Australian National University

Australian Primary Health Care Research Institute
ANU College of Medicine, Biology & Environment

Prevention and management of cancer in primary care

Presentation + interactive discussion with DoHA 11am Wednesday November 7th 2012

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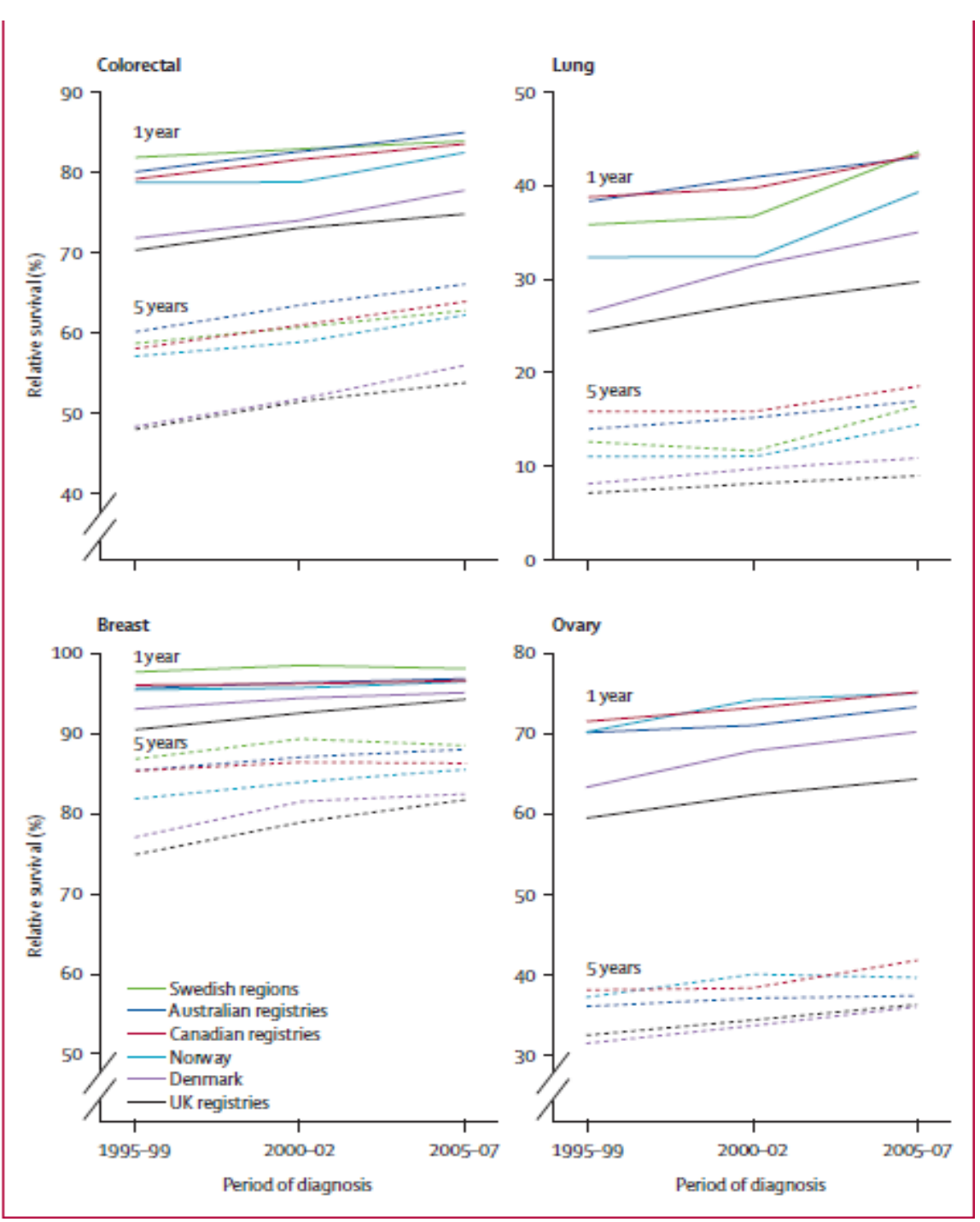
Overview

