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Royal Australian College *of* General Practitioners

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9 March 2022

Australian Cancer Plan
Cancer Australia
Locked Bag 3
Strawberry Hills NSW 2012
Via email: australiancancerplan@canceraustralia.gov.au

To Whom It May Concern,

Re: The Australian Cancer Plan 2023-33

The Royal Australian College of General Practitioners (RACGP) welcomes the opportunity to provide comment on the upcoming development of The Australian Cancer Plan 2023-33 (the Plan).

General practitioners (GPs) and their teams play a vital role in all aspects of cancer care. The holistic, patient-centred, and relationship-based approach of general practice can help ensure the effective delivery of preventive care and treatment. GPs and their teams identify those at higher risk and provide advice on modifiable lifestyle risk factors (such as smoking and obesity) and screening. GPs also provide care coordination for patients with cancer and cancer survivors, including the ongoing management of any other health conditions (such as chronic disease or mental health). Enabling GPs to work to full scope of practice will increase capacity and access to oncology for patients who need it the most, particularly for patients in rural and regional areas where there is limited access to specialist services.

The RACGP recommends the key role of GPs in cancer care be clearly articulated and supported throughout the Plan.

We provide comments below addressing the survey questions.

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

1.1 Improvements to cancer screening and prevention

It is important that cancer screening is evidence-based, aligned with sound screening principles, and applied with well thought out implementation and evaluation plans. This will help reduce inappropriate screening and treatment.

In primary care, further investment is required for well-integrated screening reminders into electronic medical records. This will allow GPs to be automatically alerted when their patient is due for a screening test, such as a mammogram, cervical or bowel screening. Furthermore, this would provide a great opportunity to expand effective integration throughout primary care electronic records more broadly. For example, results from screening programs for all cancers should be easily accessible for all GPs. Currently, bowel screening results from the national program are difficult to find and track to determine when another screen is required. Due to this inconsistency, GPs may order Faecal Occult Blood Tests (FOBTs) through private pathology.

The MBS Health Assessment Items should be expanded in order to align with the recommendations in the RACGP's *Guidelines for preventive activities in general practice* (the Red book). The Red book is an internationally recognised and utilised guideline and has provided guidance on evidence-based preventive

activities in primary care for 25 years. Well-funded and bundled preventive health assessments, which address the individual needs of patients, are currently limited to people aged 45 to 49 and the over 75-year-old population. The eligibility of these preventive health assessments should be extended to the broader general population.

1.2 Improvements for testing results

Consistency in the reporting of test results is important (for example, the bowel screening program currently does not accept private Faecal Occult Blood Test (FOBT) results). There is also inconsistency across primary care electronic records as to how test results are recorded. Results should be machine-readable so that GPs, primary care researchers and health system evaluators can take a population-health approach to screening programs by using data-extraction tools.

1.3 A focus on whole-of-person care

It is important that, following a cancer diagnosis, other health issues, such as mental health, dental health, and any other chronic diseases or comorbidities are also cared for.

Patients with all cancer types should have the equivalent of a breast cancer nurse. These nurses provide vital support and help to connect cancer patients to medical and non-medical services and peer support groups. However, to allow them to provide holistic care beyond the specific cancer, these roles should be generalist (rather than focusing on a specific cancer) and embedded within primary care.

Multidisciplinary teams should involve the patient's GP in meetings wherever appropriate. MBS item numbers are available for GPs to attend these meetings.

Shared care plans are important and should be more widely adopted. These provide information to assist the patient, their GP, and the multidisciplinary team to manage follow-up and survivorship care together. Establishing and communicating clear roles and responsibilities in care is essential.

It is important to align survivorship with chronic disease management frameworks and existing GP working models and processes. Cancer care plans used in oncology units to assist with coordinating care are valuable and general practice can also provide Chronic Disease Care Plans and Mental Health Care Plans to support people with cancer.

1.4 *Funding for general practitioners to undertake essential population health and care coordination tasks*

GPs play a significant role as part of their patient's multidisciplinary team and should be adequately funded for their work in cancer screening and in shared care coordination.

While fee-for-service structures work for an individual patient's face-to-face care, important population health tasks (looking after the needs of the broader practice-population, including identifying any gaps in cancer screening) and patient care coordination roles, are not funded under this system. For example, when GPs receive test results from private pathology providers, time is required to review reports to compare and update screening records, time which is not remunerated. Additional funding, for example, through the proposed Voluntary Patient Enrolment scheme, could help general practices finance the necessary workforce to utilise population and care coordination tasks to their full potential. For more information of the RACGP's vison for voluntary enrollment, see the RACGP's Vision for general practice.

As mentioned in 1.1 above, an expansion of health assessment MBS items so they better align with the RACGP Red book recommendations, is also recommended.

1.5 Funding for cancer programs for specific populations, including Aboriginal and Torres Strait Islander people

Targeted support for specific populations, including Aboriginal and Torres Strait Islander people, culturally and linguistically diverse (CALD) communities, LGBTIQ+ people, and other groups is essential.

