control by increasing the accuracy of general practitioner diagnosis of skin lesions
- Rationalising PSA testing through national GP and public education
- Reorganising breast cancer management to ensure seamless continuity of care from screening through to follow-up care
- Improving ovarian and lung cancer outcomes by ensuring rapid assessment at multidisciplinary specialist centres
- Developing, implementing and maintaining management guidelines
- Improving psychosocial care through provision of breast cancer nurses Improving psychosocial care through psychologists in cancer services
- Developing and implementing guidelines for palliative care.

In developing these priorities, consideration was given to initiatives that would increase quality of life as well as extend life, and in selecting those to be recommended impacts on the equity of distribution of the burden of cancer were explicitly considered.

Priorities for action in cancer control 2001-2003 is being revised in the light of comments and advice received and will be sent to the National Health Priorities Action Council, the "parent body" of the Cancer Strategies Group, for consideration for implementation.

Decisions about the provision of cancer services in rural and remote areas – such as what services are provided, where they are provided and how they can be sustained – reflected a range of vested interests, Dr John Best, of Diagnostics Pty Ltd told the conference. Communities often determined their needs from the base of personal experience – the particular medical condition being experienced by an individual at the time may set the priorities.

“Individuals within communities often generalise the needs of the community around their personal priorities. Thus, a small community may seek tertiary level services on this basis, notwithstanding the reality that the service would be unsustainable. This is not a new phenomenon; it simply reflects the desire to provide the best health care to everyone.”

- Dr John Best

The difficulty in Australia however, was working in a country where 2 million Australians live in settlements of less than 200 people; and there were approximately 10,000 of these settlements. There were 1500 settlements with a population of between 200 and 5,000. Larger settlements (with populations of between 48,000 and 249,999) such as Albury/Wodonga, Ballarat, Geelong and Toowoomba were essentially urban. These ARIA* Class B cities (which also include Darwin, Hobart and Launceston) increasingly emulated the workforce in the cities where the population was 300,000 plus in that there was recruitment of sub-specialists and a decline in the number of general specialists, together with the gradual elimination of general practitioners from the hospitals. There was significant difficulty recruiting specialists resulting in “fly-in fly-out” specialist services that did not leave any expertise on the ground. A dispersed population and a disease treated in a specialised environment represented a particular challenge to health planning.

Dr Best said the planning framework needed to be established to maintain the core of specialist expertise outside metropolitan areas so that a greater proportion of the rural population requiring treatment could access those services. Initiatives such as the establishment of rural clinical schools and university departments of rural health encouraged professional opportunities in rural and remote areas. This did not suggest economically and clinically unsustainable services such as single unit radiation in multiple small communities be created, but rather the development of expertise to manage a greater proportion of acute episodes, chronic conditions and palliation in a sustainable manner.

** Accessibility/Remoteness Index of Australia developed by the National Centre for Social Applications of Geographic Information Systems (GISCA)*

Telemedicine in rural and remote oncology

Presentation by Professor Ian Olver

Clinical Director, Royal Adelaide Hospital Cancer Centre (SA)

The management of cancer has become increasingly multidisciplinary. An effective way of planning patient management is to hold regular multidisciplinary team meetings.

There can be a disadvantage to patients who have cancer, who live in remote or small centres that do not have the full complement of cancer specialists.

A videoconferencing link was established between the Royal Adelaide Hospital cancer Centre and the Royal Darwin Hospital and evaluated. All clinicians found the telemedicine link to be either useful or very useful in at least one aspect of their practice. The major benefit was cited as enabling remote area clinicians to participate in multidisciplinary cancer meetings.

Three of the five remote clinicians who practiced solely in the Northern Territory found that the telemedicine consultation increased their workload, while only two of 13 clinicians who practice solely in South Australia reported an increase over their normal activities, the others reporting no difference.

Benefits identified included better support of isolated clinicians, decreased travel for patients, and enhanced education and peer review. Perceived difficulties were technical problems, the impersonal nature of the interaction, inability to examine the remote patient and lack of reimbursement for the consultation.

Seven of the eight patients surveyed were satisfied or very satisfied with the telemedicine consultation. Four patients wished to have access to video tapes of the multidisciplinary meeting. Of those requiring travel for treatment, all believed that the prior telemedicine consultation influenced their care and shortened their time away from home.

The future will see more teleradiology and telepathology and POTS teleoncology links between patients at home and their clinicians in hospital.

Issues

Professor Olver noted that while small desktop cameras for personal computers and Internet conferencing could be used, and would indeed be cheaper and easier than ISDN telemedicine equipment, he personally has had difficulty with their reliability and quality. He has found that people are actually not using Internet conferencing extensively in the medical field even if they find it preferable.

From the telemedicine perspective in rural health two outstanding legislative issues are barriers to its widespread use:

- Reimbursement for telemedicine and multidisciplinary conference
- The need to be registered in multiple States.

Cancer in the Bush

Optimising Clinical Services

Appendices

- 1 Meeting Program
- 2 List of Registrants
- 3 Presentations
- 4 Workshop Reports
- 5 Opening & Closing Addresses
- 6 Media Releases
- 7 New Initiatives in Improving Cancer Services
- 8 Website References

Appendix 1: Meeting Program

THURSDAY 8 MARCH

- 8:30-8:35 **Opening Ceremony**
Welcome by Convenor - Dr David Goldstein
- 8:35-8:45 **Opening Remarks**
The Hon Dr Michael Wooldridge MP
Minister for Health and Aged Care
- Epidemiology: Differences between Urban & Rural Australia**
- 8:45-9:00 Prof David Wilkinson, Centre for Rural & Remote Health - Whyalla, SA
- 9:00-9:10 Mr David Smith - The Cancer Council of New South Wales
- 9:10-9:20 Dr Liz Kenny - Queensland Radium Institute - Brisbane, Qld
- 9:20-9:25 **Questions**
- The Rural Perspective**
- 9:25-9:35 Ms Jane Redmond , BCNA Nominated Consumer - Cooma, NSW
- 9:35-9:50 Prof Kate White, Edith Cowan University - Perth, WA
- 9:50-10:00 Ms Helen Snodgrass, Mid Western Area Health Service - Orange, NSW
- 10:00-10:10 Prof Sally Redman, National Breast Cancer Centre - Sydney, NSW
- 10:10-10:20 Ms Sandi McCarthy, Toowoomba Hospital - Qld
- 10:20-10:30 Dr Sue Robertson, Hamilton Medical Group - Hamilton, Vic
- 10:30-10:40 Dr Haydn Baillie – Port Lincoln, SA
- 10:40-10:50 Ms Kim Hardwick, Haematology Cancer Patient Shared Care Project -
Perth, WA
- 10:50-10:55 Questions
- 10:55-11:05 Coffee Break
- Medical Oncology Services**
- 11:05-11:15 Dr Craig Underhill - Wodonga, Vic
- 11:15-11:25 Dr Geoff Beadle, Royal Brisbane Hospital - Brisbane, Qld
- 11:25-11:30 Questions
- Radiation Oncology Services**
- 11:30-11:40 Dr Craig MacLeod - Wodonga, Vic
- 11:40-11:50 Dr Chris Milross, Prince of Wales Hospital - Randwick, NSW
- Palliative Care Service**
- 11:50-12:00 Dr John Trollor, Base Hospital & Health Centre - Tamworth, NSW
- 12:00-12:10 Dr Will Cairns - Townsville, Qld
- Surgical Oncology**
- 12:10-12:20 Dr Tony Green - Atherton, Qld
- 12:20-12:30 Dr Bob North - Dubbo, NSW
- 12:30-12:40 Dr Frank Sardelic - Tamworth, NSW

12:40-12:50 Dr Greg Robertson, Royal Hospital for Women - Randwick, NSW

THURSDAY 8 MARCH

12:50-1:00 Questions

1:00-1:15 Summing Up

1:15-2:00 Lunch

Government Policy Overview

2:00-2:15 Prof Bruce Armstrong AM, Chair Cancer Strategies Group - Sydney, NSW

2:15-2:25 Dr Brendon Kearney, Department of Human Services - Adelaide, SA

2:25-2:35 Dr John Best, Diagnosis Pty Ltd - Sydney, NSW

2:35-2:50 Questions

2:50-3:00 Move to workshop rooms

Workshops

3:00-6:00 Medical Oncology

Facilitator: Dr Fran Boyle

3:00-6:00 Radiation Oncology

Facilitator: Dr Liz Kenny

3:00-6:00 Palliative Care

Facilitator: Prof David Currow

3:00-6:00 Surgical Oncology

Facilitator: Prof Bob Thomas

3:00-6:00 Psychosocial Issues

Facilitator: Prof Phyllis Butow

FRIDAY 9 MARCH

Presentation of Workshop Conclusions & Recommendations

8:00-8:20 Medical Oncology Chair: Dr Fran Boyle

8:20-8:40 Radiation Oncology Chair: Dr Liz Kenny

8:40-9:00 Surgical Oncology Chair: Prof Bob Thomas

9:00-9:20 Palliative Care Chair: Prof David Currow

9:20-9:40 Psychosocial Issues Chair: Prof Phyllis Butow

9:40-10:00 Open Discussion

10:00-10:30 Coffee Break

10:30-11:30 Telemedicine Demonstration

Prof Ian Olver, Royal Adelaide Hospital - Adelaide, SA

10:00-11:30 Consensus Panel Meets

11:30-12:30 Presentation of Conference Report & Recommendations

12:30-12:45 **Closing Remarks**

Senator Grant Tambling

Parliamentary Secretary to the Minister for Health and Aged Care

Appendix 2: List of Registrants

Ms Liz Abell
Manager, CIS
Anti-Cancer Foundation of SA
UNLEY SA

Dr Steve Ackland
Oncology Unit
Newcastle Mater Hospital
WARATAH NSW

Prof Bruce Armstrong AM
Director Research
Cancer Research & Registers
Division
The Cancer Council NSW
KINGS CROSS NSW

Dr Haydn Baillie
Investigator Clinic
PORT LINCOLN SA

Ms Susanne Baxandall
Unit Director, PSDU
Anti-Cancer Council of
Victoria
CARLTON VIC

Dr Kirsty Baxter
Policy Officer
Dept of Human Services -
Acute Health Div
MELBOURNE VIC

Dr Evan Bayliss
Medical Oncologist
Department of Medical
Oncology
Royal Perth Hospital
PERTH WA

Dr Geoff Beadle
Wesley Medical Centre
Wesley Hospital
AUCHENFLOWER QLD

Dr John Best
Diagnosis Pty Ltd
BALMAIN NSW

Dr John Birss
President
Rural Doctors Association of
South Australia
PETERBOROUGH SA

Mrs Phoebe Bishoff
Country Women's Association

GRIFFITH NSW
Dr Rodney Bond
Medical Oncologist
Ballarat Oncology Services
BALLARAT VIC

Dr Fran Boyle
Department of Clinical
Oncology
Royal North Shore Hospital
ST LEONARDS NSW

Mr Graeme Brien AM
Executive Director
Queensland Cancer Fund
SPRING HILL QLD

Dr Ivon Burns
Medical Oncologist
St Vincent's Hospital
FITZROY VIC

Prof Phyllis Butow
Medical Psychology Unit
University of Sydney
CAMPERDOWN NSW

Dr Will Cairns
Townsville Palliative Care
Service
Townsville General Hospital
TOWNSVILLE QLD

Ms Kate Cameron
Doctoral Candidate
Adelaide University
ADELAIDE SA

Prof Alan Coates
Chief Executive Officer
Australian Cancer Society
SYDNEY NSW

Ms Lesley Cooper
Manager, Support &
Information Services
Cancer Council of Tasmania
LAUNCESTON TAS

Ms Dee Crotty
Midwife, Breast self-
examination
QUILPIE QLD

Mrs Meredith Cummins
Clinic Nurse Specialist
Oncology Clinic

Wagga Wagga Base Hospital
WAGGA WAGGA NSW
Prof David Currow
Palliative Care
Daw Park Hospice
DAW PARK SA