- Cancer control: why consider primary care?
- Primary prevention
- Screening
- Early diagnosis
- Management and survivorship
- Cancer policy
- Conclusions

Primary care – some key features

- directly accessible, first contact care for unselected health problems
- offers preventive, diagnostic, curative, rehabilitative and palliative services
- holistic approach
- key role in management of multi-morbidity
- emphasises co-ordination and continuity of care



International Cancer Benchmarking partnership: Survival data

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Primary prevention and GPs

- Australians visit a GP five times per year
- Patients expect to receive information and assistance regarding preventive health issues from their primary care providers
- Yet few primary care encounters in Australia involve risk-factor assessment and intervention.
- In 2005–06:
  - 34.6% of general practice encounters were with overweight patients (22.2% being obese)
  - 25.9% with those who drank alcohol at risky levels
  - 17.1% with daily smokers
  - less than one in five patients are routinely asked about their drinking
  - two-thirds are asked about their smoking
  - only up to a third are asked about exercise and physical activity
  - about 15-30% of patients get some form of dietary advice

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Engagement of primary care in cancer screening

- Direct involvement
  - identification and recruitment
  - provision of testing
  - co-ordination of follow-up

- Complementary roles, with centralised programme
  - sharing of tasks
  - endorsement of screening invitations

Improving CRC screening uptake: potential roles for primary care

- Some evidence that primary care can improve uptake – largely from North America
- Endorsement of invitations
- ‘Local Champion’ role
- More extensive feedback on their patients’ participation
- Primary care-based facilitators
- Practice-based promotion of FOBT screening

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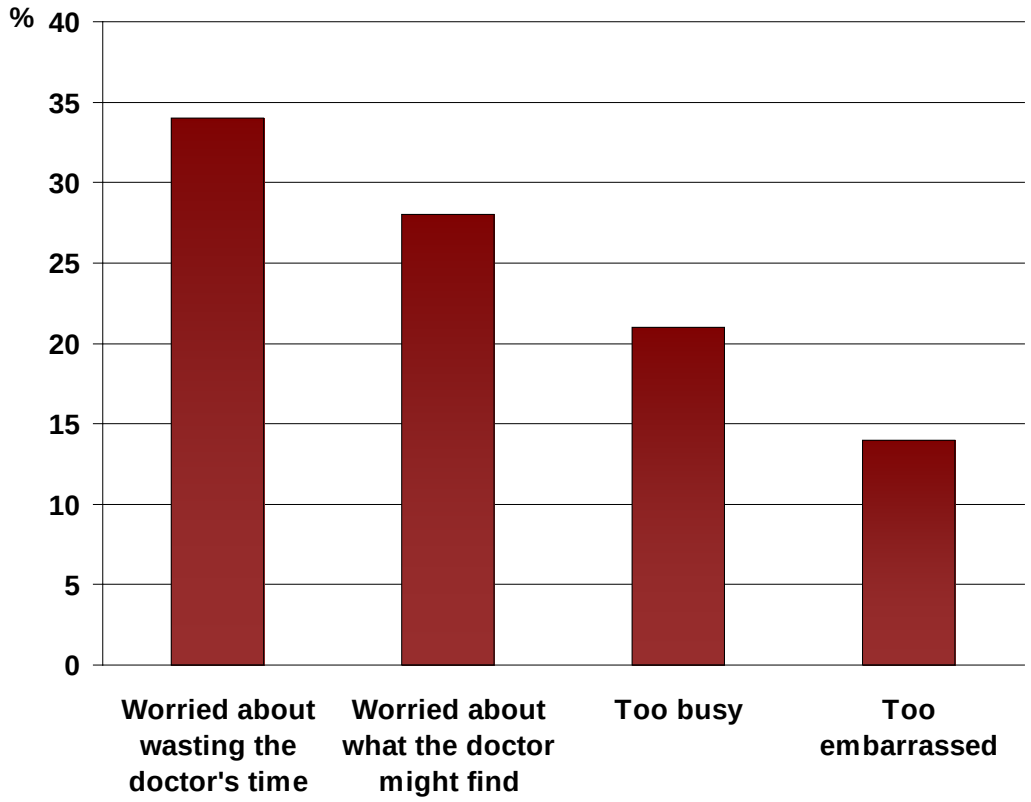
Primary care cancer epidemiology

