

## **Cancer Australia Submission**

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

**Think ahead to the next 10 years. What do you want the Australian Cancer Plan to achieve?**

**Think big – what transformational change(s) should we be aiming to influence?**

The Clinical Oncology Society of Australia (COSA) Exercise and Cancer Executive Committee, advocate for all Australian people with cancer and survivors to have the opportunity to receive assessment and intervention by a qualified exercise professional with experience in cancer care (Accredited Exercise Physiologist or Physiotherapist), as reflected in the “Clinical Oncology Society of Australia Position Statement on Exercise in Cancer Care”

(<https://pubmed.ncbi.nlm.nih.gov/29719196/>).

A summary of the transformative changes we are advocating for include:

- 1) All patients receiving cancer care at public hospitals to have access to an oncology-specialised qualified exercise professional.**
- 2) Expanded Medicare Benefits Schedule to fund more supervised sessions with a qualified exercise professional (increase from 5 sessions to 10 per year).**
- 3) Implementation of referral pathways between cancer centres and qualified exercise professionals in community settings.**
- 4) Establish partnerships between all cancer centres and universities to engage in exercise-oncology research.**

A detailed overview of the proposed changes included:

- All patients receiving cancer treatment at public hospitals to have access to an oncology-specialised qualified exercise professional during their treatment. The exercise professional will be an active member of the multi-disciplinary care team (MDT). This is to facilitate timely communication with all members of the MDT (including medical and allied health members) about patient needs and concerns to ensure the delivery of evidence-based best-care. The role of a qualified exercise professional within the hospital system would be responsible for:
  - i) Prescription of exercise therapy during an inpatient period and/or in preparation for treatment (i.e. pre-habilitation)
  - ii) Patient education regarding the role of exercise therapy during and following treatment
  - iii) Implementation of behaviour change strategies to facilitate exercise therapy beyond the in-patient period

- iv) Referral to cancer programs and/or community-based qualified exercise professionals (when appropriate and required) to ensure continuation of exercise therapy beyond the in-patient setting. This is similar to patients undergoing pre-habilitation (before surgery/treatment for a range of other chronic diseases e.g., cardiovascular and orthopaedic settings) or rehabilitation (after surgery/treatment) for cardiac and respiratory conditions.
- A funding model that allows for accessible, equitable, patient-centred, personalised care. This is in direct alignment with the vision of the Australian Cancer Plan, as well as Cancer Council Australia aims. This requires:
  - The ability to deliver exercise therapy (with reimbursement) using telehealth. Robust cancer-specific evidence shows telehealth leads to similar benefits as that achieved with face-to-face exercise therapy delivery. (Reference 1)
  - Increase in exercise therapy rebates. Cancer-specific evidence drawn from exercise services delivered within the Australian context demonstrates the cost-effectiveness of exercise as part of cancer care (References 2 & 3). However, the current rebate is insufficient and requires patients to be out of pocket. This in turn further contributes to inequities in cancer care and widening health disparities. We believe this is the very issue the Australian Cancer Plan is trying to correct.
  - Increase in the number of reimbursable sessions per year and that this number should be tailored to the patient. For example, those with more advanced disease, higher number and persistent treatment-related morbidities and low exercise self-efficacy will need more sessions compared with someone who has early-stage disease and high exercise self-efficacy. The current evidence base supports the provision of up to 20 sessions within the first-year post-diagnosis (References 1 and 4).
- All cancer centres to have established referral pathways to community-based, qualified exercise professionals. This may include referral to dedicated cancer rehabilitation programs or individual, qualified exercise professionals. Community-based delivery of exercise therapy is required to facilitate sustainable, long-term integration of exercise therapy into cancer care while also provides an avenue for referral back to the treating medical and allied health care when needed (e.g., the presence of worsening treatment-related sequelae).
- Formalise collaborations between treating cancer centres and Australian universities, which can facilitate the conduct of research required to develop the evidence-base and improve the lives of the 150,000 Australians diagnosed with cancer each year, and >1 million Australians currently living with or beyond cancer.

