

'Towards a national primary health care strategy...'

Comments in response to Department of Health and Ageing discussion paper

February 2009

Cancer Council Australia is Australia's peak non-government national cancer control organisation. Its member bodies are the eight state and territory cancer councils, whose views and priorities it represents on a national level.



The Clinical Oncological Society of Australia is the peak multidisciplinary society for health professionals working in cancer research or the treatment, rehabilitation or palliation of cancer patients.



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Overview

Primary care is seen as an increasingly important health care sector in the management of cancer in Australia. The sector's significance to broader health system reform is also increasingly recognised, through this review and in recommendations of the Government's National Health and Hospitals Reform Commission and Preventative Health Taskforce.

Cancer causes Australia's largest disease burden, with more than 100,000 new cases diagnosed in 2005 and 39,000 cancer deaths.¹ Cancer incidence is expected to increase by more than 30% in the decade between 2001 and 2011, mainly due to population ageing.² Continued ageing of the population to the middle of the century³ suggests relative increases in cancer incidence of similar scale will occur over the next 40 years.

It is therefore critical that any review aimed at enhancing primary health care in Australia identifies the important connection between the sector and cancer. Enhancements to primary care must include formal arrangements aimed at improving outcomes in relation to:

- Primary prevention of cancer (risk factor management, behaviour change);
- Screening and surveillance for early detection of cancer/precancerous conditions;
- Improved referral pathways to facilitate access to multidisciplinary care;
- The coordinating role primary care may play in cancer management for specific population groups;
- Improved data management and health system performance monitoring.

Cancer Council Australia/COSA provide recommendations for achieving improved cancer outcomes through primary care reform in response to questions in the discussion paper.

Elements of enhanced primary care – general comment

The 10 key elements of an enhanced primary care system identified in the discussion paper do, in our view, adequately cover the role of primary healthcare in relation to cancer control in a broad-brush way.

What needs to be emphasised, and is often overlooked, is the significance of cancer control to each of these elements. For example:

Access...

1. Accessible, clinically and culturally appropriate, timely and affordable;

Accessibility and affordability of primary care can be pivotal to cancer control, particularly for people in rural/remote areas; people from culturally and linguistically diverse communities and Indigenous people. Examples include the important role GPs play in:

- Care coordination (including administering chemotherapy, under supervision of oncologists) for rural/remote cancer patients;⁴
- Primary prevention through the management of risk factors;
- Practice incentives to support cancer screening of disadvantaged groups; and
- Primary care through Aboriginal Medical Services to manage multiple aspects of cancer control in Indigenous people;
- Shared care for some of the more routine aspect of cancer treatment, such as prescribing oral supportive care medications and monitoring side effects;
- Shared care for the vital role of post-cancer therapy surveillance and identification of potentially curable recurrences.

There is also the opportunity for primary care to play a greater role in the follow-up of cancer patients once an acute care episode has been completed.

The importance of these roles must be factored into any enhancement of primary care.

2. Patient-centred and supportive of health literacy, self-management and individual preference;

Examples of this element's significance to cancer control include:

- The role of primary care in patient-centred multidisciplinary care – considered by consumers and clinicians as the optimal model for cancer care;⁵
- The importance of primary care in a national electronic health strategy⁶ – a measure Cancer Council supports as integral to improving all aspects of health service delivery; and

- The role of GPs in providing advice to support informed choice in patients relating to cancer control (e.g. whether to test for prostate specific antigen).⁷

3. More focused on preventive care, including support of healthy lifestyles;

Around a third of all cancer deaths in Australia are attributed to lifestyle – particularly smoking, obesity/overweight, poor nutrition and physical inactivity and alcohol consumption.⁸ Exposure to UV radiation causes the highest economic costs of cancer in Australia.⁹ (GP consultations to treat non-melanoma skin cancer alone increased by 14% between 1998-2000 and 2005-2007 – from around 836,500 to 950,000 visits each year.¹⁰)

These cancer-risk behaviours can be influenced and in some cases managed through enhanced primary care.⁷

“Prevention” also includes early detection of cancer and precancerous conditions – where primary health care professionals can play a very important role.⁷ This review must formally recognise that the Government is in the process of implementing a National Bowel Cancer Screening Program which, with the BreastScreen and National Cervical Cancer Screening Program, will be Australia’s third population-based screening program. The full implementation of this program will be a major undertaking, and its effectiveness will depend in part on the engagement of GPs.⁷

4. Well-integrated, coordinated, and providing continuity of care, particularly for those with multiple, ongoing, and complex conditions.