	Individual GP	Group Practice
(population)	(1,600)	(10,000)
New cases p.a	7-8	50
Patients with cancer diagnosis	30-40	200
Deaths from cancer p.a	4	25
Home deaths from cancer	1	6

National Awareness and Early Diagnosis Initiative – key elements

- Achieving early diagnosis by public and patients
  - Raising awareness of cancer, symptoms, importance of early presentation
  - Reducing barriers to early presentation (fear, difficulty accessing GP)
  - Reducing barriers to screening
- Optimising clinical practice and systems
  - Raising awareness of cancer symptoms amongst GPs and other health workers
  - Promoting optimal referral by GPs
  - Optimal screening services
- Improving GP access to diagnostics eg ultrasound, MRI, colonoscopy
- Research, evaluation and monitoring

Barriers to symptomatic presentation



Unpublished findings from ICBP Module 2: Data for England only

Supporting primary care

- Practice visits supported by GP practice profile discussions
- Use of Risk Assessment Tools (7 networks; 165 practices; over 600 GPs)
- Significant Event Audit
- Improved access to diagnostics

GP Practice Profiles

Cancer indicators in (X46332) Dr Smith's Surgery, Another PCT (5XX)

These profiles provide comparative information for benchmarking and reviewing variations at a General Practice level. They are intended to help primary care think about clinical practice and service delivery in cancer and, in particular, early detection and diagnosis. They are not for the purpose of performance management and there are no 'right or wrong' answers.

