Daily Life As an Australian Medical Oncologist

By Diana Adams, BSc(Hons), BMBCh(Oxon), MRCP, AMEC, FRACP,
and Gavin Marx, BSc(Med), MBBS(Hons), FRACP

Macarthur Cancer Centre, Campbelltown Hospital, Campbelltown, and Haematology and Oncology Clinic, Hornsby, Sydney, New South Wales, Australia

Introduction

Health care in Australia is a mix of public and private health care. Public hospitals currently receive funding from federal and state governments and are managed by independent state health departments. Approximately 43% of Australians have private health insurance, in addition to their Medicare entitlement. This health insurance is generally not linked to their employment but taken out separately. Individuals and families on incomes above a certain threshold who do not opt for private health insurance pay an extra 1% of taxable income, known as the Medicare levy surcharge, to encourage greater private health coverage uptake. Many patients with private health insurance undergo their initial cancer surgery privately, citing surgeon preference and shortcutting delays in definitive surgery in the public domain. Several models exist in both the private and public sectors. This “day in the life” article reflects two models and individual clinicians’ experiences.

Macarthur Cancer Centre—A Field of Dreams: Dr Diana Adams

*“If you build it, they will come.”*¹ I am a clinician educator in a cancer center serving an urban and semirural population of 250,000 over a geographic area of more than 4,000 square kilometers with a predominantly English-speaking background. The cancer center is set within a university teaching public hospital and was built for medical and radiation oncology reviews and treatment as well as palliative care consultations. Patient consultations and treatment are federally funded via the Medicare system.

I work as a part-time specialist (0.7 full-time equivalent [FTE]) performing two whole-day clinics and seeing on average 150 new patients per annum. A 2008 Australian workforce survey set a benchmark of 210 new patients (range, 153 to 339 patients) per annum per FTE.² I work with four other medical oncologists, and together we fill a total of three FTE positions, working alongside 3.2-FTE radiation oncologists. I am paid a salary by the state government and am able to supplement this income with rights of private practice from fee-for-service billings through Medicare funding. Levels elected by the oncologist scale one’s salary as well as the degree of patient activity required to obtain a set proportion of billings. Medicare billings are weighted for consultation length and complexity as well as length and delivery mode of chemotherapy.

Electronic Health Record

Work life centers on an electronic health record (EHR) called Multiaccess. I would have to think long and hard, particularly as a

part-time specialist with commitments at home, before returning to a non-EHR-run center, given the ease with which the system operates. It is one of the reasons I commute 1 hour each way, because when I am at work, the system works, and if necessary, I can finish my work at night via remote access. Chemotherapy prescribing is paperless. Chemotherapy care plans are based on the Cancer Institute New South Wales (NSW) eviQ-approved drug regimens.³ Two-way communication is achieved for notification and dose adjustments with the pharmacy. Chemotherapy and clinic review dates as well as take-home medications are built into each care plan. Working under a clinician who embraces reflective practice and patient-centered quality improvement is another great feature of the unit in which I work. Clinical audit programs include number of and reason for admissions to the hospital, chemotherapy dosing, toxicity grading, and allergy documentation, to name but a few. A read-only version of the EHR is available for emergency and ward staff. The EHR is integrated with radiation, palliative care, and allied health staff, and referrals require documentation of tumor stream and reason for referral to assist future resource allocation.

Macarthur Cancer Centre treats only solid tumors; there is no hematologist on site. Patients requiring bone marrows are sent to a hospital 20 kilometers away. No complex sarcoma surgery is performed on site, so most sarcoma patients are managed at larger referral centers. I specialize in breast, urologic, and gynecologic cancers. New patient referrals are triaged according to urgency of review. Median time from referral to new patient visit is 5 days (range, 1 to 13 days). I am on call 1 of every 3 to 4 weeks, receiving calls 24 hours, 7 days a week, directly from the emergency room or wards. The on-call clinician is in charge of all patients regardless of treating physician. Weekly clinical rounds attended by fellow oncologists and palliative care staff occur in addition to twice weekly business rounds as well as a separate EHR multidisciplinary round. Weekend coverage is provided by the ward registrar unless an unstable patient requires consultant review. Patients can choose to be admitted to the public hospital as public or private health care-funded individuals. Private inpatient consults can be billed. Patient admissions are coded according to diagnosis-related groups, affecting subsequent remuneration to the hospital. Currently, there is no dedicated oncology ward, which I believe is a drawback. Our patient care would be enhanced through greater symptom control from dedicated oncology-trained nurses able to administer long-duration chemotherapy regimens and nurses trained to handle vascular access devices.

