



Standing Committee on Health: Inquiry into Chronic Disease Prevention and Management in Primary Health Care

Joint submission from the Primary Care Collaborative Clinical Trials Group (PC4), the Clinical Oncology Society of Australia (COSA) and Cancer Council Australia

The **Primary Care Collaborative Clinical Trials Group (PC4)** is a national group funded by Cancer Australia to build evidence around the role of primary care across the cancer continuum.

The **Clinical Oncology Society of Australia (COSA)** is the peak national body representing health professionals from all disciplines whose work involves the care of cancer patients.

Cancer Council is Australia's peak national non-government cancer control organisation. Its members are the eight state and territory Cancer Councils.

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Recommendations

1. Add a new prevention benefit item to the Medicare Benefits Scheme to support delivery in primary care practices of brief interventions and follow-up (to support implementation of the "5As" as per the recommendations of the Royal Australian College of General Practitioners Guidelines for Preventive Care).
2. The current Practice Incentive Payment scheme should be expanded from a focus just on cervical cancer screening to include all three cancer screening programs, with clearer reporting and increased remuneration for tasks such as contributing to the National Bowel Cancer Screening Program register etc.
3. Review the current Medicare item numbers relating to General Practitioner (GP) involvement in clinical cancer care (cancer as a chronic disease) to ensure Medicare incentives are extensive and targeted to support increased involvement of the GP for pre- and post- treatment care.
4. Existing Medicare Chronic Disease Management items should be applied systematically to support cancer survivorship care in the community.
5. The Primary Health Networks should take a lead role in supporting general practices to implement evidence-based systems to raise cancer screening participation. This could include, for example, establishing recall and reminder systems and sending GP endorsement letters in advance of cancer screening invitations.

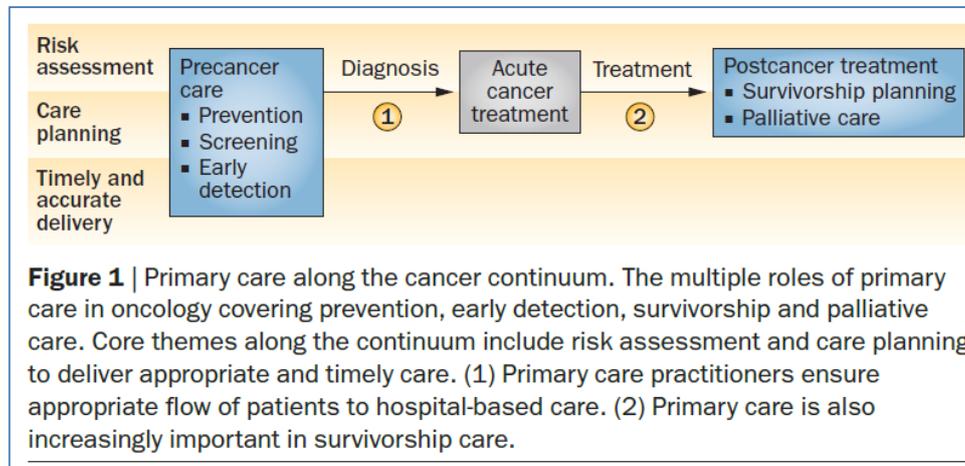
6. The Primary Health Networks should take a lead role and work with State and Territory Governments and Local Hospital Networks to define clear referral pathways in the public hospital system for patients with a high suspicion of cancer. This should prioritise suspected cancers where there are long waiting times for diagnostic services (e.g. bowel and gastro-oesophageal cancers) or where there are large variations in diagnostic pathways and access to multidisciplinary teams (e.g. lung cancer).
7. Incentivise use of evidence based clinical practice guidelines where general practice involvement is included and endorsed by Royal Australian College of General Practitioners.
8. Promote the coordinated uptake of optimal care pathways by State and Territory Governments health systems where general practice involvement is included and endorsed by Royal Australian College of General Practitioners.
9. Scoping opportunities for collation of hospital data to enable large scale audits of current and future referral pathways of patients with suspected cancer to allow calculation of conversion and detection rates and measure the impact of new diagnostic initiatives. This requires investment in appropriate information systems by State and Territory Governments as this data belongs to them.
10. State and Territory Governments support the establishment of new models of follow-up involving primary care initially for breast, bowel cancer and prostate cancer. This should become the standard model of follow-up care for cancer survivors at low risk of recurrence or adverse treatment effects.
11. The federally funded My eHealth Record should be developed and implemented to support communication and care between healthcare providers in cancer follow-up.