Cancer causes Australia’s largest disease burden⁸ and is often a highly complex and in many cases chronic condition. Its ongoing management can also in some cases be comparatively straightforward. A more systematic approach to managing cancer must be built into any enhancement of primary care in Australia.

Service delivery arrangements that support...

5. Safe, high quality care which is continually improving through relevant research and innovation;

Safety and quality are core principles of optimal cancer service delivery. Formal application of clinical practice guidelines, accreditation and credentialing should be explored as options to help ensure safety, quality, continuous improvement and use of the latest research and innovation are built into cancer control at the primary care level.

Please see the separate Cancer Council/Clinical Oncological Society of Australia submission in response to the COAG consultation on health professional accreditation, available at: http://www.cancer.org.au/policy/submissionstogovernment/CancerCouncil_COSA_submission_to_accreditation_paper_2008.htm

6. Better management of health information, underpinned by efficient and effective use of eHealth;

Cancer Council Australia calls publicly for a national electronic health strategy. The role of enhanced primary care in cancer control would be an integral part of such a strategy, with the potential to contribute to significantly improved cancer outcomes through patient management – e.g. prevention (risk monitoring), early detection (screening and surveillance)

data), electronic enhancement of multidisciplinary care pathways and improved population monitoring and epidemiological research.

An efficient eHealth network would also significantly improve communications and information exchange between the hospital and primary care settings – an area of great importance for enhancing care coordination of cancer patients.⁵

7. Flexibility to best respond to local community needs and circumstances through sustainable and efficient operational models.

In a number of settings and population groups, GPs and practice nurses already play a comparatively enhanced role in cancer control (Indigenous, rural/remote, some ethnic groups who are shown to rely on their community GP to access all components of the health system).

Primary care may also play an enhanced role in longer-term management and surveillance of patients with chronic cancer or at increased cancer risk. Enhancing primary care therefore provides an opportunity to build more structure into these roles in relation to cancer control across the spectrum.

Supporting the primary health care workforce...

8. Working environments and conditions which attract, support and retain workforce;

Cancer Council Australia/Clinical Oncological Society of Australia call for a proper needs analysis of cancer patients in rural/remote Australia and the establishment of a network of multidisciplinary cancer in larger non-metropolitan settings, to reduce the distance patients in isolated areas need to travel for treatment.

In our view the establishment of such centres must occur eventually if larger, non-metropolitan centres and their satellite communities are to expand and remain viable. We call on this review to support the plan, as anecdotal feedback from primary care providers indicates they would be easier to retain in non-metropolitan areas that provide quality clinical and allied healthcare locally.⁴

9. High quality education and training arrangements for both new and existing workforce.

Evidence shows cancer competency in medical graduates has diminished in recent years.¹¹ Cancer Council Australia/COSA call for the introduction of an ideal oncology curriculum¹² to help ensure medical graduates have an improved professional understanding of cancer control across the spectrum. With cancer incidence rates likely to increase by around 30% every decade until population ageing peaks in the middle of the century, it will be increasingly important for primary care practitioners to have high-level cancer control competency.

Our joint submission to a separate medical education review makes a number of recommendations for improving cancer outcomes through education and training arrangements. It is online at:

<http://www.cancer.org.au/File/PolicyPublications/DESTmedicaleducationMAR06.pdf>

Primary health care is...

10. Fiscally sustainable, efficient and cost-effective.

All Cancer Council/COSA recommendations are shown to be either cost-effective or cost-beneficial. Reducing cancer morbidity through enhanced primary care, particularly as a result of prevention and early detection, would deliver wide-ranging economic benefits, as explained throughout this submission.