Ms Lauren Dalton
National Breast Cancer
Centre
KINGS CROSS NSW

Mrs Pauline Denton
North West Regional Hospital
BURNIE TAS

Mrs Syliva Dolphin
Lock CH&WC
LOCK SA

Dr Jennifer Donovan
Royal North Shore Hospital
ST LEONARDS NSW

Ms Margaret Duckett
The Cancer Council NSW
KINGS CROSS NSW

Dr Kerry Dunbabin
Cancer Screening & Control
Services
HOBART TAS

Dr Jeff Dunn
Queensland Cancer Fund
SPRING HILL QLD

Dr Mary Dwyer
Department of Radiation
Oncology
Westmead Hospital
WESTMEAD NSW

Dr Eric Fairbank
The Cambourne Clinic
WARRANAMBOOL VIC

Miss Jennifer Fawcett
Roche Products
DEE WHY NSW

Mrs Dianne Foster
Breastscreen NSW South
West
WAGGA WAGGA NSW

Ms Andrea Franke

MORUYA NSW

Ms Dianne Fraser
National Palliative Care
Program
Department of Health and
Aged Care
CANBERRA ACT

Mr Peter Gilbar
Snr Pharmacist -
Oncology/Pall Care
Toowoomba Health Services
TOOWOOMBA QLD

Dr David Goldstein
Dept of Medical Oncology
Prince of Wales Hospital
RANDWICK NSW

Dr Tony Green
Atherton Specialist Medical
Centre
ATHERTON QLD

Ms Kim Hardwick
Cancer Shared Care Project
Coordinator
Sir Charles Gairdner Hospital
NEDLANDS WA

Mrs Sally Harrold
Look Good . . . Feel Better
BAY VILLAGE NSW

Ms Carmel Haynes
Snr Project Officer, Acute
Health, Grampians Region
Dept of Human Services
BALLARAT VIC

Dr Jane E Hill
Wagga Wagga Base Hospital
WAGGA WAGGA NSW

Mrs Christine Holt
ICPA, Mainouru Station
KATHERINE NT

Ms Benedicte Houfflain
Cairns Base Hospital
TRINITY PARK QLD

Dr Paul Ireland
National Control Initiative
CARLTON VIC

Dr Michael Jackson
Radiation Oncology
Royal Prince Alfred Hospital
CAMPERDOWN NSW

Ms Rebecca James
Consultant
ASHBURTON VIC
Dr Peter Jeal
Townsville General Hospital
TOWNSVILLE NSW

Ms Valerie Johnson
Manager Service
Development
Breastscreen Victoria
CARLTON VIC

Ms Jane Jones
Project Mgr - NBCC
Barwon - South Western
Region
GEELONG VIC

Prof Brendon Kearney
Director, Statewide Division
Dept of Human Services
ADELAIDE SA

Dr Liz Kenny
Dean, Faculty of Radiation
Oncology
BROOKFIELD QLD

Prof Kerry Kirke AM
Executive Director
Anti-Cancer Foundation of
South Australia
UNLEY SA

Dr Alan Kline
VMO
Shoalhaven Hospital
NOWRA NSW

Dr Rosemary Knight
Director Health Priorities
Asthma and Cancer Control
Dept of Health and Aged Care
CANBERRA CITY ACT

Mrs Felicity Lehmann
Rural Consumer
Cancer Voices
TEMORA NSW

Dr Rodney Lynch
Radiation Oncologist
Andrew Love Cancer Centre
GEELONG VIC

Dr Craig MacLeod
Dept of Radiation Oncology
Albury Wodonga Health
Service
WODONGA VIC

Ms Franca Marine
C/- Royal Australian College
of Physicians
SYDNEY NSW
Ms Sandie McCarthy
Toowoomba Hospital
TOOWOOMBA QLD

Mr John McCleary
Director, Breastscreen NSW
Central & Western
ORANGE NSW

Ms Kerrie McFarland
Clinical Nurse Consultant
Oncology/Haematology
Port Macquarie Base Hospital
PORT MACQUARIE NSW

Ms Nicole McGinn
Manager, CIS
ACT Cancer Society
JAMIESON CENTRE ACT

Ms Kathy Meleady
NSW Health Department
NORTH SYDNEY NSW

Dr Craig Milross
Dept of Radiation Oncology
Prince of Wales Hospital
RANDWICK NSW

Mrs Frances Mitchell
Community Nurse
GMHS
WEST WYALONG NSW

Dr Graeme Morgan
Radiation Oncologist
St Vincent's
Hospital/University of NSW
ROSEVILLE NSW

Ms Jennifer Muller
Manager, Qld Health
Women's Cancer Screening
Services
BRISBANE QLD

Ms Kay Murray
Project Coordinator, Qld
Health
Women's Cancer Screening
Services
BRISBANE QLD

Ms Ellen Nightingale
Director, Cancer Services
Cancer Foundation of
Western Australia

SUBIACO WA

Dr Bob North
Surgeon
DUBBO NSW

Ms Lera O'Connor
Cancer Support Groups
Coordinator
Anti-Cancer Council of Vic
CARLTON VIC

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Director Medical Oncology
Royal Adelaide Hospital
ADELAIDE SA

Dr Helen Paull
Radiation Oncology Registrar
Royal Adelaide Hospital
PERTH WA

Dr Nick Pavlakis
Medical Oncology Staff
Specialist
Sydney University (RNSH)
CHATSWOOD NSW

Ms Adrienne Pearson
Community Develop &
Volunteer Mgr
Leukaemia Foundation NSW
MOSMAN NSW

Mrs Joanne Pearson
Director Nursing Services
Bowral Diagnostic Centre -
O/P Chemo
BOWRAL NSW

Dr Michael Penniment
Consultant/Staff Specialist
Rad Onc, Royal Adelaide
Hospital Oncology
ADELAIDE SA

Ms Sue Perrot
North Queensland Oncology
Service
GARBUTT EAST QLD

Ms Susan Perryman
Oncology & Palliative Care
Nurse, Bega
Oncology/Haematology Unit
BEGA NSW

Ms Nancye Piercy
Chief Executive Officer
Wagga Wagga & District Div
of Gen Practice
WAGGA WAGGA NSW

Mrs Jenny Pitman
ICPA
CORRIGAN WA

Dr Robert Porter
Mid North Coast Areas Health
Service
PORT MACQUARIE NSW

Ms Gabrielle Prest
Leukaemia Foundation NSW
MOSMAN NSW

Ms Alison Pryor
Senior Social Worker
Liverpool Health Service
Cancer Therapy Centre
LIVERPOOL NSW

Ms Sue Purtell
Cancer Screening Section
Department of Health and
Aged Care
CANBERRA ACT

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National Breast Cancer
Centre
WOOLLOOMOOLOO NSW

Prof Sally Redman
Director
National Breast Cancer
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WOOLLOOMOOLOO NSW

Ms Jane Redmond
Southern Area Health Service
Cooma Community Health
COOMA NSW

Mr Lawson Ride
Cancer Council of Tasmania
HOBART TAS

Dr Greg Robertson
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RANDWICK NSW

Dr Sue Robertson
Hamilton Medical Group
HAMILTON VIC

Dr William B Ross
Coffs Harbour Base Hospital
COFFS HARBOUR NSW

Dr Frank Sardelic

TAMWORTH NSW

Dr Sid Selva-Nayagam
Royal Darwin Hospital &
Darwin Private Hosp
CASUARINA NT

Mrs Robyn Simes
Clinical Nurse Specialist
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Wagga Wagga Base Hospital
WAGGA WAGGA NSW

Mr Mark Simpson
Radiation Oncology
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Royal Adelaide Hospital
ADELAIDE SA

Dr Isabella Smith
NSW Department of Health
NORTH SYDNEY NSW

Mr David Smith
Cancer Epidemiologist
Cancer Rsch & Regs Div
The Cancer Council NSW
WOOLLOOMOOLOO NSW

Ms Helen Snodgrass
ORANGE NSW

Mr John Stephenson
Country Manager
The Cancer Council NSW
TAMWORTH NSW

Dr Margaret Stevens
Cancer Foundation of WA
WEST PERTH WA

Mrs Mary Templar
Country Women's Association
ULVERSTON TAS

Prof Bob Thomas
Dept of Surgical Oncology
Peter MacCallum Cancer Inst
A'BECKETT STREET VIC

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TAMWORTH NSW

Dr Mary Boyd Turner
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Department of Human
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MELBOURNE VIC

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Dr Craig Underhill
Border Medical Oncology
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WODONGA VIC

Mrs Heather Wain
Retiring Director of Social
Work
MAWSON ACT

Ms Cathy Wall
Department of Health and
Aged Care
CANBERRA CITY ACT

Mrs Joy Weller
Country Women's Association
LOCKINGTON VIC

Prof Kate White
School of Nursing & Public
Hlth
Edith Cowan University
CHURCHLANDS WA

Prof David Wilkinson
SA Centre for Rural & Remote
Hlth
University of South Australia
WHYALLA NORRIE SA

Dr David Wood
ALBANY WA

Ms Patsy Yates
School of Nursing
Qld University of Technology
KELVIN GROVE QLD
Dr Eric Yeoh
Director, Radiation Oncology
Royal Adelaide Hospital
ADELAIDE SA

Dr Desmond Yip
Staff Specialist in Medical
Oncology
The Canberra Hospital
WODEN ACT

Prof John Zalcborg
Dept of Medical
Oncology/Haematology

Appendix 3: Presentations

Epidemiology – The Difference Between Urban & Rural Australia

The Rural Perspective

Medical Oncology Services

Radiation Oncology Services

Surgical Oncology Services

Palliative Care Services

Government Policy Overview

Telemedicine in Rural & Remote Oncology

Epidemiology: The Difference Between Urban and Rural Australia

1. *Cancer Epidemiology: Urban – Rural Differentials?*

Professor D Wilkinson, South Australian Centre for Rural & Remote Health

Does cancer risk, morbidity and mortality differ in the country compared with the city?

Data: SA Health Monitor, SERCIS and Health Omnibus, 1995-2000, SA Cancer Registry, ABS Mortality data, Census data: GPs

SA Health Monitor etc

- **Ever had cancer**

	1999	2000
City	3.2%	5.6
Country	3.9	4.4

- **Major cancers (cervical, breast, prostate)**
No significant self-reported difference country vs city

- **Smoker (at all, ever regular, current)**

City	18%	35	18
Country	23	39	14

- **Alcohol (non-drinker)**

City	17	Country	18
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Skin cancer

- **Tan type (burn/red)**

City	48%	Country	46%
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- **Sore / tender sun burn (no)**

City	70%	Country	68%
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- **Wear hat mid-day / sunscreen (always)**

City	36%	40
Country	40	35

Screening

- **Pap smear: 83% city vs 88% country had smear in 1995**

- **Mammogram: 38% and 39%**

Cancer registry- treatment

- **Testicular, prostate, cervical, lung, colon, rectal: no significant differences in treatment modality**

- **Breast cancer: more radiation and chemotherapy, but less hormonal therapy in the country**

Cancer registry-survival

- **Lung, rectal, colon, NHL, brain, testicular: equal survival**

- *CLL, MM: lower survival in country*
- *Cervical, ovarian: trend to higher survival in country*
- *ALL, HL, trend to lower survival*
- *Prostate: consistently lower survival*

Cancer in the country

- *No evidence for systematic differences in frequency*
- *No evidence for systematic differences in KAP, major risk factors, behaviours*
- *Evidence for variation in mortality (not rural)*
- *No evidence for inadequate treatment*
- *Some evidence for variation in survival*

What next?

- *Efforts to reduce cancer frequency*
- *Increase further KAP*
- *Prevention, screening and treatment in the country*
- *Models of care that suit country Australia*
- *Move away from “country care must be same as city care”*

2. Incidence, Mortality and Survival in New South Wales

Dr D Smith, Cancer Epidemiology Research Unit, The Cancer Council NSW

Introduction

- This paper presents a description of the epidemiology of cancer in New South Wales according to the Access and Remoteness Index of Australia (ARIA). It describes differences in outcomes between urban and rural populations.

Method

- Data were obtained from NSW Cancer Registry for all newly diagnosed cases of cancer and all deaths between 1992-1996
- Survival data were obtained for all people newly diagnosed with cancer in 1992 to 1996, followed up to the end of 1999.
- Measures of age-standardised incidence, age-standardised mortality, percent of people with localised disease and five-year relative survival were calculated
- The Access/Remoteness Index of Australia was used to allocate case to “Remoteness” group based on Local Government Area of residence at diagnosis
- Data for the 20 most common types of cancer are presented

Results

- There was no significant difference in either incidence or mortality between highly accessible or remote populations for All Cancers considered together.
- The incidence of cancers of lung (female), prostate and head and neck (male) were significantly higher in the bush than in urban areas of NSW.