Overview

Cancer is the leading cause of disease burden in Australia accounting for 19.4% of the total disease burden, more than cardiovascular disease (18.0%), diabetes (5.5%) and mental health disorders (13.3%)¹. The AIHW recognises cancer as a chronic disease; the National Public Health Partnership's paper, 'Preventing chronic disease: a strategic framework' focused on 12 chronic conditions which pose a significant burden in terms of morbidity, mortality and health care costs in Australia, and are amenable to preventive measures². These included bowel and lung cancers.

The role of primary care in cancer control is increasingly recognised as a vital component of cancer services in Australia. Cost-effective healthcare relies on the delivery of appropriate care by the right team at the right time. Healthcare systems with a strong primary care component have been demonstrated to be more cost-effective than those which are predominantly led by hospital specialists³. This is probably due to more efficient care when delivered and coordinated by a generalist, rather than multiple specialists, and through managing access to more expensive hospital-based care. The key elements in a conceptual model of general practice and generalism are accessibility, holistic patient-centred, team-based care, care coordination, continuity and management of complex multiple problems⁴.

Figure 1⁵ presents an overview of processes of care along the cancer continuum, adapted from two key sources^{6,7}, both of which discuss the need for integrated approaches to disease prevention and management of cancer by applying chronic disease models.



In 2013 PC4 was commissioned by the Sax Institute and NSW Cancer Institute (NSWCI) to review the evidence on the role of primary care in the early detection and follow-up of cancer, and make recommendations to the NSWCI⁸. Our submission to this Inquiry is based on this evidence review and ongoing update of the evidence in this area. For the purposes of this submission we wish to clarify our definitions of chronic disease prevention and management:

1. Disease prevention:
 - a. Primary prevention is aimed at reducing disease incidence by reducing exposure to known disease risk factors, for example tobacco and alcohol.
 - b. Secondary prevention is the early detection of disease. This can be achieved through cancer screening in asymptomatic populations but also early recognition and diagnosis of cancer in people presenting with cancer symptoms.
2. Disease management: in the context of cancer and the role of primary care, this relates to care both during acute cancer treatment and, more importantly, following cancer treatment and the longer term follow-up of cancer survivors.

As recognised by the Royal Australian College of General Practitioners in its Red Book (*Guidelines for preventive activities in general practice*) and Green Book (*Putting prevention into practice: guidelines for the implementation of prevention in the general practice setting*), the primary care team can make significant contributions to primary prevention. In the context of cancer prevention this includes reducing tobacco and alcohol use, promoting healthy diet and physical activity, reducing sun exposure and accessing available vaccinations. The Green Book provides a framework for general practice to implement systems to increase disease preventive activities. For this submission we focus on the role of primary care in the prevention and management of cancer.

Addressing the Terms of Reference

1. Examples of best practice in chronic disease prevention and management, both in Australia and internationally

Australia has some of the best cancer survival outcomes in the world. A recent study published in *The Lancet* showed five-year survival in Australia was high for all eleven cancers, but particularly for cancers of the bowel, breast and prostate⁹. This is mostly likely due to improvements in screening, early detection and treatment.

National cancer screening programs in Australia saves lives. Accelerating the expansion of the National Bowel Cancer Screening Program to achieve biennial screening by 2020 will prevent more than 70,000 deaths¹⁰. National cancer screening programs are a key part of cancer control policy in Australia and these programs will save more lives if participation is increased. Currently there are national cancer screening programs for cervical, breast and bowel cancers. Participation rates in all three are not ideal, and in particular there remain significant challenges for the National Bowel Cancer Screening Program with participation rates of only 36%.

Several systematic reviews have examined a range of strategies aimed at altering either physician recommendation for ordering cancer screening tests, or primary care level interventions that improve patient uptake of cancer screening tests^{11,12,13,14}. The effect of GP involvement in the initial invitation to have a cancer screening test has also been examined in several trials^{15,16,17,18}. To summarise this evidence:

1. Organisational changes shown to increase cancer screening uptake in primary care include: GP endorsement letters, recall and reminder systems, feedback on screening uptake and cancer prevention clinics.
2. Involvement of non-medical staff including organising patient and clinician reminders, patient education, scheduling screening appointments and general administrative support are core elements of this organisational change.
3. Practice support and incentives for these organisational changes are important for implementation.

