



**Supporting Regional and
Rural Access to Radiation
Oncology Services**

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Key Issues

There are multiple barriers for rural and regional cancer patients to access services:

- The availability of quality and timely cancer care;
 - Financial burden of cancer and its treatment has a disproportionate impact on patients based on their geographical location;
 - Travel to receive treatments and the associated social burden;
 - Opportunities in communications technology still waiting to be harnessed to improve care and patient convenience;
- Rural and regional radiotherapy centres face challenges with recruitment and retention of workforce;
- Lack of effective coordination in service planning and workforce development for rural service provision.

Objective

Rural and regional patients have timely and affordable access to radiation oncology services.

Defining Success

A nationally coordinated and focused approach to improving rural and regional patients' access to radiation oncology services, including:

- Comprehensive, quality cancer care is available to patients, which includes a national patient travel and accommodation scheme;
- Models of care are locally tailored and appropriate to rural and regional areas;
- Strategies in place that recognise and ameliorate the financial and social impact of cancer on patients and carers in rural and regional areas;
- Innovative approaches to patient care are implemented, evaluated and supported.

Introduction

Providing equitable access to healthcare services for Australians living in rural and regional communities is a national priority. When compared to metropolitan populations, rural and regional patients have a number of specific challenges because they:

- Are more likely to present with late stage diagnosis;
- Have lower survival rates;
- Have greater difficulty accessing treatments of equal quality;
- May face a greater financial burden from cancer diagnosis and treatment¹.

Research indicates that people with cancer in regional areas are 35% more likely to die within 5 years of diagnosis than patients in the city². Death rate for patients with rectal cancer rises by 6% for every extra 100km a patient lives away from radiation therapy facilities³. There are numerous studies⁴⁻⁸ of health outcomes for cancer patients being compromised due to access to and/or distance from a treatment facility and access to the most clinically effective treatments.

Concerns highlighted in stakeholder submissions during the consultation process have been categorised into three main areas: patient access, facility workforce, and service planning, as illustrated in the following figure.

| Patient Access | Facility Workforce | Service Planning |
|--------------------------------|--------------------|--|
| Financial Impact | Recruitment | Tailored models of care |
| Travel & Accommodation schemes | Retention | Linked to a comprehensive cancer and specialised service |
| Innovation | | Allied health services |

Patient Access to Quality Services

Regional and rural patient access to cancer care services, including radiation oncology services, are adversely impacted by a number of key factors such as distance from facilities, financial burden caused by the cancer and the added emotional distress if there is a need to stay away from family and friends whilst undergoing treatment⁹.

Financial impact of cancer on patients

Cancer treatments, including radiotherapy, may impose financial pressures on patients, carers and their families. Examples of additional expenses include:

- The cost of travel and accommodation when treatment is sought from a facility away from home. Reimbursement of travel and accommodation can be process oriented and time consuming, and not reflecting the full costs;
- The cost of accessing alternative treatment providers, i.e. private or public facilities. In the former case, it may be gap payments and upfront expenses for the treatment; in the latter it may be the cost of travelling and staying away from home;
- The loss of income for patients, carers and their families; for example if travelling for treatment requires taking leave from work or bearing the loss of income for small business owners;
- Extra expenses such as child care fees while parents travel to metropolitan centres and stay away from home for the duration of treatment.

In many cases, radiotherapy treatments follow a significant number of medical investigations and services, at the time when the patient has already reached or is about to reach the Extended Medicare Safety Net thresholds. In some instances, patients may be required to pay significant out of pocket costs as gaps or may have to pay upfront for treatment. It was noted during consultation that there is not sufficient information about costs associated with treatment, alternatives and reimbursements, particularly for patients in rural and regional areas where treatment options can be limited.

Of significant concern to all stakeholders is that financial pressures regularly influence the choices that patients from rural and regional areas make with regards to their treatments. Without doubt, these pressures contribute to the poorer health outcomes experienced by cancer patients in rural and regional areas.

Patient travel and accommodation schemes

The State and Territory governments offer travel and accommodation assistance to patients living in regional and rural areas of Australia to access specialist services. These patient travel and accommodation assistance schemes (PTAS) are essential to patients and carers as they reduce some of the financial barriers for accessing appropriate clinical care.

Submissions from professionals, peak groups and experts working in rural and regional health services consistently commented on the fundamental importance of PTAS funding. The current schemes across Australia were criticised for their complexity and their insufficiency. The issues highlighted during consultation were supported by existing research^{9,10} and include:

- Significant differences in the eligibility criteria and reimbursements between jurisdictions;
- The reimbursements not reflecting the commercial cost of travel and accommodation;
- The complexity of procedures to access PTAS and delay in processing PTAS applications;
- Cross border jurisdictional issues complicating patient access to travel and accommodation assistance;
- Shortages of supported accommodation facilities linked to the radiation oncology centres.

