SARRAH

Services for Australian Rural and Remote Allied Health

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Services for Australian Rural and Remote Allied Health (SARRAH) response: Australian Cancer Plan 2023-2033

Thank you for the opportunity to comment on the revised draft National Medicines Policy (NMP). We appreciate the consultation closed cob yesterday. While we provided a partial through the on-line survey, which close on Friday 4 February, we would appreciate it if you would accept our full response as provided in this submission. Our on-line submission reference is ID: ANON-SE61-Y1U2-G.

Services for Australian Rural and Remote Allied Health (SARRAH) is the peak body representing rural and remote allied health professionals (AHPs) working in the public, private and community sectors, across primary and other health settings, disability, aged care, and other service systems. SARRAH was established in 1995 by and as a network of rurally based allied health professionals and continues to advocate on behalf of rural and remote communities to improve access to allied health services and support equitable and sustainable health and well-being. SARRAH maintains that every Australian should have access to health services wherever they live and that allied health services are fundamental to the well-being of all Australians.

SARRAH strongly supports the overarching purpose of the proposed Plan and Cancer Australia's assessment that *"To achieve world-class cancer outcomes for all Australians, we need national action to address issues that contribute to differences in cancer incidence, and that lead to variation in cancer outcomes and experience. And we need a way of sharing, learning from and scaling-up activities that are making a difference."*

We strongly support the focus and priority Cancer Australia is placing on addressing inequitable health risk and outcomes, and the effort to highlight:

> *"A person's risk of cancer, their experiences during diagnosis and treatment, and their survival are influenced by where they live, their background and personal circumstances, and the type of cancer they have. Such differences and variation are unacceptable."*

Unfortunately, but unsurprisingly, this same pattern describes almost any area of health risk and outcome variation experienced by Australians, as the Australian Atlas of Healthcare Variation and volumes of research journals, reports, national plans and strategies substantiate. However, some of the primary actions needed to address avoidable variations in health risk and outcome, for cancer and across

the system more generally, are understood but require a genuine, sustained commitment from policy and decision-makers and funders.

Key issues were identified in presentations made to Australian Cancer Plan Ministerial Roundtable held in April 2021, with numerous complementary themes identified and reinforced.

Professor Dorothy O'Keefe's, CEO of Cancer Australia, presentation set the scene: nationally cancer rates are rising but so are survival rates; trends which contrast with the experience of Aboriginal and Torres Strait Islander people, who as a group face increased incidence and mortality rates – up 26 per cent since 1998. Other disparities include 33 per cent higher mortality rates in low socio-economic areas (which are disproportionately located in rural and remote Australia); and 15 per cent higher in rural and remote Australia, worsening with increased remoteness. These factors overlap to some extent and are reflected in compounding disadvantage. The presentation illustrates precisely why Australians need far more nuanced, locally supported and adaptable health systems and services than exist now.

Many align with SARRAH positions on improving health and well-being in rural and remote Australia.

- The Clinical Oncology Society of Australia called for better multi-disciplinary care, including more funding for allied health.
- Tanya Buchanan Chief Executive Officer, Cancer Council Australia identified priorities that inherently involve and require AHPs and services.
- The Consumer Health Forum identified problems of inequity, including the urban vs rural experience, and the absolute need for person-centred care and coordinated treatment.
- Professor Jacinta Elston spoke to Indigenous perspectives on cancer control and illustrated the worsening absolute and relative situation for Aboriginal and Torres Strait Islander peoples in the incidence and outcomes of cancer highlighted, among other things, cultural and social barriers to care, the impact on accessibility, health care system barriers including Indigenous identification, data sovereignty, accessibility, and workforce capacity;
- Professor Shelley Dolan, CEO of the Peter MacCallum Cancer Centre presented on International Models of Effective Cancer Control delivering research-led discoveries and major advances in prevention, diagnosis and treatment of cancer, with proven benefits for local communities from transdisciplinary research, through the dissemination of evidence based findings; measurable improvements in access and the quality of care for disadvantaged populations, even when compared to hospitals European approaches to overcome differences in access to diagnostics, treatment and therapeutic options that patients experience in different parts of Europe with more resources or smaller proportions of underserved populations. OECI specialised its accreditation and designation programme in multidisciplinary integrated cancer care and research.
- Professor Grant McArthur Victorian Comprehensive Cancer Centre on the Research and Data Perspective argued for prioritised research into health inequities, notably First Nations peoples, regional and remote communities and lower SES. "Failure to reduce disparities will significantly limit improvements in cancer outcomes as a nation".
- Former Australian Health and Hospital Association CEO, Allison Verhoeven argued for transforming for value in cancer care – to promoting value based healthcare, eliminating barriers to care and preventing duplication, improving quality care for underserved population groups and team-based care, members working to top of scope.