Clinics are supported by a dedicated chemotherapy nurse who attends new patient consults, provides patient education, organizes vascular access devices, and so on. Patients known to the center can attend a nurse assessment unit to deal with five core treatment-related toxicity problems as well as symptom-control issues. Admission from the nurse assessment unit when indicated is conducted directly by the ward. This was established as a Cancer Institute NSW pilot project; at the end of the study, we faced a watershed moment and therefore allocated internal resources to keep it operating.

Recent investment from the Cancer Institute NSW has enhanced phase II and III clinical trials. Patients eligible for trials not available at the center are referred and generally accepted at larger metropolitan centers. An electronic portal provides clinicians with all information required to randomly assign and treat patients on trials.

Shortfalls to Cancer Care

Shortfalls to improved cancer care include a lack of on-site clinical care coordinators. We have no on-site tumor stream care coordinators apart from a charity-provided (McGrath Foundation, Northbridge, NSW, Australia) breast care nurse. A non-tumor stream care coordinator model has been proposed and awaits funding decisions.

Reliance on Nongovernment Funding

Many noncore issues to enhance the cancer journeys of patients are subsidized by local charity funds and private patient donations. Examples include complimentary massage and Reiki sessions, diversional therapists, additional clinical psychologists, and DVD players for patients during treatment.

Barriers to palliative care include limited number of hospice beds, necessitating acute hospital admission even though palliative care consultation is available. The local unit, which is 15 kilometers away, has 10 beds and also receives funding from local charities. Its base funding comes from Medicare and federal government project grants. Because of the limited number of palliative care beds for the population, patients requiring longer-term care are transferred to nursing home beds; however, younger patients experience difficulties in accessing this accommodation. Community medical palliative care is available, with 25% of deaths as a result of cancer occurring at home. There is a national shortage of palliative care specialists.

Predominantly Private Practice: Dr Gavin Marx

Several models for private practice exist in Australia. Oncologists can be involved as sole practitioners, part of a group practice with associations with chemotherapy day clinics, or part of a group practice that supervises chemotherapy delivery at a specific independently owned and managed oncology day unit.

I work 80% in private practice and 20% as a staff specialist in clinical trials at a teaching hospital. My private practice is in a private group practice with associates who run independent practices but share administration, overheads, and on-call and annual leave cover. The practice consists of three medical oncologists and

two hematologists as well as a clinical psychologist, dietician, and palliative care physician. Multidisciplinary meetings are conducted fortnightly across most tumor groups. We are closely associated with a state government-funded local palliative care unit that provides inpatient and community-based palliative care.

The unit operates at two main sites, with rooms that are colocated and a chemotherapy suite that is owned and managed by the Sydney Adventist Hospital, a privately run hospital. I see 270 new patients per year. The waiting time for new patient appointments is determined by urgency of referral but is usually within 1 to 2 weeks.

Inpatients are managed at the Sydney Adventist Hospital, which has an emergency department, intensive care facilities, and a dedicated 37-bed oncology and palliative care ward. We are individually responsible for and are on call 24 hours a day during the week for our own patients; however, we share the weekend call on a one in five basis, in which we are responsible for daily hospital rounds for all patients of the practice and all emergency calls. The hospital is accredited to have a federally funded registrar training position.

Our clinical trials unit offers investigator-initiated trials, national cooperative group trials, and pharmaceutical industry-supported trials. It has been supported by grants for clinical research nurses through the Cancer Council and the NSW Cancer Institute.

Income in private practice is generated by a Medicare-subsidized consultation fee, which does incur gap payment for patients. Patients with specific financial concerns, pensioners, and veterans are charged a subsidized fee. Patients receiving intravenous chemotherapy are admitted to the day unit, and fees for consultation and chemotherapy supervision are charged directly to the private health fund, with no gap for the patient. Access to chemotherapy drugs is obtained through the Pharmaceutical Benefits Scheme (PBS) for approved drugs or via negotiation with health funds for non-PBS-approved indications. Access to non-PBS-subsidized drugs is an ongoing challenge and frustration. The Private Cancer Physician Association is a national group established to address the issues specific to private oncology and hematologic practice in Australia.

Common Issues

There are a number of issues in the access, delivery, administration, funding, and political arena that are relevant to both the private and public sectors. As a busy clinician on the front line, limited dedicated teaching time is a challenge, as is the growing population of patients with cancer.

Additionally, as unofficial geriatric oncologists, we share the common view that new models of assessment and care for the expanding elderly cancer population are needed. As survival improves in various tumor groups, we are acutely aware of the need for improved survivorship care models. Otherwise, both these growing populations will compound the workforce issue that we in Australia face, as do those in other countries.⁴

Drug Approval

Medications in Australia require Therapeutic Goods Administration (TGA) approval and are subsidized via the Medicare-funded PBS for approved indications. Most high-cost chemotherapy

drugs require prior telephone approval by the appropriate authority before prescribing. The listing of indications takes longer than we would ideally want for our patients. As examples, bevacizumab for first-line metastatic colorectal cancer and sunitinib for renal cell cancer were PBS listed in 2009. Discussions of private payment for nonlisted indications creep into daily practice and are a great frustration in patient care. Requests for compassionate access to drugs are usually the result. Examples include drugs such as paclitaxel for endometrial, cervical, and bladder cancers as well as those for rarer diseases, such as gemcitabine for nasopharyngeal cancers and biliary tract tumors. Covert rationing of drug access is occurring. Patients receiving therapies such as bortezomib for myeloma and docetaxel for prostate cancer are only entitled to a finite number of PBS-funded cycles.