Specific questions by 'element'

1. Accessible, clinically and culturally appropriate, timely and affordable

1.1 How can we ensure appropriate services for all geographical areas and population groups?

To ensure appropriate primary care cancer control services are available to all individuals, regardless of geography, ethnicity, socio-economic status etc., the National Primary Health Care Strategy must address three main areas:

- Workforce
- Centralised Information technology (IT) strategies, in particular eHealth
- More equitable access – geographic, cultural etc.

Detailed recommendations in these areas are made throughout this submission.

1.2 How could primary health care services/workforce be expanded to improve access to necessary services?

The focus of recent government inquiries into future healthcare arrangements (e.g. the 2005 Productivity Commission study into health workforce¹³) reflects an intention to streamline the system to effectively get more from less.

In this climate, it is difficult to envisage government finding necessary funds to adequately expand the primary health workforce to meet demand; while Cancer Council Australia/COSA understands the outlook is consistent with an anticipated reduction in taxpayer base and an increase in patient numbers as the population ages, some key points must be made to ensure the primary care workforce can be expanded to meet demand and support a necessary systemic culture change:

- Improved efficiencies should be sought, but additional budget funds must nonetheless be invested into the primary care workforce to ensure future demand can be met. No level of creativity and flexibility in administration can substitute for actual service provider numbers;
- Expanded numbers of primary care practitioners will only assist in managing Australia's growing cancer burden if effective, formal structures are introduced to ensure GPs and practice nurses are more actively involved in cancer control;

- Efficiencies and quality assurance measures could be built into health professional training and placement by streamlining elements of the current system that are fragmented across multiple tiers and bureaucracies. Options include:
 - as recommended by the Productivity Commission,¹³ COAG investing more in prevention to reduce long-term chronic disease workforce costs;
 - the Commonwealth directly funding training places from a national pool, according to a comprehensive, needs-based analysis of population needs;
 - a system of accreditation and credentialing, based on standard competencies and designed to facilitate career paths and staff movement across the system. This would help to underpin care standards as flexibilities in roles (e.g. between general practitioner and nurse practitioners) are introduced to reduce costs;
 - national professional and/or registration bodies to act as accrediting agencies, with models of care approved by Cancer Australia; and
 - expanding credentialing to include the use of clinical practice guidelines, including among primary care practitioners.
- Improved cancer competency through medical training would help to ensure an expanded primary care workforce was also better equipped to accommodate the projected increases in cancer incidence over the next 40 years;
- Quality and safety measures must be built into the system to ensure efficiencies do not come at the expense of care standards;
- Policy makers must remain conscious of the likelihood that capacity building in one segment of the health system (e.g. primary health) may be a drain on another segment (e.g. hospitals), and plan accordingly.

One practical way in which primary care could be more actively involved in cancer management is the development of shared care models, with guidelines, clearly articulated roles and responsibilities and performance benchmarks. The National Breast and Ovarian Cancer Centre is exploring this approach in relation to breast cancer;¹⁴ there is great potential for this approach to be effective in enhanced management of all cancers.

A cultural shift in primary care is essential to improving access to services. The focus of this review and the pivotal role of primary care in the interim recommendations of the National Health and Hospital Reform Commission reflect the Government's demonstrated interest in primary care being enhanced to play a more pivotal role in system-wide reforms.

In summary, we call for adequate investment in genuine, sustainable workforce expansion, a streamlined and needs-based approach to training, placement and career support; improved cancer competency; and measures to ensure safety and quality are not compromised by a drive for efficiency.

1.3 What more needs to be done for disadvantaged groups to support more equitable access?

Performance guidelines should be developed that are relevant to particular population groups. A policy for ensuring these performance guidelines are adhered to is required, and a system for evaluation would need to be incorporated.

Engagement with primary care practitioners (e.g. through the RACGP and other representative groups) on how best to build the use of such guidelines into the system is critical.

Suggestion for the implementation of best practice care plans for chronic disease management and prevention are addressed in section 4.1. This should include addressing specific care needs, risk factors and monitoring techniques that are relevant to different population groups.