There were calls for better integration of care, systems and a Plan, centred on patient centred care delivered by multi-disciplinary teams. That, in turn, depends on strategies to address chronic workforce maldistribution and associated service access inequities.

The reference document from the 2021 Roundtable provides a coherent description of the elements needed to establish and promote an effective National /cancer Plan. SARRAHs response concentrates on several of the closely related elements, notably:

- Support the role of primary care providers in investigating suspected cancer early and referring appropriately; promote value-based healthcare and embed optimal care pathways; support patients to navigate the system and coordinate their care, across primary, secondary and tertiary settings and between the public and private systems; accelerate implementation of evidence-based, best practice care, while reducing the financial burden of cancer on patients, and crucially
- ***"Plan future workforce capacity and capability requirements by identifying national trends, addressing current and future skills shortages and planning for future care needs; consider the need for a national cancer workforce strategy."***

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

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

The Plan will be a success if leads to and sets the conditions for a sustained and measurable trend reduction in the differential outcomes in the health and wellbeing for each of the groups identified as being at greater risk of cancer, together with overarching improvements in cancer prevention, early detection and survival rates at a national level.

Notwithstanding notable successes and impressive developments in knowledge and treatments these advances have not translated consistently or equitably into prevention, early detection or optimal care pathways for large groups of people. That sets the key challenge for the Plan.

For example, the relative impact of cancer for Aboriginal and Torres Strait Islander people has worsened despite increased public awareness and technological advancements. Contextual factors have contributed, including inadequate systemic policy and engagement approaches. Similarly, the higher risks and prevalence of disease in the rural and remote population and lower socio-economic groups continue despite being well known for years. Correlating factors, such as differences in access to services and workforce maldistribution remain as major contributing factors and have not been addressed.

Major challenges in ensuring the Plan develops and progresses effectively include:

- Securing a genuine and ongoing (cross-)government commitment to prevention, ideally backed by resource and actuarial models that help governments identify and take account of positive budgetary impacts (including downstream savings) attributable to prevention and disease amelioration (which would exemplify a major and necessary shift in approach to sustainable health funding and delivery); and
- Balancing the need to focus specifically on cancer while ensuring necessary supports for compatible priorities - avoiding a) a continuation of the disease focus rather than a wellness focus and b) the fragmentation risk associated vying for competing profiles and support in the context of short-term priorities and low long-term investment mindsets.

More specifically from SARRAHs perspective, the Australian Cancer Plan will be more effective if it supports and benefits from:
An improvement in the understanding of and systemic supports for allied health services which have a major role in quality care across the spectrum, from preventing, diagnosing, treating, rehabilitation and recovery and/or palliative care.
The importance of allied health services could be expected to increase as current shifts in the experience of cancer, as a chronic disease, more frequently involving recovery and where the nature of palliative

care increasingly includes consideration of ongoing support to enable quality of life: consistent with current trends[1].
The following examples illustrate a small portion of the role allied health treatments play in cancer treatment and recovery:

- Exercise should be a part of standard cancer care (for function, and chemo uptake), and education on the benefits of exercise provided to cancer patients
- Diet and nutrition are crucial to maintain strength and aid recovery, in addition to the obvious prevention elements;
- Mental health, emotional and stress-related supports provided by psychologists, social workers and others;
- Specific and specialised supports provided by speech pathologists, physiotherapists audiologists, occupational therapists, pharmacists, podiatrists, prosthetists among others.