Multiple difficulties surround trastuzumab. This achieved late-stage listing as a complex drug via the government rather than the PBS. Negotiations on vial size and cost are now difficult. Only taxane-containing regimens can be concurrently prescribed on the PBS, although nontaxane regimens are used and still unwittingly funded by the PBS.⁵ Cost indicators currently dictate that trastuzumab cannot be recommenced after failure of lapatinib. This has influenced clinician prescribing of lapatinib to end-stage patients after failure of multiple lines of chemotherapy-trastuzumab combinations. Patients receiving treatment in private centers can avoid some of these issues, because payment may be via health care funds or self-funded. Novel technologies such as Oncotype Dx (Genomic Health, Redwood City, CA) are neither PBS nor health care funded, and at a cost of \$5,000, they are discussed but not often taken up by patients.

Recent Investment in Cancer Care, 2009 to 2010

This article describes models of care for some urban and regional centers. Inequality in rural cancer care in Australia as a result of under-resourcing has been well documented.⁶ Lack of infrastructure in the public sector leaves private models to fill the gap. Isolated rural physicians may have little option but to charge gap fees to fund administrative and infrastructural charges. In the federal budget for 2009 to 2010, the government has responded by committing \$560 million to establish 10 best-practice regional cancer centers to improve cancer care in rural, regional, and remote areas of Australia.

The Medical Oncology Group of Australia is the peak representative body for all medical oncologists in the country, working with government and other cancer societies as well as industry and

consumer advocacy groups. Streamlining for prescription medicine submissions, recommendations to government for PBS listing, ways to improve patient care, health care models, and workforce issues are among many aspects of the group's work.

Proposed Health Reform

Access, resourcing, availability, remuneration, research, and affordability of cancer care remain complex issues in Australia, as they do around the world. As a consequence of access and waiting lists for public patients, the federal government has proposed sweeping changes to both the funding and structure of the health care system in Australia. If accepted, federal sources will fund the majority of the whole public health care system for the first time, including 60% of all public hospitals, in part by retaining one third of a goods and services tax previously managed by the state governments. Control via funding is to be taken away from the central bureaucracies of the state governments and handed over to local hospital networks.

Conclusion

Several models of practice exist in Australia, presenting benefits and challenges to the physicians involved and the communities for which they care. Ongoing evaluation and reflection is required for continued improvement and health care reform.

Accepted for publication on March 25, 2010.

Acknowledgment

We thank Associate Professor Stephen Della-Fiorentina, MBBS (Hons), FRACP, for his constructive review of this manuscript and Christopher Steer, MBBS, FRACP, for his contribution in the discussion of this article.

Authors' Disclosures of Potential Conflicts of Interest

The authors indicated no potential conflicts of interest.

Author Contributions

Conception and design: Diana Adams, Gavin Marx

Manuscript writing: Diana Adams, Gavin Marx

Final approval of manuscript: Diana Adams, Gavin Marx

Corresponding author: Diana Adams, BSc(Hons), BMBCh(Oxon), MRCP, AMEC, FRACP, Therry Rd, PO Box 149, Campbelltown 2560 NSW Australia; e-mail: Diana.Adams@sswsahs.nsw.gov.au.

DOI: 10.1200/JOP.878901

References

1. Field of Dreams. Dir. Phil Alden Robinson. Universal Studios, 1989
2. Medical Oncology Group of Australia: Australian Medical Oncologist Workforce Study 2009. <http://www.moga.org.au/news-events/australian-medical-oncologist-workforce-study-2009>
3. Cancer Institute New South Wales: eviQ Cancer Treatments Online. <http://www.eviq.org.au>

4. Hortobagyi GN: A shortage of oncologists? The American Society of Oncology workforce study. *J Clin Oncol* 25:1468-1469, 2007
5. Pearson S-A, Ringland CL, Ward RL: Trastuzumab and metastatic breast cancer: Trastuzumab use in Australia—Monitoring the effect of an expensive medicine access program. *J Clin Oncol* 25:3688-3693, 2007
6. Underhill CR, Goldstein D, Grogan PB: Inequity in rural cancer survival in Australia is not an insurmountable problem. *Med J Aust* 185:479-480, 2006