- The mortality from cancers of the cervix and prostate were significantly higher in the bush than in urban areas of NSW.
- Patients from the bush with prostate cancer or stomach cancer were more likely to present with non-localised disease compared to patients from urban areas, for all other cancers there were no differences between these groups.
- Cancer patients (all cancers) from the bush had approximately 30% excess risk of death at five years compared to patients from urban NSW.
- Patients from the bush with cancers of the pancreas (males), head and neck (males), prostate, cervix and rectum (males) had higher relative risks of death at five years compared to patients from urban NSW.

3. Cancer in the Bush - Radiation Oncology **Dr L Kenny, Queensland Radium Institute**

Utilisation

- The current national benchmark for the utilisation of radiation treatment is 50-55%.
- During 2000 the utilisation of radiation treatment was 38% averaged across Australia.
- The consequence of this is that 10,000 Australians, who would have otherwise benefited, miss out on radiation treatment each year. This represents a lot of unnecessary deaths, and morbidity. The staffing levels are falling and it is unlikely that we will be able to maintain this figure. If this continues to decrease at the current rate, it is likely that up to 20,000 Australians per year will not receive radiation treatment.
- The NCCI has been commissioned by the Commonwealth Department of Health and Aged Care to assess the evidence base for the utilisation of radiation treatment. When this figure has been formally determined it should be actioned.

Infrastructure

- The infrastructure that is required for the delivery of radiation oncology is well defined and quantifiable.
- It requires an equipment base and a complex staffing base. Radiation Oncology is a highly interdependent specialty
- The Faculty of Radiation Oncology, RANZCR has commenced a national strategic planning process, in conjunction with the AIR, the ACPSEM and governments, looking at the infrastructure requirements for the delivery of radiation treatment. The workforce is well documented and the aim is to increase the infrastructure of radiation oncology in a sustainable manner, with the rate-limiting step likely to be the workforce. The recommendations from the national strategic plan need to be implemented.
- In addition to the implementation of the national strategic plan, there needs to be an urgent updating of the cost model with appropriate flow on to the MBS. Radiation treatment has always been plagued by fiscal restraint, and there will need to be a realistic increase in the funding of services in order for the service to expand.

Rural/Regional vs Urban

- By virtue of the required infrastructure, radiation oncology services are principally city or regionally based. The minimum population base to support a two-machine

department is approximately 250,000. It is unlikely that there will be a significant number of single machine units in the foreseeable future. Although there is a trial of single machine units in Victoria, Minister Wooldridge has placed a moratorium on the granting of HPG's in the rural sector until the results of these trials are evaluated.

- With respect to the utilisation of radiation treatment urban versus rural, the best data comes from NSW. This demonstrates that the utilisation of radiation treatment is region dependent but that this is mainly influenced by the exposure to radiation oncology consultations rather than their proximity to linear accelerators. Access is a problem whether a patient is rural or urban based. Rural patients are not disadvantaged in their use of radiation oncology services.
- For the rural based patient, travel and accommodation are flagged as major issues. Patients are often away from their home for up to seven weeks. Some states require patients to live more than two hundred km. from their treatment centre in order to claim travel and accommodation. There is great inequity between states and this requires urgent review. This is a great burden for country patients.

The Rural Perspective

1. Ms J Redmond, BCNA nominated consumer

I am both a health professional and a consumer. As a health professional I am a clinical nurse consultant in women's health, based in a rural area. As a consumer, I was diagnosed with breast cancer at the age of 39, as a working wife and mother of two. I had a modified radical mastectomy with axillary clearance, chemotherapy, hair loss, premature menopause, depression and financial loss.

These are the issues I want to raise:

- There is a lack of multidisciplinary teams in rural Australia. They exist in the city but not in the country.
- The GP is the primary carer. Your cancer journey is dependent on the GP you see on the day, on his/hers knowledge, networks and psychosocial skills. GPs require more support and education
- Breast care nurses urgently needed – evidence based models exist but actual nurses don't exist in the country. They are on screening program but as soon as women return home, they no longer have the support on the ground
- Psychosocial improvements required – survivorship issues need to be addressed
- Financial Assistance needs reassessment: travel/accommodation schemes are inadequate; discrepancies between States /Territories
- Breast prosthesis –amendment to Medicare rebates to reduce morbidity. A breast prosthesis is more than cosmetic. It is necessary for balance and posture. The imbalance makes some dizzy or gives them headaches and because of their fear of cancer recurring, they have brain scans. Some fall over and break ribs or bones and develop lymphodema. Prohibitive costs mean some women are using footy socks or small pouches of birdseed instead.

There is a lot we don't know about cancer. Let's change our perspective. The things we do know will make a difference. Our challenge is to put the many recommendations already in place into action now!

There is much material from: Parliamentary Papers 1994, 1995
Making a Difference paper 1998
Psychosocial Guidelines 1999
Breast Nurses Evidence Based Models 2000

2. Professor K White, Edith Cowan University

This presentation was based on a program of research that focuses on rural cancer and palliative care patients and families.

Three key areas:

1. Practical and emotional support needs of rural cancer patients and families
2. Approaches to meeting these needs
3. Health service delivery issues

Three studies were presented:

First stage explored the support needs of rural families' when a cancer patient is in the palliative care phase of their illness.

Patients and families were recruited from eight of the nine rural AHS in NSW.

Rural cancer patients identified:

- ***There are positive and negative aspects of being rural. The positive was living in a supportive rural community that cared for and supported each other at times of illness, and financial hardship. This needed to be considered in context of the social demographics of rural Australia. Increasingly an aged population, with family that had relocated outside the region. Rural communities have historically relied heavily on voluntary services such as meals on wheels, CWA, etc.***
- ***Numbers of volunteers has decreased dramatically with aging population, and no younger people coming though to take on these community roles. This has meant a substantial loss in community services in rural areas.***

Identified significant support needs for cancer patients and their family in the following areas:

- the impact of caring for a dying relative on family

- received limited preparation for the physical and emotional impact of caring, often became increasingly isolated during the palliative care phase, lack of bereavement services compounded isolation
- **limited and varied access to practical support in providing practical care**
- older women caring for older physically heavy men on rural farms age, geography, once less rural and regional towns HCP input decreased substantially, limited choices available for home or hospital care
- metropolitan vs rural treatment for cancer or palliative care was problematic. Both required travel and financial cost. Often reimbursement was more likely if treatment given in the city, therefore for financial reasons patients would opt to travel to city even when this was less desirable, continuity of care
- cancer vs palliative care, access to equipment & drugs improved once patients was seen as palliative care, prior to that costs were often required to be met by patients or equipment was denied
- need to travel, for everything
- knowledge of local services: government and health care was limited and often services did exist at a local level but no one either referred patient onto those services they did not know about them
- caring and maintaining a business: Families were frequently trying to maintain a business (shop, farm) and be principle carer. Financial could not afford not to maintain business. Access to financial support seem to be very problematic.
- **coping with final stages of life and immediately after death was difficult due to isolation and decreased access to basic support such as funeral getting a GP to travel to country to certify death, funeral director or ambulance to collect body**
- **preparation for physical changes, after hours support**
- **access to information and support was problematic but again it did exist**
- **privacy is a major concern in rural areas, financial issues are a problem, but part of the rural culture is that this should not be discussed. Need for a central source of information**
- **consistent community support services across rural areas. The type and level of service varied enormously across rural regions and there did not seem to be any rational behind why one area had more or less services than another. Seemed to be dependent on having a local identity that had lobbied hard for a particular service.**
- **travel and accommodation schemes for rural patients and family were the major source of complaint, confusion and frustration. Frequently claims were not lodged even in financial hardship simply because carers did not have the time to complete the forms while trying to care for a dying relative.**

Cancer patients:

- travel remains an issue
- access to practical and emotional support in rural areas
- privacy issues
- paediatric patients. This was a small group that was identified to have special needs that were difficult to access in rural areas.

Key problem was access to healthcare, most problematic after hours.

Approaches to meeting support needs

Need for after hours access to care was the major factor identified by all rural families

Second stage developed and piloted a model for providing after hours support to rural patients and families.

Needed to identify a model that could work in a rural setting and was sustainable in the long term.

Needed to consider:

- human resources available:
 - skills, training, number of staff etc
 - funding
 - safety
 - sustainability
 - evaluation
- *mobile phones in rural areas*

The After Hours Telephone Support Service

- AHTSS was established using a 1800 telephone number
- Nine community nurses provided the AHTSS, working a 48 hour on call roster. On call once every eight weeks
- Establish pilot in one area
- Evaluation family, patient, GP, CN overwhelming positive
- AHTSS funded now by AHS and being implemented across AHS
- 12 month evaluation comparing this model with specialist after hours model currently underway

Health service delivery issues

- ***Providing cancer and palliative care to rural consumers need to consider:***
 - equity of access to health care
 - minimum standard of care
 - service options that are feasible, sustainable & flexible
- ***This may vary depending on the needs of a specific rural area***
- ***Staffing issues***
- ***Alternative models of care***

Need to recognise can not replicate the metropolitan model of cancer care in all rural centres and have to consider issues such as specialists versus non-specialist services, role of the primary healthcare team, upskilling local health care staff and working with rural communities to assist them to establish the services they need.

Currently working in WA to develop what is being called a “Pop up service”. That is, using existing health care resources in a new and coordinated way that comes into place when a cancer or palliative care patient requires this, as opposed to creating a specified cancer palliative care service in each town

NBCC QI Kit is being used as a model for developing this type of service.

- ***Education and skill base is crucial and needs to be carefully considered.***
- ***Access to ongoing education for rural health care professionals***
- ***Needs of rural patients in the city currently being investigated.***

3. Then, Now & In the Future

Ms H Snodgrass, Mid Western Area Health Service

Positive aspects of present situation

- Volunteer support services in most major rural towns and cities
- Oncology & Palliative Care nurses proactive in their support of volunteers services
- Oncology & Palliative Care Outreach Services exist in most major towns and cities

Ad hoc nature of rural oncology set-ups in the past

- Radiation and/or Medical oncologists arrived in rural areas without strategic or financial planning
- Poor support resulted form allied health, community health, other health professionals and financial planners

Oncology & Palliative Care Nurses expected to be the “be all and end all of support” in rural areas

- Social worker
- counsellor
- dietician
- occupational therapist
- VMOs registrar
- Health professional’s information source
- GPs sounding board
- patient and/or carers best friend

Rural patients’ and carers’ issues today

- Lack of professional psychosocial support
- A sense of being uninformed, lost in the system
- High anxiety levels

Access

- Travelling away from home – real issues of isolation, leaving loved ones behind
- Waiting for treatment
- Organising accommodation, travel,; babysitters, housesitters, petsitters, etc
- Financial stresses

Psychosocial Issues

- High anxiety levels
- Fear of known and unknown
- Lack of available sounding board
- Facing sense of mortality

Lack of information and direction

- Questions not always answered properly
- Treatment directions not understood
- Prognosis not clearly described

Referral patterns

- Returning patients to rural areas for treatment where no service available
- Reluctance to return patients from metro clinics to rural area when service available
- Lack of knowledge re level of expertise available (or otherwise) in the bush

Issues of time

- VMO seeing >70 people with cancer in 8 hrs – equals approximate consultation time of 7 mins

4. *National Survey of Women with Early Breast Cancer: Perceptions of Care* Professor S Redman, National Breast Cancer Centre

Selected results from a national survey of women diagnosed with early breast cancer were presented. Telephone interviews had been completed with 540 women selected from the cancer registries to constitute a representative national sample. The survey explored the extent to which women reported that their care was in accord with *the NHMRC Clinical practice guidelines for the management of early breast cancer*.

The findings indicated that in many respects the experience of women living in rural areas was similar to those in urban areas. Similar proportions of women in urban and rural areas reported care in accord with the guidelines in relation to diagnosis, information provision, involvement in decision making, breast reconstruction, follow up and satisfaction with care.

Several areas of special need for rural women were identified:

- About a third of rural women felt that their access to services or information had been limited by living in a rural area
- Women felt that they needed more information about travelling for treatment and accommodation and support near treatment centres
- A smaller proportion of rural than urban women were informed about clinical trials
- Better information was needed in relation to financial assistance when travelling for treatment - less than half of all women who travelled for treatment receiving any financial assistance.

The survey also indicated that urban women were as likely as rural women to be told their diagnosis over the telephone – suggesting that distance to travel is not the major reason for providing results over the telephone.

