



School of Population Health

MBDP M 431

1st Floor Clifton Street Building

Clifton Street

Nedlands WA 6009

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**Written submission to the Senate Committee:
Inquiry into services and treatment options for persons with cancer**

The delivery of high quality equitable cancer care to produce optimal outcomes across the population of Western Australia has been the focus of my work during the last three years. Surgical patterns and survival after diagnoses of breast, lung, prostate and colorectal cancer were examined, with a particular focus on disadvantaged groups. The groups examined included people who are socio-economically disadvantaged, rural and remote, without private health insurance (or not admitted to private hospitals) and the Indigenous community. The comments I make here originate from that published work, copies of which are attached. They are my personal views and not those of the University of Western Australia where I work as a lecturer in health policy and economics.

Across the four cancers the research found substantial variability in the surgical rates and cancer survival. In general, most cancers showed decreased surgery and survival rates in the disadvantaged groups. As discussed in the publications, there are a number of plausible explanations for this. First, is the possibility that people in disadvantaged groups are diagnosed with later stage cancer beyond the time when surgery may be appropriate and thus reducing survival times. The Australian and international literature does not, however, wholly support this argument. Furthermore, even if this were to be the case, it suggests we must examine why this is happening and implement better community, patient and physician education to improve prevention and early detection rates in vulnerable groups.

Access issues and barriers exist at the diagnosis, referral and treatment stages and therefore standardisation of procedures at these stages across the population should make the care pathways fairer. Clinical practice guidelines have been forwarded as one way of ensuring health care fairness and as their use becomes a more regular occurrence in Australian health care they may help to alleviate disparities by encouraging general practitioners and specialist physicians to practice in accordance with them.

In response to the Senate Committee's Terms of Reference: a.i to a.iii; from my work, I consider that one of the most effective and efficient methods to deliver cancer care is through 'Cancer Centres of Excellence'. Most importantly, these centres would, by their use of best practice, reduce variability in cancer services thus ensuring that cancer care is provided equitably. Inherent within this concept is that world-class care would be provided with multi-disciplinary teams, case managers and psychosocial care. The literature supports all of these, whether the patient is considered potentially curative or palliative. One of the most important aspects would be that all patients are given the option of attending such a centre. One of the suspicions raised by the research, and as yet unproven, is that people in disadvantaged groups may not have the same patterns of diagnostic testing and referral as other patients and hence surgery may be delayed or not offered. Professor

James Bishop also forwarded the idea of Cancer Centres in a major review of cancer services in Western Australia in 2003.

One concern, supported by the literature, is that smaller centres may see insufficient patients in any one year with a specific cancer to be able to offer world-class effective and efficient cancer care. Some authors suggest that at least one patient per week with one specific type of cancer is the minimum requirement. This would suggest that smaller outer-metropolitan and rural centres service insufficient population numbers to be able to offer quality equitable care. Furthermore, as cancer care becomes increasingly technological, it is very expensive and it is not cost-effective to provide high technology at all centres.

The above argument outlines my reasons for not supporting rural and regional cancer services. At present, surgery and survival rates for patients in these areas are poorer and action is needed. The vast majority of people in these areas are not farmers, as many seem to believe, and most are as eager to access quality services as metropolitan patients. However, the major barrier for these patients in accessing rural care is financial. The present financial schemes for these patients require extensive evaluation and strategies for the future to be costed and implemented. Furthermore, our studies found that admission to a rural hospital, rather than the patient's place of residence was the major factor affecting treatment patterns.

If 'Cancer Centres of Excellence' were established clinicians working in rural areas must be considered. One solution that would potentially encourage their inclusion in the process and cause the least disruption to patients, and their families with repeat travel to the city, would be a mixed-care mode. Perth based specialist surgeons could carry out the surgery and oncologists could monitor patients' adjuvant radiotherapy and chemotherapy. Telehealth connections between the local centres and the specialist cancer centre's oncologist and surgeon could monitor progress jointly with local physicians. Imperative for this plan to work effectively is the notion of a case manager who tracks the patient through the system. Whilst rural and non-specialist centre surgeons will not approve of this twenty years of data show that significant health system changes are required if rural and remote patients are to be treated in line with the Medicare principles and have equity of cancer care and outcomes. Patients also retain the choice to be managed locally but will be cognisant of the limitations of this choice. I strongly believe that regional and rural patients should have the same access to world-class care as people in metropolitan areas and that placing ad-hoc services in rural centres does them an injustice. We presently have research underway examining access barriers for rural patients with lung cancer.

People in lower socio-economic groups were found to have less surgical intervention and worse survival in my research. As mentioned before, this may be related to the stage of their cancer at diagnosis; however, other health system access barriers cannot be ruled out. This may include care at non-teaching hospitals, slower referral pathways and patient or provider demand characteristics. These issues require further investigation. In Perth, the teaching hospitals are centrally located and within easy travelling distance of the more affluent areas. The outer suburbs tend to have lower socio-economic status indicators and are also where the non-teaching hospitals are situated. If general practitioners refer locally then it may be that affluent patients attending teaching hospitals are more likely to receive specialist multi-disciplinary care congruent with the clinical practice guidelines and have improved survival. The concept of 'Cancer Centres of Excellence' with easily accessed referral pathways for diagnostic and treatment services may begin to alleviate

these discrepancies. Furthermore, by their use of best practice care the present variability in treatment patterns across socio-economic groups may be reduced.

In our examination of breast reconstructive surgery rates after breast cancer, we found considerable variations in uptake between advantaged and disadvantaged groups. This type of care is specialised and many smaller centres would be unable to offer these important but overlooked services. The introduction of 'Cancer Centres of Excellence' with surgeons able to offer this service routinely would increase the quality of life of many women who experience mastectomy. Again, being cared for in a multi-disciplinary team with a case manager would help to identify suitable candidates and efficiently manage their surgical care package.

'Cancer Centres of Excellence' would offer comprehensive cancer care at all stages from diagnosis to treatment and palliation options equitably across the population. They could also provide education services for general practitioners, other health care workers and to the community at large. Importantly, their services would be provided in the most efficacious, efficient, effective and cost-effective manner. Teaching hospitals are proactive in terms of quality management and on-going education of staff. Placing the 'Cancer Centres of Excellence' under their umbrellas would inevitably increase the uptake of clinical practice guidelines and ensure that practice is world-class. They have the resources in terms of staff, facilities, collaborative networks and resources to do this.

Lastly, new cancer care policies require monitoring to ensure that they are efficient, effective and that vulnerable groups are not being discriminated against. With administrative data linkage systems (i.e. cancer registry and hospital morbidity data), it is now viable to actively monitor practice and compliance with best practice without using large amounts of resources, although this would need the support of the clinicians and government. Importantly, at present cancer stage information is not routinely held at the Cancer Registries and this requires urgent action so that variations in cancer stage at diagnosis can be considered.

In conclusion, I make the following points:

- At present, people in disadvantaged groups receive less surgery for their cancer and have decreased survival
- 'Cancer Centres of Excellence' would reduce variability in care with care based on best practice
- These centres would have diverse facilities ranging from screening, diagnostic, treatment, palliation and education of both health care staff and the community
- All patients would have the option to attend
- Mixed-mode services could be offered to rural patients to reduce travel requirements
- Cancer Registries must routinely collect stage of cancer data
- The monitoring of new cancer care policies must be at a population level to identify if the new system is working across the entire population and specifically to ensure people in disadvantaged groups are receiving equitable care

Attachments: six published papers examining cancer care in Western Australia; AMA rural conference paper.