1.4 With limited public health dollars, how could priorities for accessing primary health care services be determined and targeting of public resources improved?

An important measure to ensure needs-based targeting of public health dollars is to use burden of disease data to inform the development of benchmarks and plan and support services accordingly. The achievement of benchmarks could be encouraged through incentives (see 3.1 & 3.5). Better prioritisation of funds would also occur through a more needs-based approach to service planning and delivery.

Cost efficiencies could be delivered through better use of guidelines and protocols at the primary care level, which could reduce inappropriate referrals and investigations. Examples include:

- Patients with benign breast disease that could be managed in the primary care setting rather than being referred for expensive, unnecessary radiotherapy;
- Patients concerned about bowel cancer who are referred for colonoscopy instead of the far less expensive faecal occult blood test;¹⁵
- Better targeted referral for invasive procedures generally.

Clinical practice guidelines provide guidance on a number of these scenarios; the application of guidelines in primary care could be formally built into the system to improve cost-efficiencies.

Savings could also be made in improved prevention and early detection, in areas where government currently under-invests – e.g. tobacco control, obesity control, skin cancer prevention, bowel cancer screening.¹⁶ Part of these savings, along with a major potential boost in revenue from raising tobacco excise to meet international best practice, could be re-invested into elements of the primary health care system.

2. Patient-centred and supportive of health literacy, self-management and individual preference

Objective: Primary health care services respond to the individual preferences and circumstances of patients, their families, and carers, and actively support them in achieving best possible health outcomes.

Questions

2.1 *What is needed to improve the patient and family-centred focus of primary health care in Australia for:*

- *individual patient encounters;*
- *health professionals;*
- *health service organisations;*
- *the broader primary health care system?*

Cancer care planning over recent years has shifted increasingly to a patient-centred, multidisciplinary care model. While evidence is still being collected on the relative clinical effectiveness of varying care models, the multidisciplinary, patient-centred approach is overwhelmingly endorsed as superior to an ad hoc approach by consumers and clinicians.⁵

Efficient, patient-centred referral pathways – which inherently involve primary care professionals, particularly in remote areas or for specific population groups (e.g. the role of Aboriginal medical services in supporting Indigenous cancer patients) – are a critical component of multidisciplinary cancer care.⁵

To this end, we support the NHHRC's recommendation to introduce grant funding for structuring improved multidisciplinary care of people with complex and chronic conditions into the primary health care system.¹⁷ (This would need to be accompanied by reciprocal arrangements ensuring hospitals – public and private – and allied health workers are partners in care planning with primary care providers.)

2.2 *Are there specific strategies that are needed to better support consumer engagement and input?*

- **Voluntary sector engagement:** Commonwealth support through policy and practice, and the engagement of the voluntary sector (e.g., organisations such as Cancer Council and COSA), in developing and improving consumer engagement and input. These organisations have a proven track record in supporting patients' self-management, improving health literacy and understanding individual preferences in seeking treatment and other services option. Cancer Councils also provide high levels of supportive care; improved primary care linkages with Cancer Councils would increase patient access to these services.
- **Local consumer representation:** the National Primary Health Care Strategy should support a policy that engages consumer organisations (e.g., Cancer Voices regarding cancer policy and practice improvement, etc.) through a national system of divisions of primary care¹⁷ by requiring at least one consumer representative on every service planning or delivery committee.
- **Consumer participation in research prioritisation:** in terms of setting primary health care research priorities, there is a developing interest in trialling consumer involvement in novel areas (such as Cancer Council NSW's involvement of consumer participation in research prioritisation).

3. More focussed on preventive care, including support of healthy lifestyles

Objective: All Australians are supported to stay healthy through a stronger focus on wellness, prevention and early detection, and appropriate intervention to maintain people in as optimal health as possible.

Questions

3.1 *How could primary health care be enhanced to better support prevention activities?*

While primary care can play an important role in managing lifestyle chronic disease risk factors in patients, under current arrangements there is little systemic structure to facilitate this activity and limited incentives for GPs to build prevention into their practice.

