MEDICAL ONCOLOGY GROUP OF AUSTRALIA INCORPORATED

A.B.N 94 601 175 669

SUBMISSION TO THE SENATE INQUIRY INTO SERVICES AVAILABLE TO PERSONS DIAGNOSED WITH CANCER AND INTO OPTIONS FOR TREATMENT, INCLUDING LESS CONVENTIONAL THERAPIES.

March 2005

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ABOUT THE MEDICAL ONCOLOGY GROUP OF AUSTRALIA

The Medical Oncology Group of Australia (MOGA) is the peak professional association for medical oncologists in Australia. MOGA is a Special Society of The Royal Australasian College of Physicians and a sub-group of the Clinical Oncological Society of Australia.

Medical Oncology is a sub-specialty of internal medicine devoted to the investigation, diagnosis and management of malignant diseases including preventative and palliative medicine. Medical oncologists are involved in cancer research (including biology, therapeutics, epidemiology and clinical outcomes research), health education, ethics and clinical care.

The major treatment used by medical oncologists is drug therapy for cancer. Treatment recommendations for cancer patients are based on the best scientific evidence available and are constantly revised in the light of new research findings.

MOGA's central business relates to the optimal diagnostic and medical management of people with cancer, for the benefit of the community. MOGA also has a role in collaborating with other professional groups in the fields of cancer education, prevention and screening.

Membership of the Medical Oncology Group of Australia comprises fully qualified medical oncologists and advanced trainees in medical oncology.

Submission To The Senate Inquiry Into Services Available To Persons Diagnosed With Cancer And Into Options For Treatment, Including Less Conventional Therapies.

Introduction

MOGA welcomes the opportunity to provide a submission into this inquiry into cancer services in Australia.

Many of the issues raised by this inquiry were addressed by the 2003 report, *Optimising Cancer Care in Australia: A Consultative report prepared by the Clinical Oncological Society of Australia, the Cancer Council Australia and the National Cancer Control Initiative*[i]. MOGA fully supports the recommendations for improving cancer services contained in this report, which highlight the need to reform cancer services into a more patient-centred model.

MOGA views the establishment of Cancer Australia as an opportunity to spearhead the implementation of the necessary cancer service reforms to help ensure best practice cancer care is available across Australia.

Part A: Delivery of service and options for treatment for persons diagnosed with cancer.

Multi-disciplinary care

MOGA considers that an integrated multidisciplinary approach to determining treatment pathways for cancer patients is essential to optimise cancer care and ensure access to best practice treatment.

Optimal treatment of cancer involves a complex array of services provided by a range of specialists and allied health professionals. Treatment may be in the form of surgery, radiation therapy, chemotherapy, hormonal therapy or, increasingly, a combination of these modalities.

In addition, psychosocial and practical support services for patients are provided by psychologists, psychiatrists, general practitioners and social workers, physiotherapists, nurses and community health care providers. Palliative care, covering symptom control and pain relief is also normally required during active treatment and particularly for those with an incurable cancer at an advanced stage.

A multidisciplinary approach to cancer care, in which all relevant disciplines have input to developing the most appropriate treatment plan for each patient can help to ensure that patients are offered the full range of potential treatments in a coordinated and timely manner.

Optimising Cancer Care in Australia reported that consumers were strongly supportive of multidisciplinary care and that many clinicians considered a multidisciplinary approach to be the only way to ensure optimal care for less

straightforward cases.[ii] Cancer Voices NSW also advises that they strongly support a multidisciplinary approach to treatment for all cancer patients.

A literature review to identify evidence evaluating multidisciplinary care in cancer was conducted for the *Optimising Cancer Care in Australia* report and concludes that multidisciplinary care has the potential to improve outcomes for patients with some cancers, increase patient satisfaction, improve recruitment to clinical trials and reduce health care costs. However while most of the articles reviewed provided information on multidisciplinary care, few specifically evaluated the multidisciplinary approach to cancer care. [iii]

Most of the clinical practice guidelines relating to cancer highlight the importance of multidisciplinary care and recommendations and programs to improve the implementation of multidisciplinary care in cancer are included in the National Service Improvement Framework for Cancer and State Cancer Plans.