5. *Medical Oncology Services In Rural and Remote Communities*
Ms Sandi McCarthy, Toowoomba Hospital

Strengths

- Generally very supportive communities
- Resulting in superior social and emotional support for patient and family
- Lower incidence of multiresistant microorganisms
- Medical staff who elect to work in these areas are very resourceful

Difficulties:

Tyranny of Isolation

- Lack of specialist oncological services
- Only medical staff are general practitioners
- Lack of formal training in medical oncology results in problems of diagnosis and management
- Difficulty in providing accurate information so patients can make an informed decision about treatment options
- Small number of patients treated by each practitioner making skill acquisition more difficult
- Lack of sophisticated diagnostic equipment, eg CT scans, nuclear medicine facilities
- Resulting in problems of diagnosis and assessing response
- Lack of sophisticated medical services for treating sick patients with complications of chemotherapy
- In public medicine rapid turnover of medical staff resulting in problems from continuity of care and development of rapport between patient, family and medical practitioner
- Loss of social support for patients and carers when they have to leave their community for specialist care
- Shortage of relief makes it more difficult for health professions to attend education activities
- Significant ethnic considerations regarding treatment expectations and acceptance
- Data demonstrating patients have better outcomes when treated in centres with large numbers of patients
- Small populations resulting in economic issues for establishment of sophisticated diagnostic and treatment facilities

Tyranny of Distance

- Resistance of patients and family to leave their communities
- Discomfort of travel
- Risks of transporting unstable sick patients

- Turnaround time for pathology results
- Pre each cycle with risk of delay resulting in suboptimal cycling
- During treatment
- Risk of delay in detecting severe myelosuppression
 - Results in delay before antibiotic treatment commences
 - Over compensation with inappropriate antibiotic administration
- Delay in microbiological diagnoses
- Risk in deterioration in microbiological specimens
- Risk of transporting blood products temperature control to prevent deterioration
-
- Solutions**
 - Improved distance education for health professionals in their own communities
 - Specialist outreach services to rural and remote communities
 - Telemedicine
 - Able to interview patients and their carers therefore some value for providing general counselling/bereavement support but lacks the direct person-person contact
 - Simple diagnostic procedures such as digital X-rays
 - Need to physically examine patients for diagnostic and progress assessments
 - Often need more sophisticated diagnostic investigations such as CT scans and nuclear medicine scans not available in the patient's community.

6. Cancer in the Country

Dr Sue Robertson, General Practitioner – Hamilton, Victoria

Strengths

- Community
- Continuity of care
- Patient advocate role
- Multidisciplinary teams work well

Barriers to Care

- Prevention
- Screening
 - Travel, callbacks

- Genetic counselling
- Choice

Diagnosis

- Investigations
 - time involved, coordination, cost of travel,
 - availability eg MRI
- Expert opinion
 - travel, extra anxiety

Acute Management

- Plan and communication
 - poor information flow
- Surgery
 - rural surgeons and hospitals available - competent audited care, short waiting times
 - subspecialists and facilities
- Chemotherapy
 - more could be given closer to home
- Radiotherapy
 - major problem of time and dislocation to life
 - costs
- Hormonal Therapy
- Decisions to change or cease treatment
 - access to expert opinion
 - travel time, unwell patients, stress
 - clinical trials requirements

Active Palliative Care

- Lack of communication in acute stages
- Barriers to local administration chemoR
 - support from oncologists and metro centres
 - nursing staff confidence
 - doctor confidence
 - pharmacy support
- Investigations
- Radiotherapy
 - Quality of life

Terminal Care

- Home based
 - district nursing service limited, 24 hour call only in Hamilton
 - medical visits not out of town
 - even if funding available, nurses not in district
- Hospital based
 - need to keep small hospitals open

- medical and nursing expertise, need access to support

Summary

- Expert opinion
- Treatment
- Care
- Build on existing services with support to ensure quality care and choices

7. Oncology – The Rural Perspective **Dr Hayden Baillie, General Practitioner - Port Lincoln, SA**

Geography

- local (Port Lincoln)
- regional
- health facilities

Patient perspective

- family doctor
- local hospital
- home access

Compromises

- CT scans
- MRI scans
- Biopsy
- Pharmacy
- Radiotherapy

Example:

Patient's problems and outcomes. How do we make it work?

- 1. Senior v Junior Staff**
 - knowledge of geography
 - knowledge of facilities
 - knowledge of GP skills
 - staff turnover
 - personal anxieties
- 2. Technology**
 - on-line pathology
 - tele-medicine
 - digital e-mail
 - email
 - tele-radiology
- 3. Funding**
 - staff and time for technology

4. Mindset

- take home message

8. Haematology Cancer Patient Shared Care Project Ms K Hardwick, Sir Charles Gairdner Hospital

To develop, implement and evaluate a Shared Care Model for the treatment of Haematology Cancer Patients: A Demonstration Project

Objective

The aim of this project was to develop a specifically designed Shared Care delivery partnership between General Practitioners (GPs) and hospital staff for the care of haematology cancer patients. This project resulted from a Best Practice Model report commissioned by the Western Australian State Cancer Services Planning Committee in 1997, aimed at improving coordination of cancer care across the hospital/community interface.

Methods

The project was funded for one year from September 1999 to September 2000. Using a highly consultative process with all stakeholders – GPs, patients and carers, specialists, nurses and cancer support services – a number of issues were addressed:

- A project coordinator was appointed and to facilitate the development of communication strategies including:
 - Development of a Patient-Held Record.
 - Development of guidelines for GPs on the care of patients having chemotherapy.
 - Professional forums for GPs and specialists to meet periodically.
 - Review of current and developing access to technology for the purpose of multidisciplinary communication of patient care.
- Twelve haematology cancer patients undergoing treatment at SCGH used the developed model of care over a six-month period.
- An external in-depth case study evaluation was used and focused on the acceptability of the Shared Care process to patients, GPs, specialists and nursing staff.

Results

The outcomes of the project have been:

- The development of a useful patient-held “package” that would provide an effective means of communication between the hospital and community services.
- The implementation of a highly effective process that encourages the liaison between GPs and specialists and as such improves the rapport between these two groups of doctors.
- Greater and more effective GP involvement in the care of haematology cancer patients.
- A model of care that encourages the patient to be an active participant in decision making about their own health management and can be extended to all groups of cancer patients.

Conclusions

- The Shared Care process resulted in improved communication and coordination of cancer patient care across the hospital / community interface.

Future

- Planning is now underway for an expanded project following a minimum of 100 patient using the model of Shared Care over a period of two years. Oncology and Haematology patients will be followed.

Medical Oncology Services

1. *Dr Craig Underhill, Border Medical Oncology*

Population

- ***Albury-Wodonga: 75,000 urban, 200,000+ referral pop, 60% Vic, 40% NSW***

What we had before

- ***outreach clinic***
 - q2 weeks, consultant and registrar from Royal Melbourne Hospital
 - approx 150 new pts per year
 - two oncology trained nurses
 - general physicians/GP managing day to day problems
- ***cross-border palliative care service***
- ***general surgery***

What we have now

- ***Two full-time medical oncologists; honorary appointment RMH***
- ***Medical oncology registrar***
- ***4 FTE onc nurses (x2 ABH, x2 MVPH)***
- ***750 new pts per year, x8 increase in chemo day treatments***
- ***Outreach clinics to Finley and Wangaratta***
- ***Multidisciplinary clinics***
 - breast, gynaecology, head and neck, urology
- ***Clinical trials unit***
 - 1.7 FTE research nurses
 - 15% of new pts per year enter (phase 2/3) clinical trials
- ***Dedicated oncology pharmacists***
- ***Two machine radiotherapy service, 1.5 FTE radiation oncologist (MVPH)***
- ***(Divided) palliative care service***
- ***Some surgeons sub-specialising***

What we don't do

- ***Don't treat certain tumour types***
 - sarcoma, acute leukaemia, paediatric oncology
- ***Don't perform certain surgical oncology***
 - thoracic surgery, neurosurgery, gynaecology oncology, breast reconstructions
- ***Refer to specialist unit in city***

Barriers faced

- ***Lack of funding***
 - closure of outpatient clinic
 - initial refusal to employ 2nd med oncologist
 - ongoing refusal to pay on-call for med oncs
 - closure of satellite chemotherapy service

- **resistance from some GPs/surgeons**
 - “old ways” better
- **access to allied health**
 - physio, dieticians, social worker
- **access to psychosocial support**
 - psychologists, breast care nurses, “Living with Cancer” program, cost of travel
- **access to training/CME**
 - med onc, rad onc, surg onc, onc nurses, pall care nurses, pharmacist
- **locum relief**

What’s not needed

- **Enhanced outreach clinics at the expense of developing regional cancer centres (metropolitan cancer centres should support regional centres/local providers not attempt to replace them)**
- **the perception that technology is a cure all and can replace skilled local service delivery (technology can be used to support local service providers in accessing special services)**

What is needed

- **for regional development in general**
- **to develop local services/treat people locally**
 - A new way of funding
 - money to follow the patient
- **grants for training/CME**
 - staff in the cancer centre
 - GPs/nurses in remote towns
- **Identification which areas can support a local service/ which areas to be served by outreach services**
- **adequate training of medical oncologists for rural/regional practice**
- **fostering of links between city and country centres**
- **locum relief**
- **MOG Rural Oncology Sub-Committee**
 - “Provision of Oncology Services to Rural and Remote Regions of Australia”
 - being considered by RACP/RACGP
- **MOG and Government health funding bodies and other relevant authorities can work together to develop strategies to improve the provision of medical oncology services in rural Australia**
- where necessary that additional funding and resources be made available to implement these strategies

2. Dr G Beadle, Wesley Medical Centre

Optimal medical oncology practice requires careful assessment of patients before, during and after cytotoxic drug treatment. Prescription of cytotoxic drugs is:

- based on evidence
- protocol driven
- individually calculated
- sometimes adjusted during treatment

Medical Oncology outreach typically delegates responsibility for the administration of cytotoxic drugs to medical practitioners and nurses who provide a part time service. The minimum requirements for partnership are:

- contact time between the medical oncologist and the patient
- motivated local staff
- dedicated space
- policy procedures for safe handling, administration and disposal of cytotoxic drugs

In many cases, a Medical Oncology outreach service is motivated by individual enthusiasm and is conducted in an ad hoc manner. Properly performed, the advantages are:

- more convenient service for the patient
- regular attendance possible
- technology and skills brought to the community

The disadvantages are:

- prescribing medical oncologist not at the treatment interface
- holistic care not possible
- increased time and effort in communication
- increased likelihood of errors in cytotoxic drug delivery
- legal exposure increased
- extra effort not remunerated

In order to optimise a convenient, high quality service:

- a systematic approach is necessary
- government policy and finances should recognise outreach services as an area of need for the rural community

Radiation Oncology Services

1. Dr C MacLeod, Murray Valley Radiotherapy

The optimal model to provide radiotherapy to the bush is unclear. Possibilities include:

1. all patients being brought to capital cities
2. large regional centres with 2 or 3 linacs providing service to smaller towns
3. many small country centres.

It is evident from the paper by Barton that optimal utilisation of radiotherapy can be achieved in the country by regular outreach clinics from a well resourced city hospital.

Equally, large regional centres such as Geelong and Townsville have increased the utilisation of radiotherapy both in the centre itself and draining regions.

The experimental single machine units that are planned for Ballarat and Bendigo under a State and Commonwealth agreement have resource restrictions and will not treat problems such as curative Head & Neck, Gynaecology and Lymphoma patients. They will be collecting multiple data sets and outcome data will be available in the next five to 10 years. However, it must be remembered that single machine units are very expensive to build and run and the most cost-effective department is the three machine centre. Regional centres have also had difficulty attracting and retaining staff. Therefore, the concerns of cost, staffing and quality service delivery make it unlikely that there will be a multitude of single machine departments.

The provision of appropriate radiotherapy services to country people will require access to an outreach clinic or a large regional centre in the majority of cases. City or regional centres will require access to both hospital beds and hostel or motel services.

2. In Favour of the Outreach Clinic Model of Service Delivery Dr G Milross, Prince of Wales Hospital

The current rate of utilisation of radiotherapy treatment by newly diagnosed cancer patients is unsatisfactorily low. A recently published study confirmed that only 37% of cancer patients diagnosed in 1998 received radiotherapy treatment¹. This figure falls well short of the 50% level recommended by the Australian Health Ministers' Advisory Council (AHMAC)². The available evidence also confirms that existing radiotherapy services are working at or beyond their capacity. Accordingly a strong case can be made for increasing the level of available services including the number of linear accelerators, radiation oncologists, and allied staff.

The question for consideration is where those increased services should be located. The alternatives include provision of new radiotherapy departments in regional centres or increasing resources at existing centres which are generally located at University Teaching Hospitals.