A diagnosis of and treatment for certain cancer types comes with a high likelihood of experiencing severe deconditioning, malnutrition, fatigue, distress, loss of function and mental health issues. Access to these services will need to be facilitated through a range of mechanisms, such as (among others):

- Referral pathways to allow/promote referrals to private providers (e.g., exercise physiologists for services closer to home (where available)
- Improvements in access to subsidised allied health services available through the MBS or other mechanisms, noting the highly restrictive rationing of such services at present, which impede access, prevention and recovery.
- Better access to screening services for rural and remote Australians, to help address the cost and time barriers evident in numerous public reports and the outcomes experienced by sub-populations identified as a focus for this Plan.

An article authored by the Peter MacCallum Cancer Centre (in 2020), *Implementation of a Multidisciplinary Allied Health Optimisation Clinic for Cancer Patients with Complex Needs*[2] argues:

> *Patients should be identified prior to treatment for prehabilitation and streamed directly into rehabilitation during and after treatment. ….*
> *Failure to meet the needs of these patients can have severe consequences to patient outcomes and increase the burden on the health system as demonstrated by multiple national and international evidence-based guidelines.*

The paper concludes:

> "*This study demonstrates the feasibility of implementing a multidisciplinary allied health optimisation clinic designed to improve fatigue, nutritional and functional status. The optimization clinic facilitated the coordinated and team-based care of people with cancer with complex needs. However, a number of opportunities for improvement were identified, including further consideration of flexible, potentially technology-supported approaches to care delivery. While patient outcomes were not assessed, improvement in health outcomes were perceived by patients."*

A central question is whether and to what extent the Australian Cancer Plan will facilitate access to this sort of care nationally, including in remote communities?

Another important contribution Cancer Australia, together with governance and steering committee members, would be to advocate for improved information about service coverage and workforce

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[1] See - https://pubmed.ncbi.nlm.nih.gov/33256726/ Grace Joshy ANU et al. ANU Research School Population Health

[2] *Implementation of a Multidisciplinary Allied Health Optimisation Clinic for Cancer Patients with Complex Needs* J. Clin. Med. **2020**, 9, 2431; doi:10.3390/jcm9082431 www.mdpi.com/journal/jcm

nationally, especially in allied health where there are major, longstanding data gaps and relatively little concerted effort to address them.

To this end, it may be beneficial to commission a forensic review of existing workforce and other data sources and reports that could inform the detailed development and delivery of the Plan, considering existing capacity and constraints. The present gaps in information which makes service and workforce planning difficult.

- As an illustrative example, regarding palliative care services: allied health professionals (AHPs) are extensively involved in delivering palliative care, however they are not referred to at all in the Australian Institute of Health and Welfare (AIHW) report on services and workforce in the national report Palliative care services in Australia[3]. We understand AIHW are aware AHPs deliver palliative care, however, they advise they do not have access to the data to report. AIHW have responded constructively to SARRAHs advice *notwithstanding the current limitations of the data collection mechanisms available to the AIHW, the presentation of the information without acknowledgement of the role of allied health distorts people's understanding of these services and may well influence funding and policy decisions, leading to further adverse consequences for people receiving palliative care, and the service providers attempting to meet this need.*
- Similar issues regarding the quality of information on allied health services are not uncommon. Cancer Australia may wish to test the veracity of data supplied to it in developing, monitoring and reporting on progress of the Plan.