To this end, Cancer Council Australia/COSA support the recommendations of the Government's Preventative Health Taskforce¹⁸ on building chronic disease prevention into the primary care system, specifically:

- **Incentive-based funding**
 - a prevention benefit item included in the Medical Benefits Scheme would support delivery in primary care practices of brief interventions and follow-up (whether they were directed to tobacco, alcohol, obesity or other relevant chronic disease risk factors).
 - the structure of the item could be a small add-on to standard consultations in primary care practices, when the intervention is delivered and as a stand-alone item at follow-up. Such a structure could narrow opportunities for inappropriate use and practice, as well as help improve the evidence base.
- **Supporting primary health practices to enhance their role in prevention**
 - primary health care is a fundamental part of preventative health. This is seen in many areas, including immunisation (e.g. cervical and hepatitis, which both reduce cancer risk), screening for cancers and brief interventions to discuss and advise on smoking and alcohol use. Three approaches are suggested:
 - there is increasing consensus around the need to define the population that a practice is working with and for. This would have to start with enrolling or registering patients in a practice.
 - adequate incentives at the practice level (for example, Practice Incentive Payments) or at individual practitioner level (for example, Medicare Benefits Schedule item number) must be provided. Given that brief interventions and the use and promotion of life scripts can be very adequately done by practice nurses, this incentive would be better placed at the practice level.
 - a system of accountability and reporting is needed to complement the incentive payment scheme.

It is important that this review also notes the role played by primary health care practitioners in screening to detect early-stage cancers and precancerous conditions. Of particular

importance is the National Bowel Cancer Screening Program, currently in the form of one-off screening for people turning 50, 55 or 65 up to the year 2010.

GPs are a pivotal part of the program, as:

- Participants can nominate their GP to receive their test results;
- GPs may be required to manage patients testing positive and referred for colonoscopy;
- GPs may be required to advise central registry of patient outcomes for program monitoring.

GPs and practice nurses are also involved in other elements of managing bowel cancer risk in patients, including patients not eligible for the current government screening program.

This review must incorporate the significance of primary care to cancer screening, particularly the phasing in of the National Bowel Cancer Screening Program.

3.2 How could health professionals be better supported to provide lifestyle modification advice and support consumers in behavioural change?

To a large extent our response to this question can again be drawn from the recommendations of the Preventative Health Taskforce (see above). To elaborate, additional support for health professionals to provide lifestyle modification advice in primary care could be derived from disease-specific organisations such as Cancer Council. In 2007, Cancer Council Australia partnered with the Australian General Practice Network and the National Breast and Ovarian Cancer Centre in developing a proposal for trialling a system of improved primary care performance management in cancer control, including measures to improve GP access to information and support in primary prevention of cancer. We continue to endorse elements of this proposal, available at:

3.3 How can consumers be linked with local primary health care services to support a stronger focus on population-based preventive health care with national reporting?

The key to this question is a comprehensive electronic health (eHealth) strategy. If COAG agrees to support Australia's long-awaited and much needed eHealth system, its architecture must include linkages between primary health care centres and hospitals, and national reporting to inform policy aimed at improving patient outcomes.

3.4 What measures have been, or could be, effective in addressing prevention for specific population groups (e.g. Indigenous, rural and remote, low socio-economic status, CALD)?

In relation to cancer control, primary care providers are already pivotal to the health needs of a number of population groups, including Indigenous (Aboriginal medical services), CALD groups (where community GPs are the link to all health care needs) and remote communities, where GPs perform a wide range of functions often undertaken by multiple professionals in less remote centres.

Measures to formalise prevention activity in primary care as recommended throughout this submission must be tailored to support the diverse needs of primary care professionals whose patient base includes significant numbers of specific population groups.

3.5 With limited public health dollars, how could preventive care priorities be determined and public resources subsequently targeted?

See response to 1.4.