Substantive differences between rates of radiotherapy utilisation were not observed between urban and rural patients¹. Gross underutilization was observed for patients in a number of both urban and rural area health services. By way of contrast acceptable utilisation rates were achieved in rural area health services, including New England and

Southern Health, which have been well serviced by an outreach clinic program. Furthermore, even in reportedly “over-serviced” urban area health services such as South Eastern, the AHMAC recommended utilisation rate was not exceeded¹. Overall there has only been a marginal increase in the frequency of referral for radiotherapy since 1991³. Those minor increases in radiotherapy utilisation rates that have been observed were in rural area health services serviced by an outreach or satellite clinic program provided by an urban radiotherapy centre¹. Therefore, it is arguably the accessibility and availability of the Radiation Oncologist and not that of the linear accelerator that impacts most significantly upon utilisation of radiotherapy.

Australia’s rural geography may be characterised by the sparseness of its population and the large distances which separate regional cities and towns. Consequently underutilization of radiotherapy by rural patients has been attributed to limited access to the radiation oncology department⁴. Although provision of additional radiation oncology services in rural centres might partially alleviate the problem of accessibility, the geography is such that many or most rural patients will have to travel substantive distances in order to receive radiotherapy.

Satellite clinics, which deliver the Radiation Oncologist to the rural centre on a regular basis, offer a number of distinct advantages to rural cancer patients. Primarily, such clinics allow the patient to receive an expert opinion close to home and at a time when they are well supported by their family and friends. When satellite clinics are jointly staffed by both radiation and medical oncologists it is possible to offer a multidisciplinary service similar to that available at urban centres. Patients who accept the recommendation to receive radiotherapy treatment, and travel to the city to do so, can be assured that such treatment subsequently given in major centres will be of the highest standard possible^{5,6,7}.

Satellite clinics have a number of other very important advantages, including maintenance of consultative links between regional centres and large urban centres. These links allow for example ready access to highly specialised opinions in Neurosurgery, Thoracic surgery, and Gynaecological Oncology, among others. In addition, the cost saving for the local area health service derived from utilisation of a visiting radiation oncology consultative service in comparison to construction of a new regional radiotherapy centre substantial. The establishment of a radiotherapy centre is associated with a major initial capital outlay, and subsequently by large recurrent labour costs. Furthermore the current staffing crisis being experienced by the major urban radiotherapy centres is expected to be worse for smaller regional centres.

The solution to the present problem of gross underutilisation of radiotherapy by newly diagnosed cancer patients is not simply to develop a limited number of smaller regional radiotherapy departments. Such a solution would improve access for some patients but at the risk of provision of a more expensive and less than excellent service. A preferred solution would be to structure and expand the existing outreach clinic program such that rural patients have ready access to expert radiation oncology opinion, and to remove as far as possible the acknowledged barriers to receiving radiotherapy including difficulties with travel and accommodation. Expansion of existing larger urban centres, to cope with increased demand, which could be achieved with significant economies of scale, would ensure that all cancer patients received the best quality radiotherapy possible.

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Surgical Oncology Services

1. Cancer Management in Rural and Remote Australia Dr A Green, Atherton, Qld

The issues

Ten percent of Australians could currently be classed as living in rural and remote as opposed to regional and metropolitan areas of Australia. The old problems associated with “a tyranny of distance” have not changed in many of these areas. Most people living in these areas accept that they will need to travel for the detailed assessment of their cancers and also for aspects of their treatments. In the bush there is perhaps more often a delay in diagnosis of people with cancers.

The concept of multidisciplinary care is extending in the management of many cancers usually to the betterment of the patient’s care in terms of treatment options and the standard of care. Ways and means need to be sought to improve this for rural patients.

Most people living in rural and remote Australia are there for a reason, to do with their work on a permanent long term or temporary rotational basis, they may be there because they have a background in the bush and desire to live there or may have retired there from a metropolitan or regional area. Some aspects of living in the bush can still be cheaper than living in the city. Nonetheless all Australians today demand a minimum high standard of medical management for their conditions and this particularly is true in the management of cancer. They are aware that they will need to travel for some aspects of their assessment and care but nonetheless would like as much as possible of their treatment to be done in a local or regional facility with the back up of friends and family.

Multidisciplinary care

Multidisciplinary care is indeed possible in the rural and remote areas but does require a high level of communications and collaboration with the relevant oncologists. The way in which multidisciplinary care is delivered will obviously be different because of the distances involved and it is obviously impractical for a complete multidisciplinary team in either assessment or management but to travel to the rural and remote areas of Australia.

The GP will often have a key role in helping to support the patient and coordinate the care of the patient. There is also a role for a more designated care coordinator who will act as a patient advocate and confidante. This might be a local oncology nurse, the GP or often the primary surgeon involved in the management of the patient’s cancer (if it is a surgical cancer). The surgeon particularly has a role in establishing close collaboration with medical and radiation oncologists and the patient’s initial assessment and ongoing management.

A “hub and spoke” model for the delivery of multidisciplinary assessment and care as used in Atherton Hospital will be described.

The “Hub & Spoke” model

The hub in general terms may be a regional or metropolitan area depending on the geographic and logistic situation of the rural or remote town. It is the place where diagnostic tests and staging of the cancer will occur and some aspects of treatment, particularly radiation therapy, will need to be performed in a major centre.

It is hoped that the relevant oncologist (particularly radiation and medical oncologists) would be able to provide outreach services to a nearby regional centre on a regular basis for ongoing follow up of patients or otherwise very close liaison will be with the primary care physician (GP) or the treating surgeon.

It is hoped that the “hub and spoke” method will allow education and upskilling of the medical practitioners on the ground including nursing staff and will be able to provide an ongoing back up advice service whenever necessary.

The rural or remote centre itself and the health practitioners there will have an important role in the prevention aspects of cancer management, the initial diagnosis of the cancer, the education of patients and their carers. The initial treatment usually surgery or chemotherapy can usually be performed in a local area and in many cases complete definitive treatment may be appropriately performed as can adjuvant post operative chemotherapy. Obviously most of the follow up should be performed in the local area.

Summary

There is room for improvement in the management of cancer at all levels in rural and remote parts of Australia and this will require upskilling of rural health practitioners from nursing staff through to specialists.

The key to success is collaboration via a “hub and spoke” model with adequate outreach services being provided. As much treatment as is appropriate locally will be cost effective and preferable for most patients. Extra funding will be required for this nonetheless.

A team effort is what is required to improve oncological services in rural and remote Australia.

2. Surgical Oncology on Rural Regional Areas Dr R A North, Dubbo NSW

I have been a General Surgeon in Dubbo since 1968. I have had a widespread exposure to most surgical cancer conditions and work in both the Base Hospital and Private Hospital.

Good operating facilities are available in both sectors with endoscopy as well as intensive care facilities. Two accredited surgical registrars are employed at The Base Hospital.

Medical Oncology and Radiation Oncology is available at an Oncology Unit which has been built in the grounds of the Base Hospital. As a centre of a region of 120,000

people, Dubbo is the key centre and little surgery is carried on, outside Dubbo. It is envisaged that outreach visits from surgeons in The Base Hospital will be more necessary in the future.

Good facilities are available for the diagnosis and treatment of breast cancer, colorectal cancer and most other surgically treated cancers, such as skin, melanoma, lymphoma, thyroid, testis and lung being encountered. There will be a tendency for subspecialist surgical experts to travel from the city to the Base Hospital areas at specific times to perform more sophisticated operations.

There is a need for increased Medical and Radiation Oncology visits, the creation of a position for a specialist breast cancer nurse and a palliative care specialist. Nuclear medicine facilities are available. Funding of these services is a great problem and there appears to be a conflict of interest between State and Federal Health Departments in providing rural services. Secretarial help should be available to facilitate research and audit processes in the public sector.

3. Breast Surgery **Dr F Sardelic, Tamworth NSW**

Dedicated breast surgeon probably not achievable in the rural setting, but can come close. Important to realise that even in the city, surgeons dedicated only to breast cancer surgery are rare, most have additional interests. In the rural setting because of the smaller number of surgeons "On Call General Surgery" will always be expected of any subspecialised surgeon. General surgical training is critical.

The local environment and surgical community are important to allow subspecialisation. For Breast Cancer Surgery this means access to a thriving and vital screening program as well as diagnostic mammography and ultrasound. Therapeutic and diagnostic radiological interventions are critical in allowing appropriate decision making to occur with modern day breast cancer care. Adequate Pathological and Cytological services are required. Access to multidisciplinary care is necessary for appropriate care for a breast cancer patient. Given the smaller case load, subspecialisation in breast cancer surgery is only practical in a major regional centre. Voluntary division of labour with regards to the local surgical community is vital to allow greater concentration of cases for the interested surgeons. Appropriate supportive services and surgical supports are critical.

Training for a specialised breast cancer surgeon in the rural setting needs to be very broad based and wide ranging, covering radiology, oncology, genetics as well as relevant surgical aspects. Important to realise that often the surgeon concerned is referred a great number of patients with benign problems as well as the malignant ones. Basic training in breast reconstruction could be a useful adjunct, currently not often obtained. Access to ongoing training in new procedures is important to allow the surgeon to remain relevant.

I am currently one of five general surgeons working in the Tamworth area, covering some 170,000 people. Myself and another surgeon provide most, if not all, the breast cancer surgical work in the area. This includes assessment clinics at the BreastScreen Australia Program as well as any diagnostic work. Thus I treated approximately 80 women with breast cancer in the last year. This would account for 40% of my work. I do consider myself to be a specialised breast cancer surgeon but I can only continue to practice as such with the terrific support and help provided by my colleagues and coworkers.

4. Gynaecological Oncology Services and the Bush Dr G Robertson, Royal Hospital for Women

Gynaecological oncology has been recognised as an area of subspecialisation within the Royal Australian and New Zealand College of Obstetricians since the late 1980's. This has largely been endorsed and actively supported by the majority of gynaecologists such that most women with gynaecological cancers are referred to one of the twenty five gynaecological oncologists working in the eleven major city based centres. The rationale for this is the recognition that for management of many of these diseases specialised care not only offers greater concentration of surgical skills but also allows delivery of appropriate nursing, psychological and ancillary support relevant to the disease process. Improved overall and disease free survival statistics support this. A recent prospective study conducted in Scotland showed that among women with Stage III ovarian cancer, survival was longest among those whose surgery was performed by a gynaecological oncologist rather than other gynaecologists or surgeons. Recognition of this in Australia has placed management of gynaecological cancers in the unique position of referral to specialist centres offering high standards of peer reviewed care.

The current model of care for rural patients has been established albeit in many cases without formal basis. Usually it is based on geographical lines of referral although often other factors may influence the decision as to where care is offered. However underpinning this is communication at a tertiary level between the referring gynaecologist and the gynaecological cancer centre. This appears to be effective and working although no formal assessment has been performed.

Once referred, patients are managed according to their circumstance and need. All patients are usually discussed at a multi disciplinary peer review forum where histology is reviewed and management agreed upon then referred back to their hometown for ongoing management such as chemotherapy or a regional radiotherapy centre if required. Post surgical patients are managed by the referring gynaecologist on discharge.

In some cases it is possible for cases to be operated on in their home hospital where a visiting service exists. However this is usually restricted to surgical cases which can be comfortably managed within the limitations of the centre. Realisation of the difficulties encountered by rural patients include the dislocation of them from their usual community supports, the difficulties involved with care of dependents and the cost involved with travel. All are recognised and limited as much as possible. On site accommodation is increasingly available and allows relatives to be close at hand.

Improvements in the current service relate largely to education of the referral doctors as to the objectives of the patient care by either seminars, telephone contact or by local or

hospital organised meetings. In many cases these exist and are well supported. Greater integration of nursing care occurs with rural nurses attending the specialised centres and working on the wards and clinics to allow observation of the structure of these centres. This has been very effective in organising patient referral from the home hospital to the major centres.

Overall gynaecological oncology is fortunate in that it operates within a recognised specialty framework supported by the general gynaecological community. This recognises the need for both rural and metropolitan patients alike to be treated in a specialist centre and appropriate referral exists.

