CANCER CARE ACROSS BORDERS: THE POTENTIAL FOR EXCELLENCE WHEN COLLABORATION IS GENUINE

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Abstract

The Border Cancer Collaboration is a coordination of care model developed from the documented success of the Border Cancer Care Coordination project.[1] The collaboration is designed to overcome the difficulties of providing equitable services for cancer patients, their carers and families when federal, state, public and private, acute and community health borders exist. It provides a model of potential excellence in cancer care for regional Australia.

Cancer care in north-east Victoria and south-west NSW is complicated by the jurisdictional issues of borders in healthcare: two state health services requiring compliance with respective cancer frameworks,[2,3] and cancer specialists who are for the most part private practitioners providing services in two public hospitals and two private hospitals. General Practice is Commonwealth, supported through the Border Division of General Practitioners, which services both Albury (NSW) and Wodonga (Victoria) practices.

The difficulties of these jurisdictional issues has led to inequities in the delivery of cancer and cancer support services to residents based on where they lived, rather than their needs.

Profile of cancer services in the region

The twin cities of Albury and Wodonga support a municipal population of 83,000[4] people within a regional population of 150,000. Provision of chemotherapy and radiation oncology services is to an even larger catchment, estimated at 200,000. Up until 1998 the area had been serviced by cancer outreach services from Melbourne, but now has five resident oncologists, a clinical trials unit and a two machine radiotherapy service, treating some 750 local patients per year.[5] While the clinical services are impressive and substantial, what had been lacking was the coordination of care for cancer patients, their carers and families, despite our understanding that this was essential to best outcomes[6] and an acknowledged dearth of psychosocial support for these people.

From 1999-2002 Albury and Wodonga health providers participated in the Victorian Breast Services Enhancement Program (BSEP), which demonstrated that coordination of care and multidisciplinary care could work across state, public and private, acute and community health boundaries.[7] The local BSEP stakeholders had a vision of the 'best of breast' being available to all cancer patients – that the principles underpinning breast cancer support were applicable to other cancers.[8] Between 2003-06 these principles were built on locally through the Commonwealth-funded Border Cancer Care Coordination Project (BCCCP). This project demonstrated the value of cancer care coordination positions, the benefits of multidisciplinary team meetings and psychosocial supports, the importance of accurate local data and the capacity of building the cancer service sector through a coordinated, planned approach to service delivery and support.[1]

The BCCCP had been overseen by a national external advisory group of cancer specialists, which had given it credence and ensured congruity with the national, NSW and Victorian frameworks for cancer services improvement.

The external group had provided input and advice to the local steering committee, which initially comprised the key stakeholder organisations from the BSEP. The project was externally reviewed by Professor Michael Barton[9] and was found to have successfully improved patient care and experience, established care coordination in a regional centre, successfully trialled non-nursing cancer care coordinators and modelled cancer care across borders.

The action research nature of the BCCCP had allowed the steering committee to deliver services, while at the same time evaluating their efficacy and refining their processes. At the end of the project phase, the level of cancer services in Albury and Wodonga had increased substantially and sustainably through the investment of resources (staff positions) in the region by both the NSW and Victorian governments, under the principles of their respective cancer frameworks. From NSW, the positions are funded by the Cancer Institute NSW and implemented through the Greater Southern Area Health Service (GSAHS). In Victoria, the positions are funded through the Department of Human Services (DHS) Victoria via the Hume Regional Improvement for Cancer Services (RICS). Locally, additional resources are contributed by Wodonga Regional Health Service and Upper Hume Community Health Services. A very important contribution is through the unpaid participation in multidisciplinary care and multidisciplinary team meetings by surgeons and cancer

Findings of external review of the Border Cancer Care Coordination Project[9]

The BCCCP has:

- overwhelmingly improved the range and efficiency of multidisciplinary clinics;
- improved the operation of multidisciplinary clinics in all areas and assisted clinicians to make a more efficient use of their time;
- improved access to services, particularly to general support services available in the community. This was a particular asset of a cancer care coordinator with social work background;
- developed a viable model of care coordination outside a major city. BCCCP's model should influence role design and function of cancer care coordinators rather than be subject to dictates from afar;
- identified and supported patients before and after they travel out of the region for treatment;
- made active attempts to involve general practitioners (GPs) in multidisciplinary clinics in a way that was innovative and leads the field;
- direct applicability to other regions in Australia that have similar geographic and jurisdictional circumstances.