4. Well-integrated, coordinated, and providing continuity of care, particularly for those with multiple, ongoing and complex conditions

Objective: All Australians, particularly those with multiple, ongoing and complex conditions, experience primary health care services which are coordinated across multiple care providers, with transitions across health sectors actively managed and continuity of care supported.

Questions

4.1 What target groups would most benefit from active clinical care and/or service coordination?

Cancer patients must be a priority group for any reforms aimed at improving the coordination of clinical care, particularly in light of the NHHRC's recommendations for funding increased capacity for multidisciplinary care through enhanced primary care.

Tailored approaches within this general shift towards coordinated, multidisciplinary care will be required for a range of specific population groups (Indigenous, CALD, rural/remote) as recommended throughout this submission.

4.2 Who is best placed to coordinate the clinical and/or service aspects of care?

This is a complex and relatively new field, particularly in relation to cancer care. While research into models of multidisciplinary care and care coordination is underway, Cancer Council Australia/COSA assert that any proposal to build a more robust system of multidisciplinary care through enhanced primary care must engage with specialist clinicians and allied health workers involved directly in cancer care. Health professional engagement is critical to ensuring effective, systemic change is achieved.

Specialist cancer clinicians and allied health workers are best-placed to advise on the cancer care priorities of enhancing primary care in relation to continuity of care. We recommend that this review engage closely with COSA and Cancer Council Australia, along with government cancer agencies such as Cancer Australia and the Cancer Institute NSW; significant work on cancer care coordination is already underway in these organisations.

4.3 How could information and accountability for patient handover between settings (e.g. hospital and general practice) be improved?

A comprehensive eHealth strategy would be pivotal to the efficient management of patient transition between treatment settings, particularly the primary health and hospital settings.

Other considerations include:

- Ensuring that multidisciplinary care is adequately supported through enhanced primary care (as discussed throughout this submission);

- Ensuring that “accountability” for transferring cancer patients between hospitals and general practice includes reducing chemotherapy cost-shifting between state and federal governments;
- Withholding a portion of special fees until back referral is made – alternatively an MBS item could be created for back referral; and
- Mandatory medication review.

4.4 *What changes are needed to improve integration between different primary health care organisations?*

4.5 *Would there be advantages in patients having the opportunity to ‘enrol’ with a key provider?*

Cancer Council Australia/COSA note that these questions may relate to the NHHRC’s recommendation for the enrolment of patients with complex care needs in a “single primary health provider”. This is supported in principle, provided it can be demonstrated that such an approach will improve multidisciplinary care coordination of cancer patients and overall efficiency of the primary care sector in relation to cancer outcomes.

5. Safe, high-quality care which is continually improving through relevant research and innovation

Objective: All Australians have access to safe, high quality primary health care services that deliver evidence-based care and accountability for outcomes, support continuous quality improvement, and reward research and innovation.

Questions

5.1 *What aspects of performance of the primary health care sector could be monitored and reported against (e.g. for each Element in this Discussion Paper, what are key areas of performance that could be monitored and how)?*

See section 3.1

5.2 *Who should be responsible for developing and maintaining a performance framework?*

If COAG adopts the NHHRC’s recommendation that all primary care policy and funding be run by the Commonwealth, then this should be an overarching responsibility for the federal minister for health.

One option would be for the minister to devolve primary responsibility for a performance framework to an independent board, comprised of primary care practitioners, college representatives, clinicians with specialist expertise in managing the major disease groups, public health professionals and consumers. Given that safety, quality and continuous improvement are a focus, there would need to be a mechanism to ensure the board’s work interfaces with accreditation/credentialing to underpin performance.

Effective sector performance could then be a Commonwealth requirement of the Australian Healthcare Agreements – consistent with the intention to extend the agreements beyond their historical scope, limited to public hospital funding.

5.3 Would there be advantages in linking patient health outcomes and quality of care provided to incentives for health care professionals?

This concept has merit, but it may be difficult to achieve in practice, particularly in relation to patients from socially disadvantaged population groups. Incentives alone will not empower primary care practitioners with disadvantage patient bases to deliver optimal health outcomes. Additional professional support would need to complement incentive schemes; systemic change would be required to structurally formalise this support, backed up by monitoring and reporting mechanisms.

