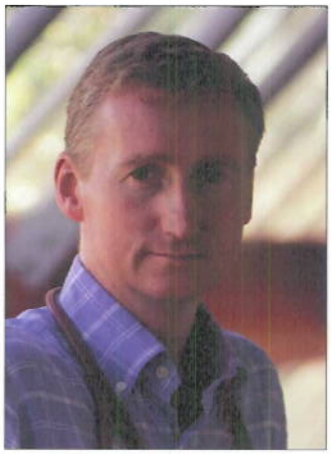
Tabled 28/3 Shane Giles 1pm

A regional perspective



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I am a medical oncologist in private practice at Border Medical Oncology, Albury Wodonga.

We are a private practice of 4 medical oncologists who provide cancer (and malignant haematology) services to a large rural/regional catchment. The estimate in our cancer centre application was a catchment of 250,000 people. Importantly, our catchment draws from both NSW and Victoria. Our area spans from Deniliquin in the west to Corryong in the east, down to Mansfield and Benalla in the south and Culcairn and Henty (halfway to Wagga) in the north. Patients can travel for over 2 hours to see us. I have a patient from Hay at the moment who travelled over 325 km one way to see me and receive treatment. We provide outreach services to Wangaratta and Deniliquin.

Our Border Medical Oncology Research Unit is a crucial component of our practice and is an award winning clinical research team that provides access to clinical trials to our rural and regional patients. We supervise chemotherapy/day oncology services at Albury Base Hospital, Albury Wodonga Private Hospital (Murray Valley Campus), Wangaratta Base and Deniliquin Hospitals. We see all patients (private or public, I don't distinguish) in our private rooms and bill the patient and Medicare for the consultation. There are no state-funded "public" clinics.

At Albury Wodonga Health there are no provisions for state-funded "public" outpatient chemotherapy services. All chemotherapy drugs (both trial and PBS funded) are provided by a local community pharmacist who orders the therapy 24 hours in advance and arranges delivery from the reconstitution facilities in Melbourne. We are currently planning the $65 million Albury Wodonga Regional Cancer Centre that was funded in the rural and regional HHF (Health and Hospitals Fund) funding round after the 2010 election. Our current oncology pharmacist provides expert, specialised care and our patients benefit accordingly.

The local risks that arise from inadequate funding of chemotherapy drug supply include:

- Our patients will miss out on potentially life saving treatments.
- If local services cannot afford to deliver…patients will need to travel over 300km to Melbourne to access the nearest state funded "public" hospital pharmacy that may have the size and budget to accept the sizeable losses associated with chemotherapy provision under the proposed arrangement. Canberra is even further away. There is nowhere else.
- The pharmacy will be forced to curtail services e.g. provision of specialist oncology pharmacist, rendering the whole procedure unsafe. This is a specialised service that not every pharmacist either wants to or is able to perform.

A quote from our pharmacist….
"We are fast approaching the point where private pharmacy oncology services will become unviable. I suspect the first impact will be that pharmacists will be forced to "cherry pick" and only provide profitable treatments. If we take my earlier example, it could mean inability to dispense loss making treatments, in my case 222 treatments in Dec 2012 and 100 treatments in Feb 2013. In our region, how would these patients would be able to continue treatment?"

Other implications of particular concern to me as a regional clinician include:

- The regional cancer centres were a key achievement of the labour government prior to the 2010 election. Failure to adequately fund chemotherapy provision will undo all of the proposed benefits of bringing state-of-the-art cancer care to the regions.
- There does not seem to be a recognition that safe and appropriate delivery of chemotherapy requires more infrastructure, time and skill and thus costs more than a routine prescription. This is particularly evident in rural and regional areas where a community pharmacist often delivers this service in the absence of a public hospital pharmacy.
- Regional and rural hospitals are more vulnerable to the problems in this program due to their relatively small patient base and inability to cover costs from other profitable areas. Larger centres in the cities are noticing the same costs but have more ability to absorb them.

So, I think the key issues for my rural patients revolve around lack of access to care, and not even good quality care, lack of any care at all! We are already told that patients in rural areas fare poorly when compared with their city cousins; we don't need yet another setback. Someone will have to pay. Will the patient be charged to enable service delivery in the place where they live rather than requiring travel to a metropolitan centre?