"BCCCP appears to have been an excellent implementation of cancer care coordination in a regional setting. The final draft report accurately portrays the project aims, methods and results. It may take several years to measure the full benefits and to assess sustainability."

specialists. The private hospital sector contributes infrastructure support for meetings and multidisciplinary team meetings.

A key issue for all parties is the need to be able to provide local solutions, while still complying with funding body principles and policies. For example, the NSW Cancer Framework mandates that cancer care coordinators must be nursing positions with direct patient contact, while the Victorian direction does not mandate nursing, but views the cancer care coordinator as a position working to develop system capacity, rather than having direct patient contact. Locally, the BCCCP had demonstrated that care coordination could be effective as a non-nursing position, as long as nursing support was available and had also shown that direct patient contact was essential for the role, while still working on systemic development. The success of local work in the context of broader conflicting models, depends on the adoption of evidence-based principles and practice of successful partnerships.

Why is Albury Wodonga cross border cancer care working?

Once the project funding ceased, the steering committee reviewed terms of references and membership in order to facilitate sustainable collaboration.

Working in a regional cross-border setting, all health professionals had a shared understanding of the barriers that borders bring to effective healthcare, and had a true desire to see ''good things'' resulting from working together for the benefit of cancer patients. We had demonstrated that this could be achieved through our BSEP and BCCCP projects. What was now required was to ensure mainstream, long-term delivery under the models we knew worked for our region.

Characteristics of effective collaboration

The steering committee members are the decision makers of their respective organisations – CEOs, chairpersons or regional managers – each able to bring resources to the table and to make decisions. They bring individual excellence, defined by Kanter[10] as having individual strength and something to contribute to the partnership.

The steering committee, through terms of reference and its formal status, has clear responsibilities and decision making processes. This extends beyond the particular people who formed it and cannot be broken on a whim.[10]

The committee has created a shared understanding of the aims of the alliance[11] – to provide patient-centred, multidisciplinary coordinated cancer care to our local communities. The literature shows that tailoring the mission and goals to fit the goals of individual member organisations, has been found to increase the chance that members will support the partnership, contribute resources and remain active participants over time.[12] In the Border collaboration, all members have to acknowledge the constraints and reporting demand made of the respective members by their funding or political masters. Internal memorandums of understandings and contracts have been developed that allow each partner to be able to fulfil their own individual organisational requirements, while still focusing on the larger picture.

The steering committee has an established history of trust and success (through the BSEP and BCCCP projects) and this has made it easier to coordinate work and divide responsibility.[12] The partners have invested in each other with long-term commitments of financial and other resources to the relationship.[10]

Synergy and transformational leadership

From the inception of the BSEP project the steering committee has achieved synergy – the power to combine the perspectives, resources and skills of a group of people and organisations resulting in creativity, comprehensive thinking, practical thinking and 'transformatic' thinking.[13]

All of the steering committee has had to embrace the mantle of transformational leadership.[14] Transformational leadership produces change through its emphasis on new values and a vision of the future which transcends the status quo. Such leadership inspires all to put aside their own interests for a collective team; this is what the Border leaders do.

The collaboration now has the opportunity to contribute to market forces through public policy, playing a critical role in fostering competition.[15] For example, it is possible that clinicians who do not participate in the multidisciplinary team decisions regarding patient care are missing market leverage and promotional opportunities and could be assessed over time as less attractive to patients. The Border group has attained a high level of domain consensus – the degree to which members agree and accept each others claims regarding products, services and clientele.[16]

Where to now?

Locally, the collaboration had been able to promote their 'quick wins'[17] and this, coupled with recurrent position funding by the NSW and Victorian governments, has resulted in a service platform which has been able to attract philanthropic and private investment. The collaboration now employs a considerable mixed workforce of professionals supporting cancer care coordination for the region (Table 1).