While cancer screening is important in the early detection of some common cancers, the majority of cancers present symptomatically and this is where primary care plays a key role¹⁹. A major challenge for GPs is that the symptoms of many cancers are common in the community and overlap with more prevalent benign conditions. GPs need to assess the risk, or diagnostic probability, of an underlying cancer and determine whether further investigation is justified. Until recently there was little epidemiological evidence on how well symptoms predict risk of an underlying cancer from primary care populations. Analysis of data from large UK general practice databases, notably Hamilton's CAPER studies^{20,21,22,23,24,25,26} and Hippisley-Cox's QCancer research^{27,28,29,30} has led to significant advances in our understanding of the epidemiology of cancer symptoms in primary care. Internationally these cancer risk models have been implemented into GP electronic medical records to provide electronic decision support and identify patients who require urgent investigation for suspected cancer. They have also informed the recently published NICE guidance (*Suspected cancer: recognition and referral*)³¹. Importantly these new NICE guidelines are based on explicit risk thresholds and recognise the significance of combinations of symptoms rather than previous guidelines, including those in Australia, which have focused on single 'red flag' symptoms. These guidelines represent the most up-to-date summary of how cancer presents in primary care and how to identify patients requiring urgent investigation for cancer.

In response to concerns about 'diagnostic delay' of cancer, particularly in the context of publicly funded healthcare systems and long waiting times for diagnostic procedures, several countries have implemented fast-track cancer referral routes for patients in whom there is a high index of suspicion of cancer. The largest implementation of this model at a national level was the 2-Week Wait Referral System (2WWRS) in England in the last decade. Fast track referral routes were linked to referral guidelines for suspected cancer. There are some important metrics of the quality of GP referrals for cancer diagnosis and the effect of fast track referral systems³²:

1. The conversion rate – the proportion of 2WW referrals that result in a cancer diagnosis (i.e. the PPV of a referral)
2. The detection rate – the proportion of cancers that are referred via the 2WW referral pathway (i.e. the sensitivity of a referral)

A national audit of 2WW referrals in England demonstrated an overall conversion rate of 11% and a detection rate of 43%³³. There was significant inter-practice variation and important correlations between the metrics relating to referral efficiency. Practices with higher 2WW referral ratios tend to have lower conversion rates but higher detection rates, but practices with higher conversion rates also have higher detection rates. Practices with high conversion and detection rates (14% and 50% respectively) represent good clinical practice in that they are using the 2WW route efficiently but also diagnosing cancers through that route rather than through slower diagnostic routes or via emergency admissions. Practices with low conversion and detection rates (4% and 17% respectively) are inefficient users of the 2WW route but also fail to identify patients with cancer who would benefit from rapid access to diagnostics.

In summary, fast track referral routes will at best detect nearly half of all cancers because symptoms are a relatively poor predictor of cancer in primary care and some patients with cancer will present with subtle symptoms that do not meet criteria for urgent referral. However, they may still be a useful approach to reducing diagnostic delay for a large number of cancer cases in systems that have long waiting times for outpatient diagnostic services (e.g. GI endoscopy). There are probably several reasons why GPs complied surprisingly well with the referral guidelines in the 2WWRS: there was a significant and sustained communications and implementation strategy for the 2WWRS that included enforced referral pro-formas to access the clinics. Furthermore, the establishment of the referral system provided a significant advantage for GPs in managing patients in whom they suspected cancer. These are important to consider in any planned implementation strategy.

Best practice cancer care is delivered by a multidisciplinary team. This ensures that the needs, including treatment, psychosocial, supportive care, of the person affected by cancer and their carer are addressed in a timely manner. Primary care has an important role in delivering best practice cancer care across the cancer continuum, including the provision of care during and after treatment.

Primary care plays a role in delivering optimal care pathways. Optimal care pathways assist:

- to map the patient journey, aiming to foster an understanding of the whole pathway and its distinct components to promote quality cancer care and patient experiences;
- to identify critical points along the care pathway and describe optimal treatment action at that point and;
- in the coordinated approach to delivery of cancer care and support communication avenues between the patient, general practitioner and specialists involved.

Improvements in treatment and early detection have led to marked improvements in cancer survival in Australia. Five-year survival rose from 47% to 66% between the periods of 1982-87 and 2006-10, and several cancers now have survival rates of over 90%³⁴. With an ageing population and a median age of diagnosis of new cancer of 67 years, there is a growing number of people requiring long term follow-up and management of the consequences of a cancer diagnosis and treatment. The escalating numbers of cancer survivors places an increasing burden on costly hospital oncology clinics, adding to the growing demand for more cancer services to be delivered in primary care³⁵.