While multidisciplinary care is generally recommended and supported for cancer, there is scope to improve the provision of multidisciplinary cancer care in Australia. In a survey of women's experiences of Breast Cancer Services in NSW in 2001 less than half of all respondents perceived their care to be co-ordinated by a multidisciplinary team.[iv] The survey highlighted a number of problems relating to the organisation and delivery of treatment, such as delays and lack of ongoing follow-up; lack of coordination; poor communication with patients; inadequate information provision and limited psychosocial support. A national demonstration project in multidisciplinary care in breast cancer by the NBCC found that while most clinicians recognised the desirability of multidisciplinary care, not all services offered multidisciplinary treatment planning. [v]

Barriers to the implementation of multidisciplinary care

The NBCC project also identified a number of barriers to the implementation of multidisciplinary care including: resistance to change; lack of time, resources and clinical staff; and challenges associated with covering large geographical areas[vi]

The NBCC project also found that current funding arrangements through the Medicare Benefits Schedule (MBS) are a financial disincentive for practitioners to engage in multidisciplinary care as reimbursement is not generally available for participation in multidisciplinary meetings. This is a particular disincentive to multidisciplinary care in the private health sector [vii] and needs to be addressed.

In addition, deficits in the cancer workforce in almost every category are a significant barrier to the implementation of multidisciplinary care, both because of the lack of available practitioners and because multidisciplinary meetings add more work to already busy schedules. This is particularly evident in rural areas (see below). Workforce issues are referred to in more detail in other sections of this submission.

MOGA supports measures, such as those identified in the NBCC project, the *Optimising Cancer Care in Australia* report and National and State Cancer plans, which encourage the implementation of multidisciplinary care for cancer patients. The implementation of multidisciplinary care should also be one of the key priorities for Cancer Australia.

Case Manager/Case Co-ordinator
The complex and multifaceted nature of cancer treatment can be confusing for cancer patients and their carers and the use of cancer case managers/case coordinators can help them more easily navigate their treatment path while also providing a central contact for providing advice and support. This can significantly improve a patient's cancer experience. There is also evidence that the provision of a case coordinator can increase referrals for psychosocial care.

One of the principal conclusions drawn by the NBCC multidisciplinary care demonstration project was that a breast care nurse in a multidisciplinary team provided benefit both to patients and clinicians by enhancing continuity of care and recognition of the need for appropriate referral for psychosocial support.[viii]

Different models may be more appropriate in different settings and in addition to nurses, case co-ordination could be undertaken, for example, by administrators who support multidisciplinary meetings, or in rural settings, by the General Practitioner.

MOGA supports the allocation of case managers/case co-ordinators for cancer patients. This person should be an integral member of the multidisciplinary team.

Psychosocial support
The provision of psychosocial support for cancer patients is an integral part of optimal, patient-focussed cancer care given that, up to 66% of people with cancer experience long term psychological distress.[ix] Many clinical practice guidelines relating to specific cancers include evidence based recommendations for the provision of psychosocial care to patients. Generic psychosocial guidelines, *Clinical practice guidelines for the psychosocial care of adults with cancer,* were published in 2003.

MOGA fully supports the implementation of evidence based guidelines for the psychosocial care of adults with cancer and their incorporation into medical training.

MOGA notes that the implementation of multidisciplinary care is a key factor in improving the provision of psychosocial care to cancer patients. This view is supported by the NBCC demonstration project on multidisciplinary care in breast cancer, which highlighted that "one of the key benefits of a multidisciplinary approach in the short term is improved provision of psychosocial support for women with breast cancer".[x] These results are likely to be applicable to all cancer patients.

Rural and regional services
Many regional and rural centres in Australia have only limited access to specialist cancer services. In the case of medical oncology, 86.5% of medical oncologists are located in a metropolitan capital city, with a further 8% in large regional centres and 5.5% in smaller rural or remote areas.[xi]

As a result, cancer patients living in rural and remote areas of Australia often have to travel significant distances to larger centres for treatment and assessment. In addition specialist services are often provided on a visiting basis, so patient care between visits

is of necessity shared with local practitioners and nurses, creating additional problems of access to and co-ordination of care, increasing stress for the patient.

Because of these additional challenges, a case-coordinator can be of particular assistance for rural patients.

Access to specialist care for patients in rural and remote areas is hampered by workforce shortages in almost every category. In the case of medical oncology, the Australian Medical Workforce Advisory Committee found in 2001 that the supply of medical and haematological oncologists was deficient, particularly in rural regional centres, by at least 40 practitioners.[xii] This is corroborated by consistent problems reported by MOGA members in filling medical oncology positions in rural or regional areas, as well as in some capital city areas.