Palliative Care Services

1. Dr J Troller, New England Health Area Service

My talk is in three parts:

- Palliative Care Services in the NW of NSW
- Some problem areas
- Working with oncology services

Palliative Care Services

- small population: large area
- advantages of local services
- a regional palliative care unit
- a 'new' service – implications
- palliative care and primary carers
- the role of a regional palliative care doctor

Problem Areas

- distance: smallness: isolation
- sole practitioners: shared roles
- home services –after hours, respite in the home
- bereavement support
- education – primary careers
- fixed palliative care funding
- old time attitudes

Rural Palliative Care and Oncology Services

- defining our relationship
- what can palliative care offer
- referrals to a palliative care doctor
- visiting oncology services –records, letters, busy clinics, city-regional links

2. Palliative Care in Rural and Remote Communities Dr W Cairns, Townsville General Hospital

- Small numbers of patients who die each year
- Full range of health responsibilities
- Palliative care is not the only priority
- Isolation and limited resources
- Strong community networks

**People like to die in their home community, if not actually at home.
What do we need to do to help this to happen?**

Realistic assessment of probabilities

Early discussion with the patient and their family

Attitudes of people from rural areas to death and dying

I believe that:

- rural people are more accepting of the reality of limitations of cure
- less likely to pursue futile treatment, and seem more accepting of death and dying. Perhaps because they are exposed to the whims of nature and death in day to day life, they do not have the illusion of control that people in cities do

Early referral to Palliative Care Services in Tertiary Centres

- May be the only opportunity to consult with specialised services
- Assessment of levels of support
- Arrange necessary equipment
- Address symptom management
- Explore psychosocial issues
- Liaise with home community

Networks of Palliative Care

- All tertiary oncology centres should have an in house palliative care service - levels of service
- Formal relationships between tertiary centres and their referral catchments
- Educational support for rural centres
- Awareness of problems for rural practitioners

Education and Training Opportunities

- Palliative Care as part of all health worker training
- Visits to small communities by Pall Care teams
- Use of contemporary technology
- Frequent communication and networking

Summary

- Everybody dies
- People should be enabled to die in their home community whenever possible
- This can only be achieved with collaboration between oncologists, palliative care specialists, and rural health workers.
- Open Communication

Government Policy Overview

1. Federal View

Prof B Armstrong AM, Cancer Strategies Group

Cancer mortality rates are falling in Australia! This is a largely unplanned triumph. The biggest fall has been in lung cancer deaths in men. Much of the credit for this goes to the early and persistent media coverage of the harmful effects of smoking; with planned action a comparatively recent contributor. Downturns in mortality from colorectal cancer, the second largest cause of cancer death, are probably due to changes in diet caused by our uptake of the healthier diets of our southern European and Asian immigrants and not to any planned health program. Falling death rates from breast cancer are definitely partly due to planned action, through the BreastScreen Program, but also to the generally undirected, if not unplanned, diffusion of advances in breast cancer treatment, such as with adjuvant hormonal and chemo-therapy. The recent increasing rate of fall in death rates from cervical cancer reflects the organised approach to cervical screening introduced in the early 1990s, but it comes at the end of steady falls through the 70s and 80s that are much less evidently due to planned action.

While saving lives from cancer is probably our most important objective, trends in mortality or not the only items on the cancer control scorecard. On the positive side, quality of life has probably increased with falling incidence of some cancers; earlier diagnosis leading to less radical treatment and the fall in death from advanced cancer. On the negative, inequality of the impact of cancer by socio-economic status in Australia has probably increased. Most of the mortality gains have been due to uptake of protective behaviours, which are almost invariably taken up more readily by the better educated and the better off. Could planned action have gained more of the former and reduced the latter? Perhaps, but we don't know for sure.

While the achievements of comprehensive cancer control planning are largely unproven, cancer control planning remains firmly on the national agenda in Australia. The approach being taken is not comprehensive but selective, based on priorities. It is supported by the recent experience of the plan developed by the National Cancer Control Initiative (NCCI) – *Cancer Control towards 2002* – that recommended 13 high priority actions after a process that was open to all comers. Just four years later, substantial new action has been taken in 10 of these 13 areas. It's too early to tell what the *health* outcomes will be, but things look promising.

In developing *Priorities for action in cancer control 2001-2003*, the Commonwealth's Cancer Strategies Group took a similar approach and sent 13 recommended priorities for action out for public comment. These priorities were developed from high priority items considered by the NCCI but not included in the top 13 and others advanced in a national stakeholder workshop conducted in 1999. Briefly, they are:

- Continuing national tobacco media campaigns
- A national Sun Smart campaign
- Increasing intake of fruit and vegetables through a national campaign
- Introducing a national FOBT screening program for colorectal cancer
- Increasing cervical screening efficiency by increasing interval from 2 to 3 years
- Increasing the efficiency of skin cancer control by increasing the accuracy of general practitioner diagnosis of skin lesions
- Rationalising PSA testing through national GP and public education

- Reorganising breast cancer management to ensure seamless continuity of care from screening through to follow-up care
- Improving ovarian and lung cancer outcomes by ensuring rapid assessment at multidisciplinary specialist centres
- Developing, implementing and maintaining management guidelines
- Improving psychosocial care through provision of breast cancer nurses Improving psychosocial care through psychologists in cancer services
- Developing and implementing guidelines for palliative care.

In developing these priorities, consideration was given to initiatives that would increase quality of life as well as extend life, and in selecting those to be recommended impacts on the equity of distribution of the burden of cancer were explicitly considered.

Priorities for action in cancer control 2001-2003 is being revised in the light of comments and advice received and will be sent to the National Health Priorities Action Council, the “parent body” of the Cancer Strategies Group for consideration for implementation. We can only hope that its “batting average” is as high as that of *Cancer Control towards 2002*.

2. State view

Prof B Kearney, Dept of Human Services SA

In South Australia the geography is different from most States, in that 80% of the population live within 80kms of the metropolitan area.

South Australia also provides visiting specialist services to a number of regions including Broken Hill, and Breast Screen and Cervical Cancer Screening achieve rates of coverage in regional and country rural areas to the same level as in the metropolitan area with a few exceptions. South Australia also provides complex referral services to the Northern Territory through telehealth facilities.

There are concerns that the PAT scheme may not adequately reimburse remote people for the costs of travelling to the metropolitan area for complex care. There is a need to improve the treatment and outcomes for the Indigenous community in remote areas.

However, the radiation oncology rate for residents across South Australia does not appear to vary significantly and the 20 year statistics covering five year survival by type of cancer from regional and remote areas does not appear to show any significant difference in survival.

Data were presented comparing five-year case survivals by place of residence for 1977 to 1997 for most common cancers. This disclosed differences between country regions and the city of up to 4% but greater than 4% within city areas.

3. Personal View

Dr John Best, Diagnosis Pty Ltd

Decisions about the provision of cancer services in rural and remote areas - such as what services are provided, where they are provided and how they can be sustained - reflect a range of vested interests.

Communities often determine their needs from the base of personal experience - the particular medical condition being experienced by an individual at the time may set the priorities. Individuals within communities often generalise the needs of the community around their personal priorities. Thus, a small community may seek tertiary level services on this basis, notwithstanding the reality that the service would be unsustainable. This is not a new phenomenon; it simply reflects the desire to provide the best health care to everyone.

The difficulty in Australia however, is working in a country where 2 million Australians live in settlements of less than 200 people; and there are approximately 10,000 of these settlements.

There are 1500 settlements with a population of between 200 and 5,000. Larger settlements (with populations of between 48,000 and 249,999) such as Albury/Wodonga, Ballarat, Geelong and Toowoomba are essentially urban. These ARIA* Class B cities (which also include Darwin, Hobart and Launceston) increasingly emulate the workforce in the cities where the population is 300,000 plus in that there is recruitment of sub-specialists and a decline in the number of general specialists, together with the gradual elimination of general practitioners from the hospitals. However, at the same time, in some large provincial cities there is significant difficulty in recruiting any specialists. Although there are plenty of examples of "fly-in-fly-out" specialist services that may appeal to metropolitan specialists for a variety of reasons, the problem is that, too frequently, expertise has not been "left on the ground".

In other words, there is a very dispersed population and a disease - cancer - that is increasingly been treated in a specialised environment. At the same time, changes in the specialist profile and the type of practice undertaken by GPs is such that effective treatment of cancer in rural and remote areas presents particular challenges to planners.

There are two important elements to be considered in planning. The planning framework needs to be established on demographic lines and recognise clearly the dispersed nature of the Australian population. The second element is to build and maintain the core of specialist expertise outside the metropolitan areas so that a greater proportion of the population requiring treatment that lives outside cities can access specialist services.

Initiatives such as the establishment of rural clinical schools and university departments of rural health which aim to move education, research and training opportunities for medical, nursing and allied health professions into rural and remote areas are an essential component in building and sustaining a strong specialist base in these areas. While this does not suggest there should, for example, be radiotherapy units in multiple small communities across the country, which would be unsustainable both economically and clinically, the development of expertise to manage a greater proportion of acute episodes, chronic conditions and palliation in a sustainable manner is an outcome that

Commonwealth initiatives such as the rural clinical schools should seek to achieve. At the same, it is essential that communities work closely with such developments as they provide the opportunity for the communities' needs to be more effectively addressed.

* *Accessibility/Remoteness Index of Australia developed by the National Centre for Social Applications of Geographic Information Systems (GISCA).*

Telemedicine in Rural & Remote Oncology

Prof Ian Olver, Royal Adelaide Hospital

The management of cancer has become increasingly multidisciplinary. An effective way of planning patient management is to hold regular multidisciplinary team meetings. There can be a disadvantage to patients who have cancer, who live in remote or small centres which do not have the full complement of cancer specialists.

A videoconferencing link was established between the Royal Adelaide Hospital Cancer Centre and the Royal Darwin Hospital and evaluated.

All clinicians found the telemedicine link to be either useful or very useful in at least one aspect of their practice. The major benefit was cited as enabling remote area clinicians to participate in multidisciplinary cancer meetings. Three of the five remote clinicians who practiced solely in the Northern Territory found that the telemedicine consultation increased their workload, while only two of 13 clinicians whose practice solely in South Australia reported an increase over their normal activities, the others reporting no difference.

Benefits identified included better support of isolated clinicians, decreased travel for patients, and enhanced education and peer review. Perceived difficulties were technical problems, the impersonal nature of the interaction, inability to examine the remote patient and lack of reimbursement for the consultation.

Seven of the eight patients surveyed were satisfied or very satisfied with the telemedicine consultation. Four patients wished to have access to video tapes of the multidisciplinary meeting. Of those requiring travel for treatment, all believed that the prior telemedicine consultation influenced their care and shortened their time away from home.

The future will see more teleradiology and telepathology and POTS teleoncology links between patients at home and their clinicians in hospital.

Appendix 4: Workshop Reports

The workshops were undertaken with the understanding that people in rural Australia affected by cancer have the right to cancer treatment services of the highest quality, that is evidence based, nationally accredited, accessible and as close to home as can be done safely. While some travel will always be required, this should be supported nationally and equitably.

Medical Oncology **Facilitator – Dr Fran Boyle**

Patients will accept treatments of considerable toxicity for small potential gains in survival. Treatment toxicity and mortality erodes survival gains. Safety is a prime consideration in delivery of services in rural Australia. Inputs are essentially portable.

Drugs

- Accessibility, affordability
- Safe mixing, transport and disposal

Workforce

- Oncologists
- Special nurses and GPs
- Pharmacists

Facilities

- Any hospital/day facility with resuscitation facilities
- Communication

Immediate actions

- IPTAS reform
- Federal funding for nurse/GP training in administration of chemotherapy

Palliative Care **Facilitator – Professor David Currow**

Caveats

- Primary carers – community nurses, GPs
- Palliative services – consultative

Proposals

- Comprehensive Cancer Centres (CCC) must have Palliative Care Services (PCS) as an integral part of their services (including at multidisciplinary clinics).
- Define model of PCS by population, geography
- Service networks – national. Everyone with a palliative role can identify the other members of their team. Infrastructure costs, esp. solo practitioners.

- Pilot project mentoring – minimise isolation and burnout.
- Pilot project – Community capacity building. Facilitate community based care by more actively mobilising and coordinating community resources, referral → bereavement.
- Remuneration – Having activated Extended Primary Care, Medical Benefit Schedule items – subsequent higher rebate for home visits, travel.

Psycho-Oncology

Facilitator – Professor Phyllis Butow

Psychosocial Issues

The workshop highlighted nine psychosocial issues to be addressed to lighten the burden for those in the bush.

Psychosocial support is needed by both the patient and the family.