5.4 How can we improve the current research culture and evidence-base in primary healthcare?

See comments throughout this submission re improving cancer competency through medical education and training. This also applies to fostering a research culture and adherence to, and understanding of, evidence-based practice.

The application of clinical practice guidelines (which use best evidence in recommending best practice) also has the potential to improve care standards.

5.5 How can we translate evidence or innovation into practice more systematically?

See 5.4.

6. Better management of health information, underpinned by efficient and effective use of eHealth

Objective: Primary health care service arrangements benefit from greater sharing and improved access to health information, clinical knowledge resources and emerging technologies to better support patient-centred care.

Questions

6.1 What is the role for eHealth in supporting the provision of quality primary health care?

As discussed throughout this submission, eHealth is essential to the long-term efficiency and effectiveness of Australia's health care system, particularly in primary care where complex conditions and co-morbidities are often managed. As delays in introducing a national eHealth strategy continue, increasing numbers of GPs may invest in their own standalone or locally networked eHealth systems, decreasing their preparedness to sign on to a new, national system.

6.2 Where should the Government prioritise its actions in relation to implementing eHealth reform?

Cancer Council Australia/COSA support in principle the priorities outlined by the National eHealth Transition Authority.

6.3 How can the various information systems be integrated (e.g. state health services and general practice)?

Cancer Council Australia/COSA support the recommendations provided by the Australian Healthcare & Hospitals Association and HISA in the National Health Policy Roundtable *Discussion Paper: Information Management*. These include:

- Accelerate the current health information infrastructure work program, establish clear milestones and provide routine reporting to the community on progress;
- Coordinate and fund the development of common registry services for clinical, public health and surveillance purposes that can be used locally and at the state/territory and national levels;
- Fund the development of a National Library for Health that provides to all Australians quality-assured timely information in electronic form;
- Support and, where necessary, fund the development of a national consensus plan for effective management of health information, which is resourced and has governance arrangements that are widely supported by both the private and public sectors;
- Ensure that state/territory and Commonwealth regulatory environments allow for the development and uptake of personal health records; and
- Establish a fund to promote the uptake of electronic medication management in the acute care sector.

7. Flexibility to best respond to local community needs and circumstances through sustainable and efficient operational models

Objective: Primary health care services in Australia operate with an accountability and governance framework which is responsive to local needs, and is sustainable, flexible and well integrated with other non-health services in local communities.

Questions

7.1 How could planning for primary health care services at the local level be improved?

Cancer Council Australia/COSA support in principle the NHHRC's recommendation that service coordination and population health planning priorities could be enhanced at the local level through the establishment of divisions of primary health care.¹⁷

Another option could be to integrate primary care service planning into the current system for tertiary services planning (by regional/area health services), e.g. Indigenous health service plan.

7.2 What advantages/disadvantages would there be in having a regional organisational structure with responsibilities (ranging from local planning through to service delivery) for primary health care services?

Improved coordination, from planning to service delivery, would provide a range of advantages through better targeting of services to need. Challenges (rather than “disadvantages”) would include ensuring that:

- Practitioners (in particular clinicians) are adequately engaged in the process;
- The authority responsible has a genuine mandate to manage service planning and support delivery according to population need;
- Measures to help ensure equitable access to services for all population groups (as articulated throughout this submission) are formally built into the process. (Improved access for isolated patients would also require increases in patient travel and accommodation support, as a complement to any enhancement of primary care.)
- These requirements are built into the system in a way that makes the Commonwealth (if COAG adopts the NHHRC recommendation for overarching, sole Commonwealth responsibility).

7.3 Who could undertake this role? – What changes would be needed to existing organisations (e.g. Divisions of General Practice, Area Health Services) to undertake this?

See 7.1.

7.4 What advantages/disadvantages would there be if regional organisations were responsible for purchasing some primary health care services for their communities - that is, should they ‘hold funding’ for health services?

7.5 What mechanisms could be used to improve the accountability of primary health care services being delivered in a locality (in respect to quality of care, reach and equity)?