The collaboration now oversees monthly Albury Wodonga multidisciplinary team meetings for breast, colorectal, haematology and urology cancers, and a general tumour stream meeting in the city of Wangaratta. Through the Commonwealth research projects, the collaboration is also developing mentoring links toward multidisciplinary care in head and neck and paediatric cancers.

However, the differing politico-administrative culture of Victoria and NSW in the face of central policy dictates, creates barriers in mounting strategies relevant to local communities.[18]

The only components of the Border model that are not now recurrently funded are the management and infrastructure costs of keeping the collaborative model intact. This is the real risk of the collaboration. Without the management component to manage staff as an integrated team, to negotiate and manage the complex contracts and memorandums of understanding necessary in complying with various state and Commonwealth demands, the collaboration will have no future.

The Border Cancer Collaboration has overcome the classically renowned and long standing view that healthcare is 'a strife of interests'.[19] The steering committee and staff have achieved this by changing organisational culture in positive ways. The collaboration has built relationships, cooperated over the care of cancer patients and negotiated constructively when difficulties arise.[20] The evidence seems to be saying that changing the structure of the financial and delivery aspects of a health system may be a precondition to viable change, but of far more importance is the need to find, promote and nurture shared values and practices. It involves building relationships, working collaboratively, cooperating over the care of patients and negotiating constructively when differences arise.

The Border Cancer Collaboration has been able to develop horizontal and vertical integration, terms derived from economic theory, in patient care.[21] Horizontal integration is defined as the integration of activities which occur at the same level in the

Table 1. *Professionals supporting cancer care coordination*

Position	Full-time equivalent	Funding source
Cancer care coordinator - general	1	Cancer Institute NSW GSAHS
Continuity of care coordinator	0.8	DHS Victoria – Hume RICS
Cancer care coordinator	0.8	Wodonga Regional Health Service
Oncology social worker	0.6	Cancer Institute NSW GSAHS
Oncology dietetic support	0.2	Cancer Institute NSW GSAHS
Loss and grief counsellor	0.4	Upper Hume Community Health
Multidisciplinary team meetings administrator	0.6	Cancer Institute NSW GSAHS
Multidisciplinary team meetings administrator	0.6	Hume RICS
Website development and management	0.4	Cancer Institute NSW GSAHS
McGrath breast care nurse	1.0	McGrath Foundation
Leukaemia support services coordinator	1.0	Leukaemia Foundation
Manager mentoring research projects	1.8	Department of Health and Ageing

production process. In the border collaboration, the community health centre for example, employs the nurse cancer coordinator integrating a new product (cancer nurse coordination) into its more traditional social services product suite. The collaboration has also achieved integration vertically whereby the acute sector – inpatient, surgical and oncology treatments – integrate with the community sector – psychosocial supports, general practice and primary care – to provide seamless continuity of care.

Towards a centre of excellence

Despite the governance arrangements of Australia, many people would agree it is high time we resolved the politico-structural impediments to providing healthcare in an integrated way.[22] The multi-tiered nature of the Australian health system, particularly the discrepancies in state-to-state, state-to-federal and public-to-private systems, can create artificial and often frustrating and inefficient ways of working in cancer care. These can be overcome by health services seeking new, more cost effective configurations of services across speciality and organisational structures.[22] As the report says: "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".[23]

The evidence, considering rural inequalities in cancer care and outcomes, strongly suggests that we need to develop well-defined patient pathways that each person with cancer can follow to receive timely expert care. Such pathways necessitate effective interaction between the many services involved in cancer care, innovative information systems and cooperation between governments.[24]

The Border Cancer Collaboration is an innovative and flexible model that is integrating cancer services for our rural communities. It has demonstrated efficient navigable pathways for patients, their families and carers, and effective interaction between providers in multidisciplinary care.

It is now time for policy makers at all levels to acknowledge the success of the model and allow the collaboration to develop its full potential as a regional centre of excellence in cancer care. This will involve allowing the assessment of the risk of doing things differently and the resources to allow those risks to be managed.

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