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

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

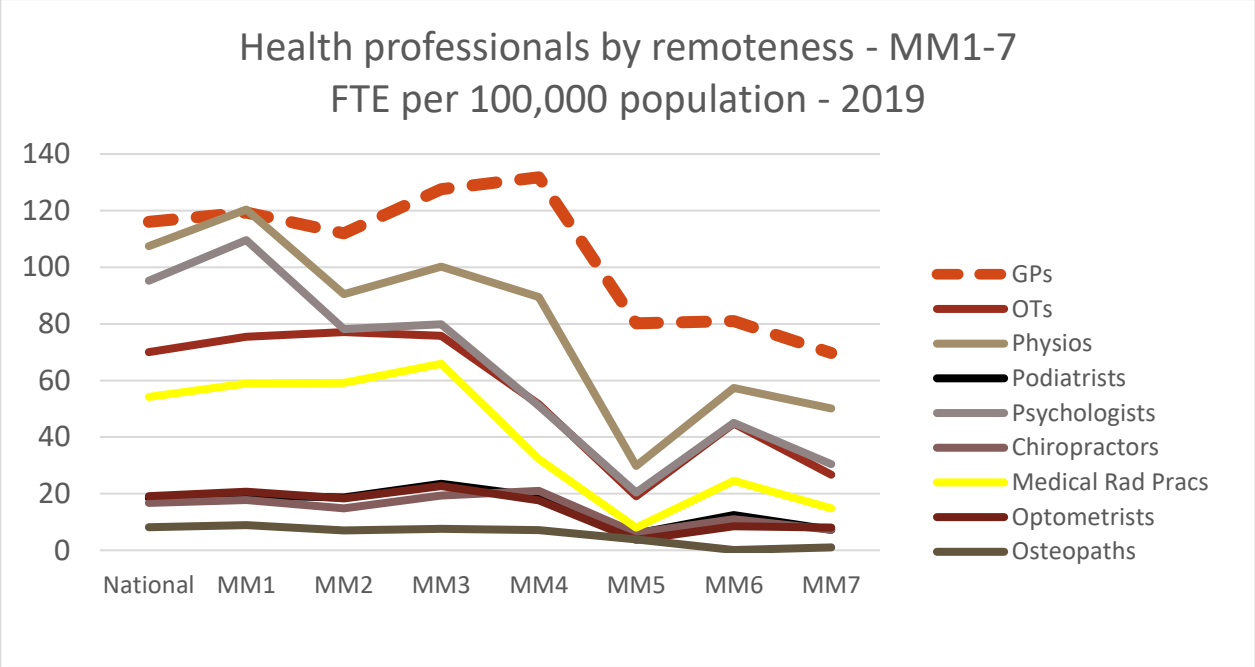
In summary, SARRAH believes the delivery of more equitable and effective cancer related prevention, diagnosis, treatment, responses and support (throughout the continuum) requires the availability of and access to a range of skilled, health professionals. The continuing, chronic and well-known health workforce shortages across rural and remote Australia correlate closely with the access challenges and poorer health outcomes experienced by people living in rural and remote Australia. The correlation continues as remoteness increases. These workforce and access shortages and constraints are further exacerbated /reinforced by funding mechanisms that bias services that are subsidised and/or are 'at hand' rather than what is what might be clinically required and align best with their health and wellbeing: an example being use of prescription medications for pain relief, where other therapies could be more effective and beneficial for the person's overall health[4].

A range of government programs target maldistribution of the health workforce, and some have proven reasonably effective, especially where the support has been reasonably secure and continuing, involve multiple layers of support that apply to education and training, practice supports and service-related subsidies etc. The best examples in Australia relate to medical workforce, notably GPs. These have had a positive impact and helped address the shortage of rural medical practitioners (GPs and other specialists) although maldistribution remains a serious access issue for people. In terms of allied health (including those working across the continuum of cancer related care) rural workforce shortages are far more severe - on a per head of population basis around twice as severe as for GPs.

[3] Last updated 27 January 2022

[4] For example – see https://www.choosingwisely.org.au/resources/consumers-and-carers/5-questions-to-ask-about-using-opioids-for-back-pain-or-osteoarthritis

The following graph[5] illustrates the extent of the problem for a range of health professions.



The extent of allied health mal-distribution is also evident in information held on the Commonwealth Department of Health's website.

For any health professional it is important to note that for those working in remote and very remote settings, the same sized service population may be spread over an area the size of Victoria, compared with a few square kilometers in a major city: this greatly amplifies the challenges of access for rural and remote residents and effective service delivery for any primary health care professional. A great deal of information has been produced about the factors that contribute to the attraction and retention of health professionals in rural and remote Australia[6]. Unfortunately, despite repeated calls for a national allied health workforce plan over many years, there is none. The most comprehensive review of the situation was produced by the inaugural National Rural Health Commissioner, Professor Paul Worley, who delivered his report *Improvement of access, quality and distribution of allied health services in regional, rural and remote Australia*[7] in June 2020. The report included recommendations designed to build and sustain an increased rural allied health workforce capacity. The Government's response to the report has been patchy to date. In December 2021, a short document responding to Professor Worley' report was placed on the Department of Health's website.[8] Similarly, the current Stronger Rural Allied Health Strategy contains comparatively little to support allied health services[9]. A far more extensive rural and remote allied health workforce strategy is needed, to support development and implementation of the Australian Cancer Plan and other plans with the objective of improving access and outcomes in rural and remote health.