See comments re accreditation, credentialing.

7.6 How can greater community engagement be supported in primary health care?

NGOs such as Cancer Council have a role in providing community based education programs on risk factors and evidence-based behaviour modification techniques is vital to community engagement on preventative health care.

Cancer Council Australia/COSA recommend that the services of evidence-based NGOs are promoted through primary health care, contributing to a more health-literate community. (Findings from the Australian Coordinated Care Trials suggest that personal and community responsibility for health increases as knowledge and access to community care options increases.)

Cancer Councils provide a range of community-based resources, telephone advice and peer support. Awareness of these resources could be raised through better networks with primary care centres.

Cancer Councils also provide a range of evidence-based resources for health professionals, including a National Cancer Prevention Policy and specific advice on complex issues such as testing for indication of prostate cancer.

7.7 What other approaches could improve planning and service integration at the local level?

As described in 2.2, consumers could form a part committee who determine service planning at the local level.

8. Working environments and conditions which attract, support and retain workforce

Objective: Primary health care professionals work in environments which support a team-based approach and a work/life balance, with conditions that attract, support and retain a strong local workforce.

While advice on supportive working environments must be formally sought (and acted on) from primary health care professionals, Cancer Council Australia/COSA make the following general points:

- Building capacity in multidisciplinary cancer care to more effectively involve primary care practitioners would improve professional support;
- Building improved cancer competency into medical training and incentives for primary care practitioners to continuously improve their cancer competency would, in our view, have potential to enhance overall professional development;
- Investing in multidisciplinary cancer care in larger regional centres and ensuring networks are able to export and exchange knowledge with smaller, more remote centres would increase overall healthcare standards, potentially attracting primary care professionals to areas that current struggle to recruit and retain staff.

9. High-quality education and training arrangements for both new and existing workforce

Objective: The current and future primary health care workforce is provided with high quality education (undergraduate, postgraduate and vocational) and clinical training opportunities that support interdisciplinary learning.

As discussed throughout this submission, system-wide cancer competencies, including in the primary care sector, will need to improve to accommodate significant projected increases in cancer incidence.¹¹ To this end, Cancer Council Australia/COSA recommend:

- That the improvement of cancer management competency be formally identified as a core medical education priority;
- That minimum standards in cancer management competency for graduates be established nationally, along with a mechanism to monitor continual improvement in postgraduate cancer skills and knowledge;
- That Cancer Council Australia/COSA's Ideal Oncology Curriculum¹² be adopted throughout Australian medical schools;
- That undergraduates and interns perform minimum clinical cancer management practice and that a cancer exit exam, based on the outline developed by Cancer

Council Australia/COSA, be incorporated into relevant medical curricula;

- Medical students in rural locations have adequate access to clinical experience in all elements of multidisciplinary cancer care, including modalities such as radiation therapy for which there is limited local infrastructure;
- That the increased role GPs play in cancer prevention and early detection, particularly in the diagnosis and treatment of skin cancer, be factored into prevocational and postgraduate training;
- That training modules in the prevention and treatment of chronic disease be developed nationally, according to current epidemiological evidence and projections; and
- That the role of practising clinicians as on-the-job trainers of medical undergraduates and interns be formally recognised and supported through national train-the-trainer and incentives schemes.

10. Fiscally sustainable, efficient and cost-effective

Objective: All Australians have a primary health care system which is efficient, including making the best use of the available workforce, and is cost effective, fiscally sustainable for governments and affordable for individuals and families.

Funding models are a matter for the professions and government health policy makers. In general terms, Cancer Council Australia/COSA support models that:

- Ensure services are funded on the basis of comprehensive and targeted needs analyses;
- Ensure flexibilities are built into the system to foster more equitable access to services for disadvantaged groups;
- Funding is tied to performance benchmarks where feasible;
- A national eHealth strategy is implemented to improve long-term economic efficiencies and improve health system performance monitoring and service planning; and
- Investment is made in prevention and early detection of chronic disease to deliver long-term economic gains and reduce future strain on the health system.

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