Appendix III provides a snapshot of the PTAS arrangements as of 1 April 2012 across the Australian jurisdictions illustrating the differences in eligibility and rate of reimbursements and the gaps between the rate of reimbursement and the actual cost of travel and accommodation.

In 2007 the Senate Standing Committee on Community Affairs made sixteen recommendations on the PTAS in their report 'Highway to health: better access for rural, regional and remote patients'¹⁰, which highlighted many of the issues raised above. The Commonwealth Government's response to the Senate report supported many of the recommendations¹¹ yet the matter was largely deemed to be the responsibility of State and Territory governments. Since the publication of the Senate report, PTAS across jurisdictions have been reviewed, however, as the consultation for the Tripartite Plan has highlighted, significant shortcomings remain.

Although a detailed examination of PTAS is outside the scope of this Plan, the findings of the Senate report remain current and a further streamlining of the schemes is required to improve patient access to essential radiation oncology services.

Use of innovations to aid service provision

Innovative approaches to provide consultation, treatment and follow-up for patients should be incorporated into regional and rural patient service models. Telemedicine, enabled by the National Broadband Network, provides significant opportunities to improve professional support to regional radiation oncology services, outreach services and patient follow up¹². Telemedicine is vital to extending the benefits of multidisciplinary care to regional patients and reducing the associated cost of care. Although this is already established in Australia, the level of use of remote/telemedicine in radiation oncology is well behind other countries such as Canada and other medical disciplines in Australia.

There are existing initiatives in radiation oncology capitalising on the potential of telehealth, for example:

1. The North Coast Cancer Institute in NSW runs nurse-led phone follow-ups, doctor-led phone follow-up clinics, and video-conferenced clinics with patients.
2. Radiation Oncology Queensland are enabling nurses to follow-up patients about skin conditions two weeks after treatment using tablet computers, so patients do not have to travel to facilities once their treatment is completed.

Lessons learnt¹³ from successful telehealth projects in other health disciplines suggest that telemedicine has the potential to:

- Improve access to specialist health services;
- Reduce patient travel;
- Encourage local case management;
- Improve staff training and support;
- Improve recruitment and retention of staff.

Cancer care is increasingly multi-modal and multidisciplinary team (MDT) care is the gold standard of treatment. It is not always possible for regional and rural health services to support every discipline that makes up an MDT. In this context, telehealth can also alleviate some of the pressures that specialist shortages in rural areas create. The use of videoconferencing or web-conferencing technology can enable access to tumour-specific MDTs¹⁴. Patient access to these telehealth innovations are further supported by the Medicare Benefits Schedule item numbers, making it a feasible and practical direction for regional health planning.

Facility Workforce

Challenges around recruitment, retention, and professional isolation for the health workforce in rural and regional Australia are well documented¹⁵. Submissions to the Tripartite Plan from radiation oncology professionals, jurisdictions and peak groups have all highlighted a significant concern around workforce sustainability in regional cancer centres. Submissions stressed that regional radiation oncology centres are currently experiencing difficulties with recruitment and retention of specialist staff in the absence of a planned national approach for regional radiation oncology workforce. The issue is expected to become more acute over the coming decade as new regional cancer centres become operational.

Recruitment

Radiation oncology should learn from the experience of other acute medical services which have a longer history with service provision in rural and regional areas. There have been a number of studies undertaken to identify barriers to ensuring sustainable workforce in rural and regional areas. Research indicates a connection between a number of factors and rural practice, which affect recruitment and can be summarised as follows¹⁶⁻²⁶:

- Rural and regional origin;
- Partners of rural origin and other family considerations;
- Professional background and career plans at the time of admission to medical school;
- Long term earning potential;
- Professional development opportunities;
- Availability of quality primary and secondary education; and
- Rural undergraduate and post graduate training experience.

At present, radiation oncology workforce training is necessarily concentrated in metropolitan centres. This may have an impact on the availability of workforce to staff regional cancer centres²⁷. It is therefore pivotal that training is extended to rural and regional locations. However, this must be done in a sustainable and clinically appropriate way, so as not to compromise patient care and to ensure appropriate level of training and supervision.

Workforce planning for rural cancer centres must ensure comprehensive care inclusive of expert radiation oncology nurses, all allied health groups and psycho-oncology professionals, in addition to access to multidisciplinary medical teams.

Retention

Retention of skilled workforce in regional and rural areas similarly requires a proactive approach and planning. There are personal, professional and service-related considerations that play a part. Consultation findings suggest that these considerations in radiation oncology include:

- Level of workload;
- Quality of service and the availability of modern techniques and technologies;
- Incentivised payment structure for staff;
- Access to and ability to participate in clinical trials and research;
- Professional development opportunities (such as conference attendance); and
- Career progression opportunities.