Cancer survivors, as part of the ageing population with increased longevity, often have several comorbidities. Many oncologists continue to monitor their patients for cancer recurrence long after the risk of recurrence has significantly diminished. This hospital-based model of follow-up focuses on detection of cancer recurrence, failing to attend to the management of other chronic comorbid conditions, many of which will ultimately cause death and morbidity in those who have survived cancer³⁶. The multiple needs and comorbidities of these patients are more appropriately dealt with from a generalist perspective. This has become increasingly important as the number of people living with and beyond cancer continues to rise.

A number of trials have assessed primary care-led and shared care for cancer follow-up, finding them to be broadly equivalent to hospital specialist care. The strongest evidence for this is among patients with earlier stage breast and bowel cancers³⁷. A recently completed PC4 trial (The ProCare Trial)³⁸ also showed no differences in a range of outcomes for a model of shared care for prostate cancer compared with routine hospital follow-up. This also has advantages in terms of reduced travel costs for regional and rural patients. Support for greater primary care involvement by both patients and providers is increased after direct involvement in trials in which primary care is adequately supported to take on this new role. Shared care requires clear guidance for patients and primary care professionals about treatment and follow-up plans, as well as management of treatment adverse effects and mechanisms for rapid referral and consultation to specialist advice if required. Early contact with the patient's primary care provider at the time of discharge is also important to implement these models of care.

Further research is needed to examine the role of electronic patient held records to improve communication as part of shared care models.

2. Opportunities for the Medicare payment system to reward and encourage best practice and quality improvement in chronic disease prevention and management

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. Exposure to UV radiation causes the highest economic costs of cancer in Australia³⁹ of all modifiable risk factors. 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 year⁴⁰.

These cancer-risk behaviours can be influenced and in some cases managed through primary care. 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 chronic disease prevention into their practice.

The 5As is a key framework for interventions for prevention in primary healthcare⁴¹. The 5As provides a framework for organising interventions across modifiable risk factors (Figure 2).