Issues relating to rural cancer services in relation to medical oncology are discussed in MOGA's paper Provision of Oncology Services to Rural and Remote Regions of Australia. This paper is available at www.racp.edu.au/moga/rural_services.pdf . This paper highlights the need to ensure effective linkages between a rural based service and a tertiary hospital with the infrastructure and support services to deal with complex or high risk cases. This linkage can also assist in the delivery of multidisciplinary care in the rural site with distant practitioners able to participate via video- or tele-conferencing if necessary.

Barriers to the Implementation of Best Practice in Cancer Services

Two important barriers to the implementation of multidisciplinary care and best practice cancer treatment are an inadequate oncology workforce and drug access issues.

As already noted, deficits in the cancer workforce in almost every category are a significant barrier to the implementation of multidisciplinary and best practice care for cancer patients.

Current workforce shortages will be exacerbated in the light of current trends such as increasing cancer incidence and prevalence as a result of an aging population; increasing indications for chemotherapy treatments, including second and third line chemotherapy treatment; increasing complexity of treatment, including greater emphasis on multidisciplinary treatment; and improved survival rates amongst patients.

If optimal care is to be provided to cancer patients, it is important that measures such as increasing training positions in all the cancer specialties and in allied health areas, be implemented to ensure there is an adequate oncology workforce to match future needs.

In relation to the medical and haematological workforce, MOGA supports the implementation of the recommendations of the AMWAC report[xiii] to address workforce shortages which hamper the provision of optimal cancer care.

In addition to requiring an adequate workforce to deliver treatment, optimal cancer care also requires timely access to the most up-to-date scientifically proven

treatments. In the case of medical oncology, problems in implementing best practice in Australia sometimes arise under current drug listing arrangements due to the length, expense and complexity of the registration/listing process and the fact that there is little incentive for sponsoring companies to apply for listing for drugs for which there is relatively little commercial benefit to be gained. This also applies to applications to extend the indications for an already listed drug, or to list a drug in a different, more appropriate dosage.

As a result there are a number of anomalies on the Register of Therapeutic Goods and on the Pharmaceutical Benefits Schedule where medications are listed in inappropriate doses or drugs are not listed for indications for which they are the internationally accepted best-practice treatment. For example, cisplatin is recognised as a major component in chemotherapy regimens for non-small-cell lung but is not registered in Australia for that indication. Another example is etoposide which is not registered for use in the treatment of germ cell (testicular) cancer although it represents international best practice treatment for this disease.

MOGA recommends that the current drug registration and listing processes be reviewed to make it more timely and flexible and to allow for treatments to be adjusted in line with internationally accepted best practice and with new evidence as it arises.

MOGA notes that the increasing trend towards new targeted therapies in cancer treatment, which are often very expensive, will also create challenges for the PBS listing process. PBS listing requirements and criteria will require review if patients are to have timely access to these therapies in future.

Part B: How less conventional and complementary cancer treatments can be assessed and judged

MOGA supports evidence-based, best practice clinical care for cancer patients, underpinned by a strong and ongoing research effort to investigate all promising options for new treatments.

MOGA notes that a small number of complementary and alternative (CAM) therapies that were originally considered purely alternative, have become more accepted in mainstream treatment. Acupuncture, for example has been found to be effective in managing chemotherapy induced nausea and vomiting[xiv]. In addition some people find that certain complementary therapies, such as meditation and yoga, can be helpful in improving their quality of life.

However, many CAM therapies remain unproven and critical questions regarding their safety and efficacy have yet to be answered through well-designed scientific studies. While some of these therapies may be of value to patients, there is also scope for unscrupulous manufacturers or practitioners to take advantage of patients at a time where the stress of diagnosis or treatment makes them most vulnerable.

MOGA supports the recommendations of the Expert Committee on Complementary Medicines in the Health System for the TGA to ensure there are appropriate legally enforceable standards for ingredients used in complementary medicines and to require

more rigorous assessment of the evidence to substantiate the therapeutic claims for these products.[xv]

There are two particular areas of concern regarding the use of CAM therapies in cancer patients:

a) When the CAM therapy may be harmful, either in itself or when used alongside conventional therapy. [xvi] Some herbs or dietary supplements for example may cause harmful interactions with other drugs used as standard treatment by cancer patients.[xvii] For this reason, the treating doctor should be aware of any complementary therapies being used by the patient, both to avoid possible interaction and complications and to allow informed discussion of alternatives. Open communication between a patient and their treating doctor is important so that patients can feel comfortable about discussing CAM therapies.[xviii]. It is also important to recognise that the patients' reasons for using CAM therapies may shed light on how current treatment practices may be improved.[xix]

b) When the CAM therapy is used instead of conventional therapy or delays conventional therapy. For most cancer patients, there is only a limited window of opportunity to receive potentially curative or life-prolonging treatment. To ensure the best outcome for patients, it is very important that they have timely access to those treatments that have been demonstrated to be most effective, at the time when most benefit is likely to be achieved. To recommend an unproven treatment that would delay or replace a proven treatment for cancer would be irresponsible, unethical and likely to compromise treatment outcomes for the cancer patient.