In particular, continued and increased funding for the Integrated Team Care program in order to deliver culturally appropriate preventive health care and provide support for patients with cancer and to attend required specialist appointments.

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

2.1 Enhancing and promoting the important role of the GP

As stated above, the Plan needs to clearly articulate and support the important role of GPs in all aspects of cancer care. This includes:

- Preventive activities – Much of preventive care is provided by GPs. The RACGP provides evidence-based recommendations around cancer prevention through their flagship clinical guidelines, *Guidelines for preventive activities in general practice* (the Red book) and the RACGP & NACCHO *National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people* (the National guide). By providing lifestyle advice and support, GPs help patients lower their risk of cancer and other chronic health conditions, tailored to a patient's medical and family history. These activities may include smoking cessation, reducing alcohol consumption, and reducing obesity.

- Cancer screening, testing and diagnosis – a patients first port of call is usually their GP when they have any health concerns, experiencing symptoms that may be suggestive of cancer, or is due for routine screen.

- Active treatment and management of cancer – GPs can and should be a key member of shared care teams, GPs provide a coordinated approach to whole-person care and continue to provide care for other preventive and chronic health issues alongside the cancer treatment.

- Survivorship – following treatment, GPs continue to provide support for cancer survivors through the coordination of cancer, chronic disease management and secondary prevention.

- End of life care – GPs support their patients through end-of-life care. Patients in rural areas of Australia are particularly reliant on their GP for end-of-life care.

2.2 Improving accessibility to diagnosis and treatment

2.2.1 Quick and efficient referral processes – Timely access is essential when referring to an appropriate specialist. Slow and inefficient referral processes mean that crucial time is lost for a patient to begin their treatment. The Optimal Care Pathways provide clear referral pathways for common cancers, to ensure that all Australians receive consistent and high-quality care. These Pathways should be widely promoted and supported. The Pathways are particularly effective for people in lower socioeconomic groups and/or those at higher risk. The ability to provide electronic referrals into cancer care services should underpin quick and efficient referral processes.

2.2.2 Address inequalities – The Plan should highlight the importance of addressing inequity, as geographic and financial inaccessibility can result in delayed care. This particularly impacts rural, regional and lower socioeconomic patients when they require pathology, radiology and/or surgical procedures.

Inequality and disadvantage also have negative impacts on health risk factors, chronic conditions, disease burden and mortality rates[1], all of which impact cancer prevention and treatment for those people.

The use of telehealth models would help enhance services in regional and rural areas. Further investment in primary care in regional, rural, and lower socioeconomic areas will ensure easy and cost-effective access to primary care.

Cancer patients should also have affordable access to an increased amount of allied health services as organised through the GP Management Plan (GPMP). These patients require extra allied health services as they often have other comorbidities that may impact on their health outcomes.

2.2.3 Involvement of family and friends - Addressing patient social networks and family support is a key role undertaken by the GP. Providing both the patient and relatives with supportive information and referral is particularly important in cancers associated with genetic risks, and this should be recognised in the Plan.

3. What examples and learnings can we build on as we develop the Australian Cancer Plan

3.1 RACGP's Guidelines for preventive activities in general practice (the Red book)

The RACGP is currently updating the *Guidelines for preventive activities in general practice* 9th edition (the Red book). This guideline provides evidence-based recommendations on cancer prevention and cancer screening activities for Australians across all ages of the lifecycle. Recommendations for cancer prevention and cancer screening should align with content in the Red book.

3.2 Scoping and research into an urgent referral system

The United Kingdom has a two-week urgent referral system for suspected cancer, along with overall diagnostics, management plan and treatment (if required) within 16 weeks. Further scoping and research should be undertaken to ascertain as to whether this would be successful in an Australian context, and if so, ensuring that adequate resources and investment are provided.

4. Do you have any other comments and / or insights from your own experience that you think would be helpful to inform the Australian Cancer Plan?

4.1 Investment in cancer prevention

The prevention of common cancers requires cross-government and health service involvement and investment in coordinated public health campaigns, in alignment with the prevention advice in the RACGP's Red book. This may include media campaigns, but also requires policy development and economic modelling. For example, this could include:

- Providing incentives for agriculture and retail to promote fruit and vegetables;
- Promoting the reduction of alcohol consumption;
- A taxation on tobacco and sugar, of which is the RACGP is broadly supportive of.

Thank you again for the opportunity to provide a submission to the Australian Cancer Plan 2023 – 2033. If you have any questions regarding our submission, please contact Mr Stephan Groombridge, National Manager, e-Health and Quality Care at stephan.groombridge@racgp.org.au or 03 8699 0544.

Yours sincerely

Dr Karen Price
President

References

1. Australian Institute of Health and Welfare. Health across socioeconomic groups. Australia's Health 2020. Canberra: AIHW, 2020. Available at: https://www.aihw.gov.au/reports/australias-health/health-across-socioeconomic-groups [Accessed on 3 March 2022].