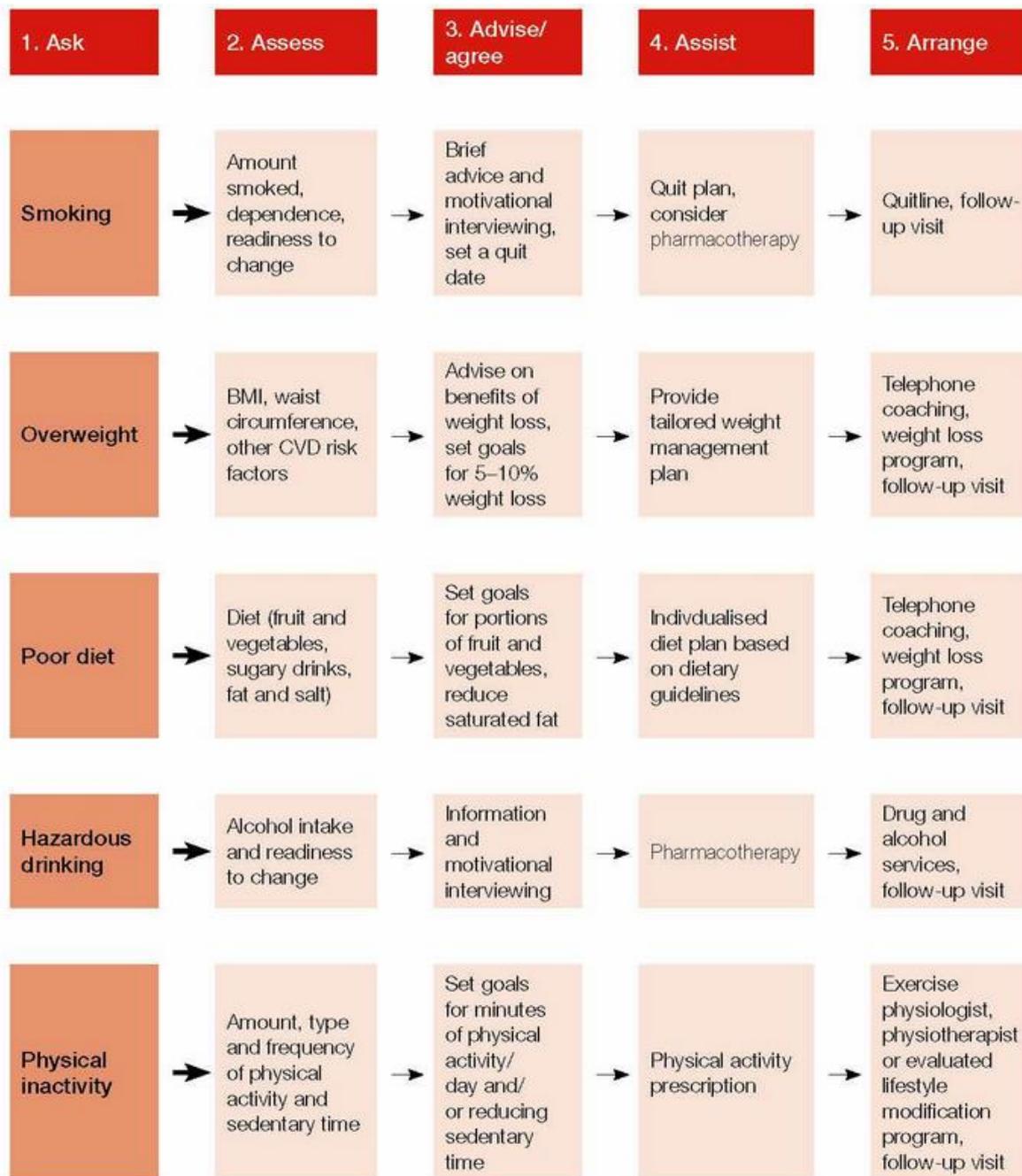


Figure 2: The 5As for behavioural risk factors in Australian general practice⁴².

Recommendation 1:

- Add a new prevention benefit item to the Medicare Benefits Scheme to support delivery in primary care practices of brief interventions and follow-up (to support implementation of the “5As” as per the recommendations of the Royal Australian College of General Practitioners Guidelines for Preventive Care).
 - 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.

Recommendation 2:

- *The current Practice Incentive Payment scheme should be expanded from a focus just on cervical cancer screening to include all three cancer screening programmes, with clearer reporting and increased remuneration for tasks such as contributing to the National Bowel Cancer Screening Program register etc.*

The introduction of a GP to the oncology care team during active treatment phase could assist in smooth patient transition to follow-up care. General practice involvement in the multidisciplinary team management of a cancer case can attract Medicare billing incentives. Medicare item numbers should be reviewed to ensure the billing structure comprehensively covers and promotes GP involvement in coordinated care planning for a patient's transfer from acute to primary care. Integrated primary care in cancer management has shown to result in improved continuity of care, greater team work, proactive rather than reactive care, and improved patient support.

In addition, current research suggests that the practice nurse role in a primary care setting could improve the coordination of patient care and the ability to perform billable services where Medicare eligible services are claimable⁴³. Alongside the GP, they have the ability to manage people with chronic diseases who require time and attention in their management.

Recommendation 3:

- *Review the current Medicare item numbers relating to GP involvement in clinical cancer care (cancer as a chronic disease) to ensure Medicare incentives are extensive and targeted to support increased involvement of the general practitioner for pre- and post- treatment care.*

Recommendation 4:

- *Existing Medicare Chronic Disease Management items should be applied systematically to support cancer survivorship care in the community.*

3. Opportunities for the Primary Health Networks to coordinate and support chronic disease prevention and management in primary health care

The following key objectives of Primary Health Networks aim to coordinate and support chronic disease prevention and management in primary care:

- increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes; and
- improving coordination of care to ensure patients receive the right care in the right place at the right time.

Primary Health Networks must work directly with primary health care providers, other clinical and supportive care providers and State and Territory Government hospitals to deliver the key objectives to ensure improved outcome for patients.

Recommendation 5:

- *The Primary Health Networks should take a lead role in supporting general practices to implement evidence-based systems to raise cancer screening participation. This*

could include, for example, establishing recall and reminder systems and sending GP endorsement letters in advance of cancer screening invitations.