It is important to recognise however that the use of CAM therapies amongst cancer patients in Australia is significant.[xx] The widespread use of these therapies highlights the need to ensure that consumers have a reputable source of information regarding their safety and efficacy. In this context, MOGA notes that most complementary medicines currently fall into the low risk category of goods assessed by the Therapeutic Goods Administration and are assessed for quality and safety, but not efficacy.[xxi] In addition, while many websites, such as The Cancer Council Australia website, provide general information regarding CAM therapies, specific information on particular therapies is not readily available from Australian sites.

MOGA considers that there is a role for a national cancer body, such as The Cancer Council Australia or the yet to be formed Cancer Australia to provide this information for consumers in the Australian context, drawing from both local and international sources.

Research into CAM therapies

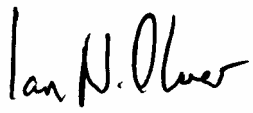
It is important that any claims about the effectiveness of CAM therapies are supported by rigorous scientific proof of benefit before these therapies are accepted into practice and that consumers have access to information relating to the safety and effectiveness of these therapies.

The USA has two major institutes which conduct research into CAM therapies. The Office of Cancer Complementary and Alternative Medicine (OCCAM) was established by the National Cancer Institute in 1998 to "coordinate and enhance

activities of the NCI in CAM research as it relates to the prevention, diagnosis, and treatment of cancer, cancer-related symptoms and side effects of conventional cancer treatment"with a budget of nearly US$120m in 2003.[xxii] OCCAM also conducts a "Best Case Series" to help identify promising non-conventional treatments for further research.[xxiii] The National Health Institute also has a National Centre for Complementary and Alternative Medicine (NCCAM) which is dedicated to exploring CAM practices in the context of rigorous science. NCI and NCCAM are currently sponsoring a number of clinical trials to study some CAM therapies for cancer. A list of currently sponsored trials is published on their websites.

At present there is no specific mechanism to fund research into complementary or alternative therapies in Australia. Commercially sponsored research in this area is often hampered by a lack of financial incentives, given that many therapies are not patentable or are out of patent. MOGA considers that there is a legitimate role for government to sponsor some research into this area, for example as it is currently doing through the NHMRC in relation to the use of the Tronado machine in Western Australia.[xxiv]

MOGA considers that any measures to encourage research in the area of CAM therapies should be considered as part of an overall cancer research funding strategy, the development and implementation of which should be overseen by Cancer Australia.



Ian Olver
Chairman

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[ii] ibid, pg 16
[iii] ibid, pp 96-100
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[v] National Breast Cancer Centre, November 2003. *Multidisciplinary Care in Australia: A National Demonstration Project in Breast Cancer Summary report* http://www.nbcc.org.au/bestpractice/resources/MDS_summaryreport.pdf
[vi] ibid pg 42
[vii] ibid, pg 2
[viii] ibid, pg 40
[ix] National Breast Cancer Centre and National Cancer Control Initiative. 2003. *Clinical practice guidelines for the psychosocial care of adults with cance,r* pg vii
[x] National Breast Cancer Centre, November 2003. *Multidisciplinary Care in Australia: A National Demonstration Project in Breast Cancer Summary report* pg 19
[xi] Based on MOGA Membership Records
[xii] Australian Medical Workforce Advisory Committee 2001. *The Specialist Medical and Haematological Oncology Workforce in Australia.*
[xiii] op cit
[xiv] "NIH Consensus Conference. Acupuncture." JAMA 1998; 280:1518-24

[xv] Expert Committee on Complementary Medicines in the Health System *Complementary Medicines in the Australian Health System* Report to the Parliamentary Secretary to the Minister for Health and Aging. September 2003 www.tga.gov.au/doc/pdf/cmreport.pdf
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[xxii] NCI CAM History and the role of OCCAM http://www.cancer.gov/cam/cam_at_nci.html
[xxiii] http://www.cancer.gov/cam/bestcase_intro.html
[xxiv] http://www.nhmrc.gov.au/advice/microw.htm