Practice population (2008/09): 10,121

PCT population (all practices): 168,907

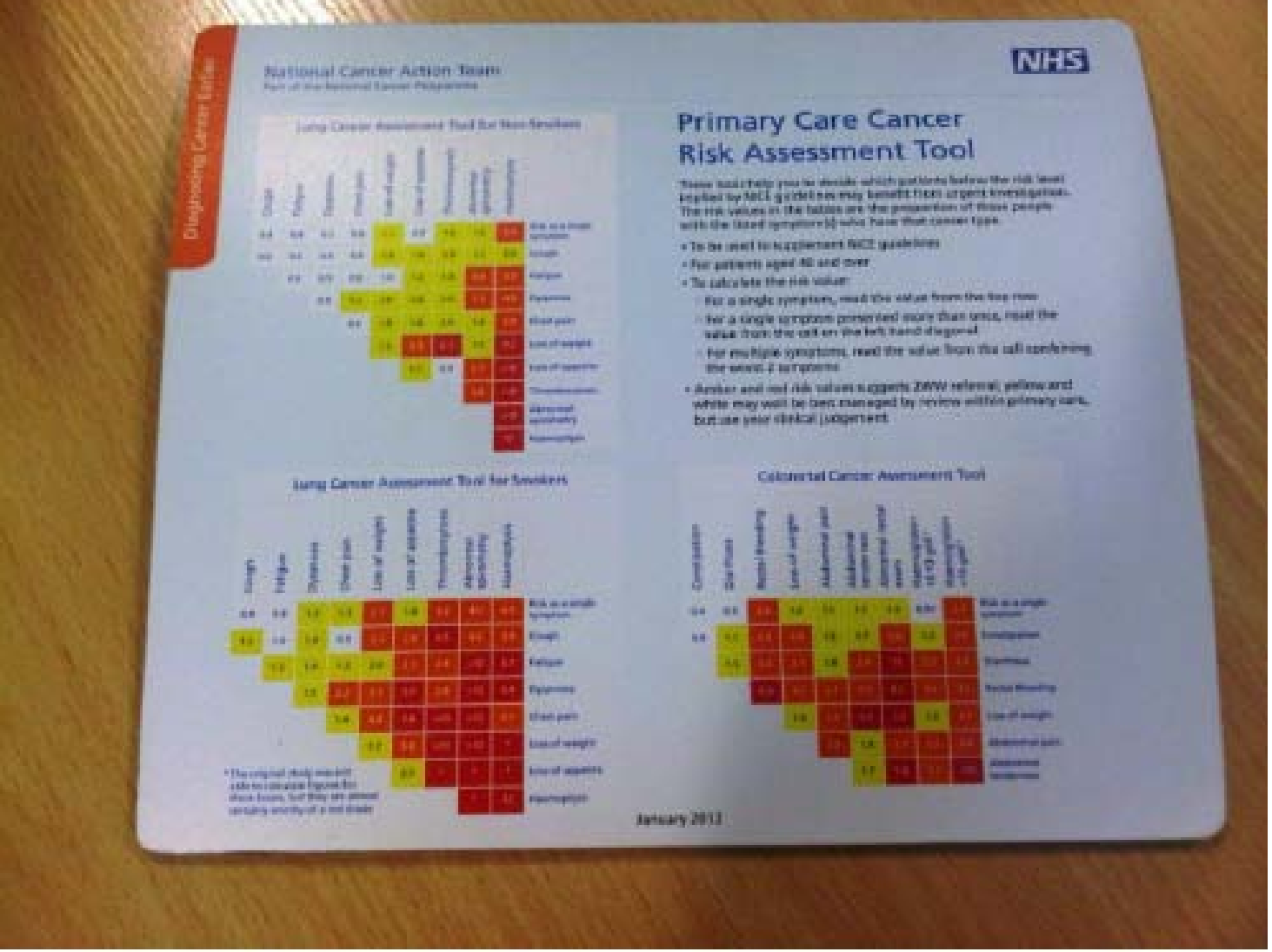
- Practice is significantly different from PCT mean
- Practice is not significantly different than PCT mean
- Statistical significance can not be assessed

England mean

Lowest in PCT | PCT 25th Percentile | PCT mean | PCT 75th Percentile | Highest in PCT