- To provide someone to talk to, privately if necessary
- To help identify anxiety and depression
- To help with referrals and access to mental health professionals
- To facilitate contact in the family
- To provide help dealing with survivorship issues
- To provide help dealing with bereavement

Management of home care

- To help manage side effects
- To help manage the household

Financial assistance

- Travel accommodation, prosthesis
- Out of pocket expenses
- Inequities
- Home modifications/equipment

Maintaining links between experts and local teams

- Telemedicine
- Coordinating care
- Appropriate handover
- Discharge and coordination

Supporting the local team

- Education
- Shortages
- Expenses
- Recognition, debriefing
- Screening

Information access

- Written sources

- Promotion of existing information
- Tailored and repeated
- From diagnosis

Prevention and early detection

- Special needs groups
- Identifying rural and remote patients in the health system

From these issues, the workshop drew up a list of 14 recommendations

- That psychosocial issues are given a high priority in the overall cancer management plan at the local level, and that this plan is resources and widely disseminated.
- That programs for upskilling local professionals are implemented to enable them to provide optimal psychosocial care, including emotional support, referral and information provision.
- That programs be implemented targeting preventable cancers, and early detection of cancers with high incidence in rural and remote areas (e.g. lung, cervical and melanoma) and that these are evaluated.
- That rural and remote patients are flagged on all medical records (electronic and paper).
- That a program of psychosocial screening be put in place to allow appropriate and cost effective services to be provided to each individual.
- That a multidisciplinary care plan be developed for each patient and documented in patient held records on an ongoing basis.
- That strategies of care coordination be implemented to ensure continuity of care and good communication between all levels of the health system in a timely fashion e.g. cancer nurse, video conferencing.
- That the patient support finding scheme be reviewed specifically as it relates to cancer services for people in rural and remote areas. This review should specifically address:
 - The lack of equity in the local administration of the scheme
 - The differential eligibility criteria used by States and Territories
 - The lack of recognition of the psychosocial support needs of cancer patients and their families
 - The specific needs of groups with special needs
 - The inadequacy of funding for cancer patients. Including considerations such as the frequency of travel required
 - That a State be identified to perform a joint feasibility study to improve services

Expected outcomes:

- a) nationally established scheme for cancer patients, with adequate funding, standard eligibility criteria
- b) standard guidelines for administration that streamline the process

- That further research be conducted to identify the costs to the patient, their family and the community of a cancer diagnosis in rural and remote areas.
- That all areas are covered by a 24 hour phone service providing emotional and practical support, using a model appropriate to that area.
- That programs are implemented nationally to support and upskill patients and their carers (e.g. Living with Cancer).
- That outreach services of specialist cancer psychosocial professionals be established.
- That peer support programs such as those for women with breast cancer, be developed, implemented and evaluated for people with all cancers, including programs for special needs groups.
- That innovative approaches and technology be expanded for providing psychosocial care.

Radiation Oncology Facilitator – Dr Liz Kenny

- Advocate for the implementation of the recommendations of the national strategic planning committee.
- A realistic appraisal be made of the cost of radiation treatment using a two machine model with appropriate staffing and workloads including start up costs (this is of particular relevance to the regional setting).
- Action the results of the NCCI Radiation Oncology Utilisation Study.
- There be an urgent review of PTS arrangements with uniformity across States and Territories addressing
 - Distance
 - Escorts
 - Accommodation allowance
- Relative cost effectiveness study of radiotherapy be commissioned (Terms of Reference to be developed by relevant professionals and cannot distract from other recommendations).
- Enhancement of regional and rural radiation oncology services.
 - Outreach clinics (properly costed into the funding model).
 - In full cooperation with surgeons and medical oncologists.
 - Strengthen linkages with GPs and paramedical staff.
- Ask the FRO, RANZCR to factor outreach services into manpower and workforce data.

Surgical Oncology Facilitator – Professor Bob Thomas

The group identified a number of issues which needed to be considered. These were as follows:

- Types of hospitals where Surgical Oncology could be carried out.

- The concept of patient triage, that is the direction of patients to appropriate services.
- The need for introduction of this multidisciplinary care.
- The training of rural surgical oncologists.
- The appropriateness of good communication between the various groups providing Surgical Oncology.
- The development of supportive services.
- The need for involvement in clinical trials.
- With respect to the categorisation of hospitals where Surgical Oncology could be carried out, it was considered that the hospitals could be best defined by the various facilities which were available including:
 - a) The appropriate level of surgical expertise.
 - b) Radiology support.
 - c) Pathology support.
 - d) HDU or ICU to support the surgical service.
 - e) Appropriate medical support.

On this basis one could divide hospitals into effectively:

- a) General practitioner hospitals.
 - b) A type of “one surgeon” hospital.
 - c) A base hospital.
 - d) A regional centre.
 - e) A major city comprehensive cancer centre.
- Patient Triage – this is a real issue which requires definition. The issue is the question of transporting a patient to an appropriate facility. It’s recognised that many patients will want to have their surgery close to their home. This needs to be balanced with the requirement in principle of providing evidence based high quality surgical care to the patient.
It was considered that it would be possible to define a list of patient conditions where an appropriate level of expertise was required in order for the surgery to be carried out. For example, in breast cancer it may be reasonable to carry out this type of surgery in a base hospital setting providing adequate radiology and pathology arrangements and services are in place. There also needs to be communication, multidisciplinary care and medical oncological and radiation oncology services available.
However patients such as those with low rectal cancers, advanced gynaecological cancer, real complex cancers or intra-thoracic cancers may need to be transferred.
 - Multidisciplinary Care – the critical part of appropriate Surgical Oncology practice. This currently relies on informal networks. These need to be flexible, accessible and patient focused. However it’s considered that organisation may help and it’s proposed that networks be established and funded via appropriate communication systems and travel and through shared video links to create

appropriate multidisciplinary care and make it available to the rurally based patients.

- Training Issues

There was considerable discussion about the training of rural and surgical oncology practitioners. In fact it was recognised that many matters were in hand with respect to this, particularly through the Royal Australasian College of Surgeons. One particular concept however which was considered innovative and interesting would be to fund so called “in reach” programs where surgeons practising solo in district hospitals could be appointed to base hospitals both to provide support in a base hospital setting but also to allow them to bring patients from their setting with cancer into the base hospital where they could get more appropriate management.

- With respect to supportive services, it was recognised that there is a continuing need for oncology nursing, oncology coordinators, transport support, funding in the form of the breast care nurses and development of programs which will enable the rural patient to feel less isolated in the management of their problems. One issue which was thought to be particularly valuable here was the development of the patient record, currently being developed in a number of breast cancer areas. This could be extended to cover many different cancers and would provide a uniform communication system for patients seeing a variety of doctors.

- Clinical Trials

It is believed that the rural communities were consistently disadvantaged by their lack of access to clinical trials. The rural community is in fact ideal for clinical trial involvement and it is believed that a program could be funded to provide database coordinators who would work with the rural practitioners and where appropriate, particularly in Surgical Oncology, contribute rural patients into clinical trials.

Appendix 5: Opening & Closing Addresses

Opening Address

Dr Michael Wooldridge
Minister for Health and Aged Care

Thank you for the opportunity to open this Conference aimed at optimising clinical services for cancer in rural communities. I congratulate everyone who has stayed on from the National Rural Health Conference – for your stamina.

The previous Conference covered an extraordinary range of topics and issues and was important for bringing together a critical mass of health professionals and community representatives who rarely have a chance to meet as a group.

At the same time, one of our greatest challenges in rural and remote health is to address the tension between access to services and quality of care.

This is particularly important for cancer, which is always traumatic for the individuals affected -- and can also strongly affect their families, friends and colleagues. So I fully support the aims of this Conference, in bringing together a range of clinical, research, consumer and government representatives to identify and address deficiencies in rural cancer care.

I firmly believe that so long as the quality of care is not compromised, cancer should be treated and managed in local communities, to avoid dislocation from family, friends and familiar surroundings at what can be an enormously difficult time.

I also believe in the power of such familiar surroundings to assist the recovery process and improve quality of life as treatment progresses.

Treatment in local communities is a substantial challenge in Australia, given the dispersion of our remote communities, so refining the solutions will require the input and experience of everyone participating in this Conference.

For our part, the Regional Health Strategy I announced last year has a number of positive benefits for treating and managing cancer in rural areas, including:

- Increasing the number of GP training positions in rural Australia;
- Providing more allied health professionals to work with local doctors to meet community needs;
- Providing specialist outreach services to bring visiting specialists into rural and regional areas;
- And a chronic disease strategy to help rural Australians prevent disease and injury.

The Australian Medical Workforce Advisory Committee estimated in 1998 that we face a shortage of around 30 radiation oncologists nationwide and this demands a response, especially as this shortfall is likely to have most impact in regional areas.

So we are funding the development of a national strategic plan by the Royal Australian and New Zealand College of Radiologists to establish the infrastructure and the medical and ancillary workforce required to improve access to radiation oncology services.

The introduction of the Single Machine Unit Trial, also offers the opportunity to examine alternative models of radiotherapy treatment for rural and remote patients.

This trial will test the extent to which Single Machine Units improve access and use of radiotherapy services, without compromising quality of care.

It will also investigate the cost-effectiveness and long-term financial viability of Single Machine services when compared to a major metropolitan centre.

This five-year trial of radiotherapy services will occur in Ballarat, Bendigo and the Latrobe Valley, whose residents have depended until now on facilities at Wodonga or Melbourne.

And the evaluation of the trial will look at clinical outcomes including the types of cancers that can be treated successfully in this way and the satisfaction of patients with the service.

More broadly, we are very active in a range of programs directed to cancer control covering the whole spectrum from prevention to detection and diagnosis, treatment and management - and, of course, palliative care.

In the area of prevention, our National Tobacco Campaign addresses the largest single cause of preventable death and disease in Australia.

The death rates for smokers are twice those of non-smokers, and the heaviest smokers have overall cancer death rates four times as great as those of non-smokers.

We are pursuing a range of measures under the National Tobacco Strategy to discourage people from taking up smoking and to encourage those people who already smoke to stop.

These include:

- education programs and campaigns;
- pricing measures;
- health warning labels on tobacco products;
- and the banning of tobacco advertising, promotion and sponsorship.

As just one example of our efforts in detection and management of cancer, the BreastScreen Australia Program is jointly funded with the States and Territories with the aim of achieving significant reductions in breast cancer mortality and morbidity by screening women without breast symptoms on a biennial basis, free of charge.

The aim of the Program is to detect breast cancer in its early stages, when the chances of successfully treating it are maximised. Screening units regularly travel throughout the countryside to increase access and utilisation by taking the service into local communities.

Importantly, the Program also offers information, support and counselling to women who are diagnosed with breast cancer, which has great benefits for women in rural and remote areas.

Our Multi Disciplinary Care Program is investigating the cost, acceptability, feasibility and impact of strategies to foster multidisciplinary care for women with breast cancer. As you may know, in multidisciplinary care there is a high level of communication among clinicians, who agree as a team about the treatment options for women with different circumstances and cancer presentations.

Multi-disciplinary care has substantial benefits for women in rural areas, as there are opportunities for their local doctors to be linked with larger centres, and we anticipate that evidence from the project could support national implementation of multidisciplinary care for breast cancer.

Overall, we are tackling cancer across the country on a number of fronts but I don't pretend that the picture is complete. This Conference has an important place in identifying and filling in the gaps so I look forward to seeing the recommendations that emerge from today's proceedings.

I know this work will ultimately benefit many individuals in many communities by reducing the tragic impact of cancer through an improved ability to treat and manage cancer locally.

So I wish you an instructive and productive day as you address the vital issue of optimising cancer control for people living in rural and remote areas.

Closing Address

**Senator Grant Tambling
Parliamentary Secretary for
The Minister for Health and Aged Care**

I appreciate the opportunity to provide the closing remarks, to what I am sure has been an enjoyable, productive and very successful Cancer in the Bush Conference.

The recommendations that you have produced are interesting and provide good food for thought. The Government will consider them carefully in the light of their policy and financial implications. I know the Health Minister Dr Wooldridge appreciates your work and interest.

As Senator for the Northern Territory, I am very familiar with the concerns and needs of people living in rural Australia. My electorate covers an area of 1.35 million square kilometres. Chronic diseases such as cancer are a major challenge, but this Government's programs are making a difference for many people living in the bush.

We support a vast range of programs in cancer control. Can I begin by highlighting just two of the more important initiatives: the cervical and breast cancer screening and treatment programs and their impact on indigenous women, an especially vulnerable group.

The Breast Screening Program provides a comprehensive service to rural and remote areas. There is a network of 46 mobile screening vehicles currently operating in Australia in over 500 locations. This is no mean feat! In some cases it has been necessary to

purpose-built 4-wheel drive trucks to allow the transport of mammography equipment by road and barge to remote communities and islands.