[5] https://hwd.health.gov.au/ More recent data is now available, however the pattern shown is long standing and based on member feedback SARRAH understands the situation may be worsening.

[6] For instance, see https://sarrah.org.au/our-work/policy-and-strategy/publications/138-strategies-for-increasing-allied-health-recruitment-and-retention-in-rural-australia

[7] https://www.health.gov.au/resources/publications/final-report-improvement-of-access-quality-and-distribution-of-allied-health-services-in-regional-rural-and-remote-australia

[8] https://www.health.gov.au/resources/publications/australian-government-response-to-national-rural-health-commissioners-report-on-improving-the-access-quality-and-distribution-of-allied-health-services-in-rural-and-remote-australia

[9] The Workforce Incentive Program (WIP) is generally cited as 'the' measure in the Stronger Rural Health Strategy to support increased allied health services in rural Australia, however funding is directed to medical GPs, not AHPs; very little consultation appears to have occurred with the allied health sector about the program; little to no information is available about take up, targeting or expenditure on AHP services; and it is widely regarded by the AH sector as not having being designed for the purpose.

Allied health shortages are felt across the entire health and social services system - in primary care, hospitals, mental health, palliative care, disability services (including the NDIS), aged care, child development and more. The situation is substantially influenced by the relative lack of supports (as described above) for allied health education, training and practice. Where they exist, such supports demonstrate substantial positive impacts[10]. However, they are generally not available on a scale, as part of a coordinated, supported pathway, or to a degree that enables maldistribution (and therefore access to services) to be addressed substantially.

Addressing this fundamental issue must be a priority for the Australian Cancer Plan, albeit one shared with many other national and jurisdictional plans and strategies.

3. What examples and learnings can we build on as we develop the Australian Cancer Plan?

Think about great examples of work within or outside the cancer sector in Australia and internationally. How can we learn from these examples and build on them to improve cancer outcomes and experience for all Australians?

Australia can point to leading edge examples of optimal access, pathways and approaches to effective care across the cancer continuum. However, these are not available to large sections of the population. Cancer Australia acknowledges this and is seeking to lift the quality and outcomes of care across the board. This is commendable and extremely welcome. To aid with design and planning, an initial audit/assessment might be made of what might constitute a notional level of service quality and access and compare that with existing service system coverage and access. This exercise should in no way be construed as arguing for a bare minimum or lesser level of care and services in rural and remote Australia, but purely as a means of identifying the gaps and degree of shortfall in existing coverage and capacity. An exercise of this kind may be an important early step if the Plan is to address the priorities it has identified – and which need to be addressed if Australia is to build a system of cancer care that improves overall quality, equity and outcomes across Australia.

SARRAH consents to the contents of our submission and our contact details being made public. If you would like to discuss issues raised in SARRAHs response or require further information, please contact me at catherine@sarrah.org.au or Allan Groth at allan@sarrah.org.au.

Yours Sincerely

For Cath Maloney
Chief Executive Officer

Services for Australian Rural and Remote Allied Health (SARRAH) exists so that rural and remote Australian communities have allied health services that support equitable and sustainable health and well-being. SARRAH maintains that every Australian should have access to health services wherever they live and that allied health services are fundamental to the well-being of all Australians. SARRAH is a national, multidisciplinary member association, has been operating for 25 years and the only peak body fully focused on rural and remote allied health working across all disciplines. (More information: http://www.sarrah.org.au/).

[10] Commonwealth funding has been provided to support small scale measures such as the expansion of the Allied Health Rural Generalist Pathway (AHRGP) into community and private settings (managed by SARRAH) and the IAHA Aboriginal and Torres Strait Islander Health Academies (both recommended by then NRHC, Professor Paul Worley). These are important programs, with substantial potential but to optimise their impact they need to be increased in scale and as part of a broader strategy and supports to address the massive shortfall in present service capacity.