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

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

Our submission regarding the importance of integrating exercise oncology into routine cancer care aligns with the principles of the Australian Cancer Plan:

- **Patient/consumer centric care.** The current Medicare Benefit Schedule funding model is a one-size fits all model that is inadequate for the majority of people with cancer (5 sessions across all allied health). Improvements including number (proposed increase to 10 sessions/year), scheduling and mode of delivery of exercise therapy sessions needs to be tailored to the patient's needs and wants. Additionally, most Australian cancer centres lack qualified exercise professionals, and thus patient-centric care would be improved in Australia if all major cancer centres supported the addition of an oncology-specialised accredited exercise physiologist in addition to dedicated cancer physiotherapists (ESSA position statement – Reference 5) as a member of the MDT.
- **Reduce outcome disparities.** The current funding model is exacerbating known health disparities – specifically, only those of higher socioeconomic status, living in urban environments can afford and access exercise therapy targeted to improving health outcomes. Rebates for exercise therapy need to be increased to remove the out-of-pocket expense incurred by patients. An increase in exercise therapy rebates, alongside implementation of standard referrals to community-based cancer programs or qualified exercise professionals, would ensure exercise therapy post-treatment is accessible to the majority, rather than the minority.
- **Close the gap.** This will require improvements in funding, alongside increases in workforce capacity and training for all members of the cancer care team. Additionally, formalising collaboration between major cancer centres and universities will facilitate large-scale, multi-site, timely research which will ensure the future delivery of best-practice cancer care for all.
- **Pursuing equity of health outcomes.** This requires understanding who experiences higher cancer survivorship burden and why and ensuring that improvements in cancer care target those in most need and cater for them accordingly. To achieve this, MBS funding for allied health should be expanded to meet the needs of people with cancer. Currently, patients are eligible under a Chronic Disease Management plan for 5 sessions per year (split across ALL allied health professionals). Given the multi-faceted needs of the cancer population, this state of play is grossly inadequate. The number of allowable, rebatable sessions with any one allied health professional is insufficient (let alone sessions shared with multiple allied health professionals). Even with a rebate, patients incur out-of-pocket costs. An increase in the number of sessions, as well as the rebatable amount will reduce the widening health disparities observed following cancer. Clinical and consumer groups have successfully advocated for improvements in other settings (e.g., diabetes – patients are eligible for an additional 8 exercise physiology group classes, Item 81115). The evidence to support similar improvements in the cancer setting is irrefutable.
- **Tumour agnostic.** As clearly articulated and justified in the ESSA and COSA position statements on exercise in cancer (References 5 & 6), exercise therapy can benefit ALL people with cancer, irrespective of cancer type or stage of disease at diagnosis. Exercise therapy remains indicated, even among patients with multiple and complex co-morbidities. However,

to ensure benefit through exercise therapy, prescription needs to be tailored to each patient's needs and circumstances.

- **Encompass whole continuum.** There is robust and consistent evidence that exercise has benefits across the entire cancer continuum (i.e. for those at high-risk of diagnosis/recurrent/progression of disease, pre-treatment, during treatment, post-treatment, and in some cases during palliative care). Exercise has been shown to prevent the occurrence of numerous cancers (colon, breast, endometrial, oesophageal, liver, stomach, kidney, and myeloid leukemia, multiple myeloma, head and neck, rectum, bladder, and lung), and has been linked with improved survival outcomes following cancer (References 1, 7, 8, 9, 10 & 11). There is consistent evidence to support that exercise can improve cardiometabolic, psychological, and musculoskeletal health across all cancer types and all phases of the cancer continuum. Therefore, exercise therapy should be supported for those at risk of cancer, during treatment and following treatment. The benefits of exercise across all phases of the cancer continuum supports the principle of patients being offered support by an exercise professional within the hospital setting, and then a suitably funded Medicare system with better reimbursement for exercise professionals working with people with cancer in the community setting (at least an increase from 5 to 10 sessions/year).
- **Future focused.** Australia has real potential to lead the world in the formal integration of exercise therapy into cancer care and in doing so, will improve Australian lives while saving money.

**3. What examples and learnings can we build on as we develop the Australian Cancer Plan? Think about great examples of work within or outside the cancer sector in Australia and internationally. How can we learn from these examples and build on them to improve cancer outcomes and experience for all Australians?**

The importance of exercise therapy has been recognised in other chronic disease management settings within Australia, and has been incorporated as part of standard care internationally:

- The cardiac rehabilitation model offered for patients (hospital/community-based supervised gym) has revolutionized how cardiac patients are managed, with drastic improvements in short- and long-term care, recovery, return to work prospects, quantity, and quality of life.
- Patients with diabetes receive an additional 8 Exercise Physiology MBS-rebated sessions in contrast to other patients with chronic disease including cancer (who only receive 5 sessions per year, split across all allied health). In a recent Deloitte report, patients with type 2 diabetes experienced one of the highest cost-to-benefit ratios from AEP interventions of all chronic diseases (8.8:1), accounting for an annual saving of \$5,107 per person in health system expenditure (Reference 12). It is plausible that enhanced access to AEP interventions for people with cancer would experience similar economic benefits.
- In specific locations across the world, standard care for oncology treatment includes participation in a community-based exercise program (Denmark; no patient out-of-pocket expenses) and/or enrolment in an exercise trial (e.g., Memorial Sloan Kettering Hospital in New York, USA) (<https://www.mskcc.org/research-areas/labs/lee-jones/overview>). These advances to cancer care have been made as a direct consequence of the strength of the evidence supporting exercise therapy as cost-effective.

There now exists the evidence and need for cancer care in Australia to leverage learnings from these examples to advance cancer care for all. Specifically, cancer-specific evidence supports integration of exercise therapy into all stages of cancer care (pre-, during and post-treatment), and supports that reimbursement of at least 20 sessions of exercise therapy within the first-year post-diagnosis is cost-effective and will lead to cost-savings (References 1 and 4). Further, cancer specific evidence supports multiple modes of delivery lead to survival benefits including individualised and group-based support and face-to-face and telehealth delivery).

**REFERENCES (all references listed below are mentioned in relevant sections throughout our response)**

1. Hayes, S.C., et al., Exercise for health: a randomized, controlled trial evaluating the impact of a pragmatic, translational exercise intervention on the quality of life, function and treatment-related side effects following breast cancer. *Breast Cancer Res Treat*, 2013. **137**(1): p. 175-86.
2. Gordon, L.G., et al., Cost-effectiveness of a pragmatic exercise intervention for women with breast cancer: results from a randomized controlled trial. *Psycho-oncology*, 2017. **26**(5): p. 649-655.
3. Gordon, L.G., et al., Cost-Effectiveness Analysis from a Randomized Controlled Trial of Tailored Exercise Prescription for Women with Breast Cancer with 8-Year Follow-Up. *Int J Environ Res Public Health*, 2020. **17**(22)
4. Buffart, L.M. et al., Effects and moderators of exercise on quality of life and physical function in patients with cancer: An individual patient data meta-analysis of 34 RCTs. *Cancer Treatment Reviews*, 2017. **52**:91-104
5. Hayes, S.C., et al., The Exercise and Sports Science Australia position statement: Exercise medicine in cancer management. *J Sci Med Sport*, 2019. **22**(11): p. 1175-1199.
6. Cormie P, Atkinson M, Bucci L, Cust A, Eakin E, Hayes S, McCarthy S, Murnane A, Patchell S, Adams D. Clinical Oncology Society of Australia position statement on exercise in cancer care. *Med J Aust*. 2018 Aug 20;209(4):184-187.
7. Friedenreich, C.M., et al., Physical Activity and Mortality in Cancer Survivors: A Systematic Review and Meta-Analysis. *JNCI Cancer Spectr*, 2020. **4**(1)
8. Hayes, S.C., et al., Exercise following breast cancer: exploratory survival analyses of two randomised, controlled trials. *Breast Cancer Res Treat*, 2018. **167**(2): p. 505-514.
9. Campbell, K.L., et al., Exercise Guidelines for Cancer Survivors: Consensus Statement from International Multidisciplinary Roundtable. *Med Sci Sports Exerc*, 2019. **51**(11): p. 2375-2390.
10. Patel, A.V., et al., American College of Sports Medicine Roundtable Report on Physical Activity, Sedentary Behavior, and Cancer Prevention and Control. *Med Sci Sports Exerc*, 2019. **51**(11): p. 2391-2402.
11. Schmitz, K.H., et al., Exercise is medicine in oncology: Engaging clinicians to help patients move through cancer. *CA Cancer J Clin*, 2019. **69**(6): p. 468-484.
12. Deloitte Access, Value of Accredited Exercise Physiologists in Australia. 2015.

**Acknowledgement:** This submission is on behalf of the COSA Exercise and Cancer Group, including members of the Executive Committee (Dr David Mizrahi, Chair; A/Prof Tina Skinner, Deputy chair; Prof Sandi McCarthy, Dr Diana Adams, Dr Sara Wahlroos, Mr Morgan Atkinson, Ms Sharni Quinn, and Ms Lucy Bucci) and advisors to the committee for this submission (Prof Sandi Hayes, Dr Rosa Spence, and Dr Carolina Sandler)