Domain		Indicator (Rate or Proportion in brackets)	Practice indicator value	Practice indicator rate or proportion	Lower 95% confidence limit	Upper 95% confidence limit	PCT mean	England mean	Practice rates or proportion in PCT: Lowest practice	Range	Highest practice
Demographics	1	Practice Population aged 65+ (% of population in this practice aged 65+)	1493	14.8%	14.1%	15.5%	17.0%	15.6%	10.1%		24.7%
	2	Socio-economic deprivation, "Quintile 1" = affluent (% of population income deprived)	Quintile 4	19.6%	18.8%	20.4%	19.7%	15.9%	10.2%		32.8%
	3	New cancer cases (Crude incidence rate: new cases per 100,000 population)	51	504	375	663	504	412	235		973
	4	Cancer deaths (Crude mortality rate: deaths per 100,000 population)	26	257	168	376	278	236	66		503
	5	Prevalent cancer cases (% of practice population on practice cancer register)	158	1.6%	1.3%	1.8%	1.1%	1.3%	0.3%		2.1%
Cancer screening	6	Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %)	837	70.1%	67.4%	72.6%	71.5%	71.8%	49.7%		79.6%
	7	Females, 50-70, screened for breast cancer within 6 months of invitation (Uptake, %)	13	28.9%	17.7%	43.4%	65.5%	74.3%	0.0%		77.4%
	8	Females, 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage, %)	1954	80.2%	78.6%	81.8%	79.3%	75.4%	65.0%		88.5%
	9	Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)	541	54.8%	51.7%	57.9%	51.6%	40.2%	35.3%		59.0%
	10	Persons, 60-69, screened for bowel cancer within 6 months of invitation (Uptake, %)	292	60.2%	55.8%	64.5%	56.8%	55.1%	40.4%		64.8%
Cancer Waiting Times	11	Two-week wait referrals (Number per 100,000 population)	162	1601	1364	1867	1417	1610	157		2599
	12	Two-week wait referrals (Number per 100,000 population, Age standardised)	162	100.9%	85.9%	117.7%	n/a	100.0%	10.5%		158.6%
	13	Two-week referrals with cancer (Conversion rate: % of all TWW referrals with cancer)	24	14.8%	10.2%	21.1%	14.5%	11.2%	5.7%		50.0%
	14	Number of new cancer cases treated (% of which are TWW referrals)	48	50.0%	36.4%	63.6%	44.5%	42.9%	12.5%		85.7%
	15	Two-week wait referrals with suspected breast cancer (Number per 100,000 population)	47	464	341	618	359	329	0		702
	16	Two-week wait referrals with suspected lower GI cancer (Number per 100,000 population)	38	375	266	515	270	251	0		771
	17	Two-week wait referrals with suspected lung cancer (Number per 100,000 population)	7	69	28	143	70	66	0		209
	18	Two-week wait referrals with suspected skin cancer (Number per 100,000 population)	10	99	47	182	146	280	0		566
Presentation & diagnostics	19	In-patient or day-case colonoscopy procedures (Number per 100,000 population)	103	1018	831	1234	877	513	302		1419
	20	In-patient or day-case sigmoidoscopy procedures (Number per 100,000 population)	40	395	282	538	324	380	55		682
	21	In-patient or day-case upper GI endoscopy procedures (Number per 100,000 population)	134	1324	1109	1568	1374	999	729		2385
	22	Number of emergency admissions with cancer (Number per 100,000 population)	48	474	350	629	583	691	239		1122
	23	Number of emergency presentations (% of presentations)	4	14.3%	5.7%	31.5%	33.7%	23.7%	12.5%		100.0%
	24	Number of managed referral presentations (% of presentations)	18	64.3%	45.8%	79.3%	46.8%	48.6%	0.0%		87.5%
	25	Number of other presentations (% of presentations)	6	21.4%	10.2%	39.5%	19.4%	27.7%	0.0%		50.0%

NCIN | NHS National Cancer Action Team | APH



Cancer Risk Assessment Tools

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Follow up - why?

- detect cancer recurrence
- treatment side effects, new cancers
- other co-morbid health conditions
- incorporate on-going therapy (eg endocrine treatments)
- quality of life issues
- psychosocial issues
- empowerment/self management

Involvement of primary care in cancer follow-up: potential benefits

- evidence that strong primary care can lead to better health outcomes in chronic disease management
- cancer patients have multiple health needs, and require holistic, co-ordinated care
- many primary care practitioners want to have a greater role
- many patients want their family doctor to be involved
- potentially:
  - promotes better-integrated care
  - more cost-effective

Involvement of primary care in cancer follow-up: caveats

- many cancer patients prefer to stay closely linked to hospitals/specialist services
- many problems experienced by cancer patients require specialised skills
- primary care practitioners often reluctant to take on these kinds of responsibilities
- may not have sufficient access to services needed
- quality of primary care varies widely