Recommendation 6:

- *The Primary Health Network should take a lead role and work with State and Territory Governments and Local Hospital Networks to define clear referral pathways in the public hospital system for patients with a high suspicion of cancer. This should prioritise suspected cancers where there are long waiting times for diagnostic services (e.g. bowel and gastro-oesophageal cancers) or where there are large variations in diagnostic pathways and access to multidisciplinary teams (e.g. lung cancer).*
 - Referral pathways and fast track referral routes should be informed by the new NICE guidelines on Suspected Cancer. GPs need to perceive these routes as offering a significant advantage and need to receive multiple, repeated information about these diagnostic routes. This requires close liaison with the Primary Health Networks to develop a program of information and education about these cancer diagnostic routes. This could potentially include dissemination through electronic resources such as Health Pathways and Map of Medicine.

4. The role of private health insurers in chronic disease prevention and management

Medicare provides all Australians with free public hospital care and funds a range of primary care and other health services. The scheme provides universal health care to Australian residents and qualified visitors. Private health insurance is an option for Australians seeking greater incentives on some health and medical services. Although private health insurance plays a role in the Australian health system, for those who cannot afford or choose not to pay additional for private health insurance, Australia's universal health care system should adequately cover the health and medical care needs for all.

5. The role of State and Territory Governments in chronic disease prevention and management

The national development of optimal care pathways promotes consistency in the delivery of cancer care across Australia. Adoption of such guidelines is required at a State and Territory Government level through the local health care system. Principles underpinning optimal care pathways for cancer care delivery include ensuring smooth transitions in treatment, follow-up and allied health services, the coordination of care between services, and the continuity of quality care throughout a patient's cancer journey.

Primary care has a critical role in delivering optimal care to their patient. This includes during active treatment, follow-up care and in the management of complex co-morbidities that are not addressed by a cancer specialist. Uptake of such initiatives and resources by general practice should be encouraged through Medicare item number descriptors relating to the development of patient care arrangements through primary care services. Additionally, endorsement of such guidelines from the Royal Australian College of General Practitioners as best practice would add a level of compliance of their use.

Recommendation 7:

- *Incentivise use of evidence based clinical practice guidelines where general practice involvement is included and endorsed by Royal Australian College of General Practitioners.*

Recommendation 8:

- *Promote the coordinated uptake of optimal care pathways by State and Territory health systems where general practice involvement is included and endorsed by Royal Australian College General Practitioners.*

Recommendation 9:

- *Scoping opportunities for collation of hospital data to enable large scale audits of current and future referral pathways of patients with suspected cancer to allow calculation of conversion and detection rates and measure the impact of new diagnostic initiatives. This requires investment in appropriate information systems by State and Territory Governments as this data belongs to them.*

Recommendation 10:

- *State and Territory Governments support the establishment of new models of follow-up involving primary care initially for breast, bowel cancer and prostate cancer. This should become the standard model of follow-up care for cancer survivors at low risk of recurrence or adverse treatment effects.*
 - *Cancer follow-up care should provide clear guidance for patients, primary care and cancer care professionals about treatment and follow-up plans as well as management of treatment adverse effects and mechanisms for rapid referral and consultation to specialist advice if required. Early contact with the patient's primary care provider at the time of discharge is important.*

Recommendation 11:

- *The federally funded My eHealth Record should be developed and implemented to support communication and care between healthcare providers in cancer follow-up.*

6. Innovative models which incentivise access, quality and efficiency in chronic disease prevention and management

Recommendations (as summarised above).

7. Best practice of Multidisciplinary teams chronic disease management in primary health care and Hospitals

As stated above, best practice cancer care is delivered by a multidisciplinary team to ensure the needs, including treatment, psychosocial and supportive care, of the person affected by cancer and their carer are addressed in a timely manner. This team approach to care includes the GP.

The following Medicare items numbers aim to encourage GP involvement in the development of cancer treatment and follow up plans through attendance at an arranged multidisciplinary team meeting:

- Case Conferencing aim is to improve the care of patients with complex and ongoing medical conditions by promoting coordinated care plans between at least three health care providers attending to the patient.
- Team Care Arrangements support the GP to deliver coordinated cancer care alongside other services to patients with ongoing chronic medical conditions. Related Medicare item numbers provide the GP with access to rebates when coordinating patient care with eligible allied health services

However, eligibility criteria can limit access to rebates. In some cases, Medicare item numbers do not comprehensively cover the range of circumstances, services required or duration of the service required, to support optimal care of the person affected by cancer.

As noted earlier, the introduction of the GP to the oncology care team during active treatment phase could assist in smooth patient transition to follow-up care. This is a shift from traditional GP involvement in cancer care which generally occurs after treatment to address the patient's ongoing care needs.

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