For example, to reach the outer Torres Strait Islands requires three separate barge trips,

- the first from the mainland coast by landing barge to the coastal freighter (where the transfer of the truck from one vessel to the other happens at sea),
- the second to Thursday Island, and
- the third from Thursday Island to the Outer Islands.

The staff of BreastScreen Australia take special care to ensure these rural visits are successful.

This requires a visit by recruitment and promotional staff prior to the mobile van visits to conduct publicity drives, inservice training for local health workers, checking the proposed screening site, power and other technical requirements, as well as access for equipment, clients and staff.

Most women who attend for breast cancer screening will get a normal result and no cancer will be detected.

However, for some women - abnormalities will be detected which require further assessment.

To enable these rural women to attend BreastScreen Australia assessment clinics, States and Territories provide a patient travel subsidy scheme. This scheme contributes to the cost of travel and accommodation, and in some cases, their carers who are required to accompany them.

Many rural communities have become strong partners in providing support for visits of the BreastScreen Australia vans.

For example, in Queensland, a team of trained volunteers from the Queensland Country Women's Association and The Older Women's Network assist women to fill out their forms when they arrive for their screening appointments.

These kinds of support programs pay off. In 1996, more eligible Queensland women living in rural and remote areas participated in the Program, than women in urban areas.

The BreastScreen Australia Program recognises the importance of public relations campaigns and media awareness to reach rural women to participate in the Program. In addition, community libraries are provided with information packs containing brochures, posters, and bookmarks, and encouraged to display BreastScreen Australia information to raise general awareness.

Sara Henderson has been the campaign figurehead for BreastScreen since 1995. Ms Henderson is a well-known identity who lives on the Bullo River property in the Northern Territory outback. Ms Henderson has been very well received by the target-age women, especially in rural areas.

I know she is hard working, plain speaking, and talks very personally to those who need to hear her breast cancer awareness message.

I would like to take a few moments now to talk about the importance of providing help for women diagnosed with breast cancer and how the whole community can help in strengthening that vital support structure.

The demands faced by women and their families after diagnosis of breast cancer are considerable, including increased emotional, practical and financial burdens. Research shows that 25-45% of women with breast cancer experience significant psychological problems.

In the May 1999/2000 Federal Budget, funding of \$4.1 million over four years was announced for the Strengthening Support for Women with Breast Cancer Initiative which will focus particularly on women living in rural and remote areas.

This Program is being established through partnership with the Commonwealth and State/Territory Governments.

Each State and Territory has begun to develop relevant local strategies. The types of programs that States/Territories are undertaking include an audit of current support services and their delivery, and the provision of breast care nurses or other models of care that are appropriate.

In my own area, the Northern Territory Cancer Council is in the process of appointing a Breast Care Nurse to support women with breast cancer and their families throughout their treatment process. Such nurses will be able to provide continuity of care by appropriate referral to other support services.

The Breast Care Nurse has been found to be of most benefit to women in ensuring good communication between health providers and women with cancer.

But discussion of breast cancer in this country cannot be done in isolation from that other significant disease for Australian women - I refer to cervical cancer.

The National Cervical Screening Program was introduced in 1991 with the aim of reducing morbidity and death from cervical cancer. A major challenge for the National Cervical Screening Program is to increase participation in the Program in those groups who do not have a Pap smear every two years.

Two of the key under-screened groups are women in remote and rural locations, and Aboriginal and Torres Strait Islander women. These women face a number of barriers to screening, such as:

- access to GPs, including distance from a surgery;
- Poor transport;
- Lack of child care facilities;
- Difficulties in having time off work; and
- Financial problems.

These factors are exacerbated for indigenous women who often lack the use of a car and who live in areas with poor public services. Other potential barriers for these women include:

- poor understanding of, or confusion about, Pap smears;
- fear of the procedure, embarrassment or misunderstandings about the nature of the test;
- unpleasant past experiences; and
- most worryingly, a belief that nothing can be done to prevent cancer.

Indigenous women are nine times more likely to die from cervical cancer than non-Indigenous women.

These are considerable problems for us to address. The Commonwealth has responded by establishing an Aboriginal and Torres Strait Islander Women's Forum, as a working group of the National Advisory Committee to the National Cervical Screening Program. I would also like to mention the exciting new program investigating methods of early detection of bowel cancer.

Bowel cancer is the second most common cause of cancer related death with the risk increasing after the age of 40. Planning for and addressing rural access and quality of care issues is fundamental to the development of the bowel cancer screening pilot program.

This brings me to the issue of chronic disease in general and the management of persistent illness.

The treatment of chronic diseases including cancer requires among other aspects, timely access to pharmaceutical products for pain management and other aspects of care. The provision of the so-called 'Section 100 arrangements' has enabled communities to order bulk supplies through pharmacies.

Appropriately trained medical professionals can supply these to patients at the point of consultation without the need to have the usual Medicare concession identification or presentation of a prescription and concession card to a community pharmacy. This greatly improves access to medicines for people receiving health services at remote Aboriginal Health Services.

This Government also recognises the need to provide appropriate care for those throughout the spectrum of cancer control, especially palliative care.

In October 2000, the Commonwealth, States and Territories agreed to the revised National Palliative Care Strategy. This strategy supports the development and delivery of flexible services for palliative care in rural and remote communities, an important component of cancer care.

This Strategy also supports the development of partnerships between rural health providers and health organisations and networks. A number of national projects funded under this Program are now in full swing and support the delivery of palliative care in rural areas.

Finally, we know that the very mention of the word cancer can strike fear into the hearts of most, and so the need to access information about cancer is especially important for the general public.

HealthInsite, the Government's website and gateway to reliable health information, has made it simpler for people to sort through the plethora of information, often of varying quality.

People can access a cancer topic, which includes comprehensive information on the cancer, with direct links to other websites. HealthInsite covers specific information about breast cancer, skin cancer, uterine cancer, cervical cancer, ovarian cancer, prostate cancer, living with cancer, support services, and statistical resources.

Cancer is consistently listed in the top ten searches conducted by consumers using the site, showing that we are indeed meeting a real need.

I would like to conclude by saying again that the Government is committed to improving health services in rural Australia, especially for chronic disease.

The number of cancer control activities you have heard about at this conference, as well as the Rural Health Strategy, are a clear indication of our achievements in ensuring that patients and communities have the best possible health care and information available to them.

Appendix 6: Media Releases



MEDIA ALERT

Cancer in the Bush: Doctors seek solutions to rural access problems

Canberra – Thursday 8 and Friday 9 March

Cancer specialists from across Australia will gather in Canberra this week to identify the unique problems facing people with cancer who live in rural Australia.

The first “Cancer in the Bush” conference will consider issues facing cancer patients rural areas in accessing quality medical, surgical and radiotherapy treatments, palliative care and psychosocial support.

Expert speakers will highlight the differences in cancer incidence and deaths in urban and rural Australia and inequities in access to both clinical and supportive care services outside metropolitan areas.

The meeting will be opened by the Federal Minister for Health and Aged Care, Dr Michael Wooldridge, at 8.30am tomorrow.

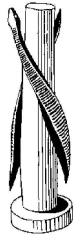
More than 120 invited participants, including cancer clinicians from rural areas and representatives of Federal, State and Territory Health Departments, will identify possible solutions.

A series of recommendations will be presented at the end of the conference [11.30am, Friday] and a full report will be prepared for the Federal Government.

The meeting was organised by the Clinical Oncological Society of Australia, Australian Cancer Society and the Commonwealth Department of Health and Aged Care, with financial support from Macquarie Bank.

Media contact

Lisa-Maree Herron, Australian Cancer Society: 0438 239 409



MEDIA RELEASE

Cancer in the Bush: Rural patients disadvantaged

Cancer patients living in rural and regional areas of Australia are facing an extra financial and emotional burden in accessing the treatment and support services they need.

A meeting of consumers, cancer specialists, nurses and government representatives in Canberra this week has found that the financial and personal burden of cancer is much greater for people with cancer in rural areas than city patients. Further analysis of cancer outcomes was needed to determine if there was a difference in survival rates between urban and rural areas.

The first “Cancer in the Bush” conference, organised by the Clinical Oncological Society of Australia (COSA) and Australian Cancer Society, has identified the unique problems facing rural cancer patients in accessing quality medical, surgical and radiotherapy treatments, palliative care and support.

Convenor Dr David Goldstein said the meeting had identified both the problems and possible solutions, which would be recommended to government.

“Many of the problems faced by rural patients revolve around financial and emotional costs of travel necessary to obtain treatment and access services,” Dr Goldstein said.

“While there is some financial assistance available to help meet the costs, eligibility differs greatly between states and territories and patients tell us the system is too complex. It is critical to reform this program so that it assists, rather than frustrates, patients.”

The meeting has recommended the development of regional cancer centres and increased delivery of services in remote areas, but acknowledged that it is not possible to provide all specialised treatments in every centre. Dr Goldstein said this reinforced the need to address the burden on patients and their families of travelling to quality cancer centres and related issues.

Conference delegates also highlighted the difficulties and sense of isolation facing rural doctors and nurses, leading to a high burnout rate and loss of services.

Dr Goldstein said workforce issues, particularly the strains on rural GPs and nurses as the primary carers in most rural areas, needed to be addressed.

“We need to establish links between city expertise and bush expertise, and improve communication between the various specialists providing treatment to a rural patient,” Dr Goldstein said.

“This meeting has identified some exciting examples of best practice strategies to overcome these problems, and we hope to work with governments and other agencies to implement them.

“On the positive side, we recognise the strength of community support that does exist for cancer patients in rural communities, and we need to take advantage of that in our efforts to improve care and services.”

Professor Alan Coates, Chief Executive Officer of the Australian Cancer Society, said while many of the solutions may have to be implemented at the state or territory level, there was a clear need for national action and minimum standards.

“Rural and regional centres deserve multi-disciplinary care and treatment services appropriate to their population and needs,” Professor Coates said.

“Currently, there are still many communities where there is a single GP or community nurse without any support or access to advice. In the bush, the GP or nurse is the key carer and we have to provide them with the skills, time and access to expert support to allow them to care for their patients.

“Comprehensive cancer care includes not only treatment, but appropriate supportive and palliative care. Regardless of where they live, cancer patients and their carers and families need information and psychosocial support. At present, we’re selling the bush short.”

A complete set of recommendations from the meeting is being prepared for the Federal and State and Territory Governments.

The meeting was organised by the Clinical Oncological Society of Australia, Australian Cancer Society and the Commonwealth Department of Health and Aged Care, with financial support from Macquarie Bank.

9 March 2001

Media contact

Lisa-Maree Herron, Australian Cancer Society: 0438 239 409

Media Release

Dr Michael Wooldridge
Minister for Health and Aged Care



MW14/2001
8 March, 2001

More access to cancer services for people in the bush

The burden of cancer on patients, families and their communities is a particularly pressing problem for people in rural and remote Australia, the Federal Health Minister, Dr Michael Wooldridge, said today.

Dr Wooldridge made the comment when he opened a two-day conference about cancer in the bush, convened by the Clinical Oncological Society of Australia (COSA) and the Australian Cancer Society (ACS), at the National Convention Centre in Canberra.

"The Government is strongly committed to rural Australia. This means reducing the tragic impact of cancer through an improved ability to treat and manage cancer locally," he said.

Dr Wooldridge said the challenge of providing health services in the bush for cancer sufferers is addressing "the tension between access to services and quality of care."

"The Government supports a number of health programs, including a multi-disciplinary cancer care approach that has substantial benefits for rural people as their local doctors can be linked with specialist cancer centres," Dr Wooldridge said.

"I look forward to considering any recommendations made as the result of this conference, which may assist with solving this tension," he added.

Media Contact:

Serena Williams, Minister Wooldridge's office 0411 261 627
Robyn Hall, Department of Health and Aged Care (02) 6289 5485

Appendix 7: New Initiatives In Improving Cancer Services

- NBCC Adjuvant chemotherapy (RHSET)
- MOGA medical oncology services paper
- Regional Cancer Centres – Wodonga, Townsville
- Single unit radiation oncology project
- Shared care in Haematology project
- Royal Adelaide teleoncology

Appendix 8: Website References

Australian Medical Workforce Advisory Committee
<http://amwac.health.nsw.gov.au>

Rural Health
www.health.gov.au/ruralhealth

National Breast Cancer Centre
www.nbcc.org.au

National Cancer Control Initiative
www.ncci.org.au