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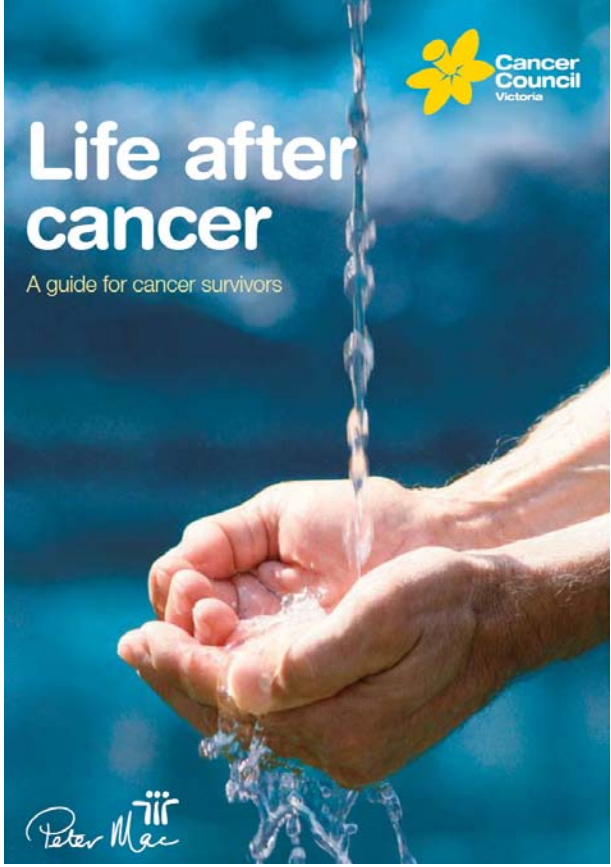
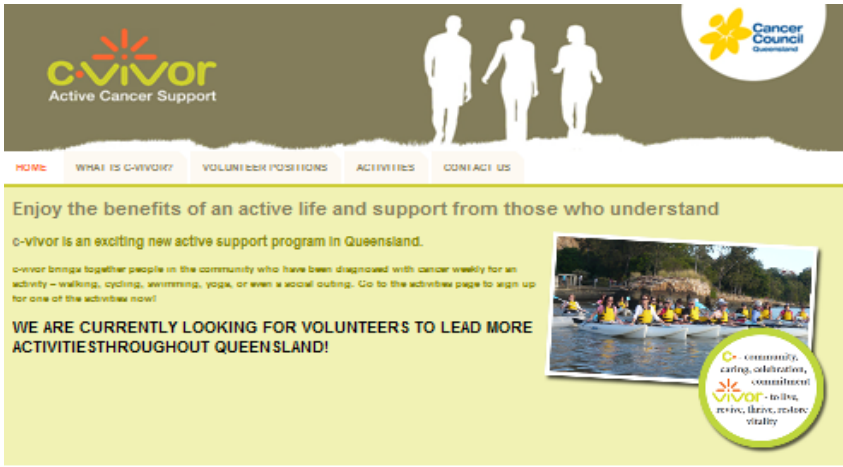
NSW Cancer Survivors Centre
renewing life

Cancer Survivorship in Australia





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Primary care: why a limited role in cancer?

- Recognised role in:
  - assessing symptoms and diagnosis
  - delivery of some screening programmes
  - palliative care
- Some noteworthy models of primary care involvement, but typically excluded in 'conventional' models of cancer care
- Reasons for limited role in many aspects of cancer journey:
  - perception that management of cancer is high technology and hospital-based
  - territorial issues, perceived lack of necessary skills amongst PCPs
  - lack of integration between primary and secondary care services
  - training, education and workforce issues

Why should primary care have a greater role in cancer prevention?

- Broad-based contribution:
  - education/awareness raising of cancer symptoms
  - promotion and delivery of screening
  - co-ordinating care for complex needs of individuals with cancer
  - primary prevention
  - management of co-morbidities
  - advocacy re poor housing, poor nutrition, inadequate water supplies
- Affordability in low-resource settings

Integrating primary care into cancer control

- National cancer plans need to recognise the potential of primary care in cancer control
- This recognition needs to translate into practical strategies in areas including:
  - primary prevention
  - screening
  - early diagnosis
- Strategies need to address:
  - financial, organisational and attitudinal constraints
  - significant gaps in research and evidence

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- Australian Primary Health Care Research Institute

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Thanks for your attention!

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