Building a sustainable regional workforce in radiation oncology requires a calculated approach, which takes into account service expansion, current capacity to train new workforce and incorporates strategies to make regional facilities attractive to work in.

Service Planning

Tailored models of care

The cancer care service models for regional and rural Australia should be tailored to suit the needs of local communities. The cultural and geographical variations in regional Australia must be accounted for when modelling healthcare provision. The importance of planning in the radiation oncology sector is enunciated in the section on Providing a Quality Radiation Oncology Service (on page 40).

To further strengthen the effectiveness of planning in rural and regional areas, cooperative involvement of key stakeholders is required. Such stakeholders include providers of radiation oncology services, regional health authorities, other service providers, patients and communities. A specific example for radiation oncology is the need for transparent infrastructure planning and the taking into account of existing private sector radiation oncology infrastructure. Consideration of costs of developing regional public facilities as opposed to providing publicly-funded access to an existing private facility is an important financial variable in this question. In this context, the advantages of public-private partnerships should be explored.

Links to a comprehensive cancers service

The lessons learned from the previous Radiation Oncology Capital Works Programs (RORIC Symposium)¹³ highlight the need for planning a comprehensive service when establishing regional cancer centres. This planning ought to focus on the health outcomes and patient experiences including the provision for integrated multidisciplinary care.

The importance of MDT care for cancer patients is explored in detail in the section on Providing a Quality Radiation Oncology Service (on page 40). Currently, some of the barriers to referral for radiotherapy treatment include: experience and training of the individual referring practitioner, training and their level of understanding of radiotherapy²⁸. Participation in MDTs improves referring physician's knowledge of radiation oncology and increases referrals for clinically appropriate radiotherapy treatments. Enabling MDT care in the specific circumstances of each regional and rural facility is a priority for quality patient care.

Networking and cooperation are critical in health care broadly, but more so in rural and regional centres. One radiation oncology expert from a regional cancer centre responded to a question 'how can rural and regional access to radiation oncology be improved?' as follows: better networks for transferring patients, better linkages to health services, better linkages to allied health, better ancillary supports, and better information technology systems to support care.

Access to allied health services

Allied health services are part of holistic cancer care and must be included in planning of any comprehensive cancer care system. Historically, the role of allied health staff, including but not limited to psychologists, social workers, physiotherapists, occupational therapists, speech pathologists, exercise physiologists and dietitians, and of nurses in radiation oncology has not been emphasised. In the absence of allied health services, cancer patients' management can be fragmented, and they can experience treatment-related problems such as social and emotional consequences²⁹. To illustrate this point, an individual diagnosed with head and neck cancer will fail to achieve excellent outcomes if their nutritional status is so compromised after treatment that they are not able to regain adequate functional capacity to return to work.

Current funding models for radiation oncology, which support patient access to radiotherapy treatments, are insufficient to fund allied health support. As a result, in rural and regional areas allied health support is often only available privately and at a financial cost to the patient and their carers and family. Stakeholder submissions to the Plan noted that access to allied health services is improving in the cities, particularly in the larger cancer centres, but is difficult for rural and regional patients.

Recommendations

Comprehensive, quality cancer care is available to patients, which includes a national patient travel and accommodation scheme

- 52. Adequately funded and equitable national patient transport and accommodation assistance schemes must be in place.
 - 52.1. Financial support should demonstrate a relationship between the subsidy and reasonable transport and accommodation expenses.
 - 52.2. The transport and accommodation support schemes should be simplified and disparities between jurisdictions should be addressed.
- 53. A comparative study of costs of providing treatment and out of pocket expenses across various private and public facilities should be developed
 - 53.1. to benchmark the costs related to radiotherapy and reimbursements or rebates;
 - 53.2. to provide governments with the necessary data to ensure equity.

Models of care are locally tailored and appropriate to rural and regional areas

- 54. Design models of care appropriate to the regional area and its population needs, including linkage to major radiation oncology centres;
- 55. Adopt a national planning approach (facilities, workforce and services) with input from regional and rural stakeholders;
- 56. Regional facility development should focus on patient care outcomes and experiences;
- 57. Establish access to specialist services through the Cancer Care Network and links between regional and comprehensive metropolitan cancer care services
- 58. Accommodate needs for future expansion and uptake of technology in regional facility planning and development

Planned workforce strategies are developed to support the expansion of radiation oncology services to regional and rural areas.

- 59. Strategies are developed to recruit trainees and radiotherapy professionals of regional and rural origin
- 60. Increased training opportunities in rural and regional centres; increased funding support for prioritisation of rural training placements
- 61. Incentives and bonuses to attract and retain rural and regional staff
- 62. Staffing models that support professional development, professional collaboration and research activities
- 63. Increased flexibility of decision-making and funding responsibilities in regional centres for specific strategies for staff retention
- 64. Individual regional facilities should develop areas of expertise, including research, and specific competencies in techniques and technologies to increase competitive attractiveness of rural work.

Strategies in place that recognise and ameliorate the financial and social impact of cancer on patients and carers in rural and regional areas

- 65. Actions to be taken such that financial consideration by rural and regional patients and carers do not influence decisions regarding treatments:
 - 65.1. Where it does not exist already, there should be expansion of arrangements for publicly funded patient access to private regional radiotherapy treatment and review of the eligibility criteria for the same.
 - 65.2. Modified billing mechanisms in private facilities where payments and reimbursements are streamlined so that patients are only required to pay the gap payments, while the facility can maintain its operating cash flow.
 - 65.3. Costs of developing regional public facilities as opposed to providing publicly-funded access to an existing local private facility need to be considered.
 - 65.4. Reimbursement of out of pocket expenses incurred should be an option for those who are forced to pay more because of their place of residence.

Innovative approaches to patient care are implemented, evaluated and supported

- 66. A planned adoption of telehealth into radiation oncology services for consultation, care planning and follow up of patients
 - 66.1. Such adoption should focus on cancer care outcomes and patient experiences.
 - 66.2. Clinicians should be consulted to identify clinical needs and the best supporting technology.

Appendix III: Comparison of Patient Travel Assistance Schemes across Australia

| Patient Travel and Accommodation Assistance Schemes | | | | | Commercial accommodation ²⁹ | |
|---|----------------------|--|--|--|--|----------------|
| State/ Territory | Name of scheme | Minimum travel distance to be eligible | Travel – fuel subsidy/ km | Accommodation assistance per night per person | City | Rate per night |
| NSW | IPTAAS ³¹ | Minimum 100 km each way or cumulative distance of 200 km per week | 19 cents | \$43 for single and \$60 for double | Sydney | \$80-\$100 |
| QLD | PTAS ³² | 50 km one way | 15 cents | \$30 per night-commercial, \$10 per person for private | Brisbane | \$70-\$100 |
| VIC | VPTAS ³³ | > 100 kilometres one way or on average 500 kilometres / week for a minimum of five consecutive weeks | 17 cents | \$35 plus GST per night per person | Melbourne | \$70-\$100 |
| SA | PTAS ³⁴ | 100 km each way | 16 cents per km for private car, contribution of \$30 / trip for public transport, air travel-pre approved | \$30 per night +GST for commercial accommodation, escort has to pay for first night, then eligible for rest of the days | Adelaide | \$90-\$100 |
| WA | PTAS ³⁵ | 70-100 km | 16 cents | \$20 per night for private accommodation (\$40 if travelling with an escort) and \$60 per night for patient or \$75 per night for patient travelling with an escort for commercial accommodation | Perth | \$80-\$100 |
| TAS | PTAS ³⁶ | 50 km one way | 19 cents per km, cheapest economy fair for travel | \$46 per person – commercial accommodation | Hobart | \$70-\$99 |
| NT | PTAS ³⁷ | 200 km | 15 cents /km, \$40 per return trip for ground travel if interstate | \$10 per night for private accommodation and \$35 per night for patient /escort per night –commercial accommodation | Darwin | \$75-\$100 |
| ACT | IPTAS ³⁸ | Interstate travel for treatment | Rebate to the amount specified for each city and mode of travel please see list below | \$36.90 per night each patient and/or escort (commercial). \$11.28 per night each patient and/or escort (private accommodation). | | |

Notes

PTAS are a contribution scheme, not a fully supported program. For example, SA has contribution of \$30 per trip as that is the cost of travel for patients not eligible for PTAS, those living close to treatment facilities, NSW also has a co-contribution arrangement for non-pensioners and non-healthcare card holders.

Average duration of treatment for breast cancer is six weeks and for prostate cancer is 6-8 weeks.

If patients choose to have treatment and stay in commercial facility in Sydney, close to RPAH for 6 weeks, the average cost to patient and escorts would be \$1500 after subsidy, when the cost of meals and other associated costs of living away is factored in, the out of pocket expenses would be even higher unless there is an assisted accommodation within the area at a subsidy rate.

For a person in low income earning category, raising funds for treatment and accommodation would be harder unless there are agencies other than commercial lenders to offer assistance or a government scheme of financial assistance in advance which the patient can pay back over a period of time.

Patients have to access treatment in the nearest facility- the waiting period may be longer in the nearest facility. Nearest facility is not always in a capital city, it could be a regional centre.

The rates above are the cheap hotel accommodation within 15 km of city centre, with disabled access.

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