
Introduction

The Clinical Oncology Society of Australia (COSA) is fully supportive of the development of an Australian Cancer Plan (ACP) and appreciates the opportunity to participate in the consultation.

COSA is the peak national body representing health professionals from all disciplines whose work involves the care of cancer patients. COSA's activities are driven by our specialist groups, a number of whom have made separate submissions to this consultation – Exercise and Cancer, Geriatric Oncology, Survivorship Policy Working Group and Survivorship Primary Care Working Group. COSA fully supports each of the submissions.

COSA also supports the submission of our colleagues at Cancer Council Australia, and CanTeen Australia. Whilst COSA does have an Adolescent and Young Adult (AYA) Group, we endorse CanTeen as being well placed to focus on AYA specific recommendations for the ACP consultation.

We agree the ACP should provide an overarching national approach to cancer control that meets the needs of all Australians now and into the future. Over the past 30 years there has been substantial progress towards improving outcomes for people with cancer, however we recognise we can do even better with a nationally coordinated approach that links state and territory cancer plans to an overarching national cancer plan.

The ACP must deliver an agreed national shared purpose, cover the spectrum of cancer control, maintain a sharp focus on reducing inequity in cancer outcomes, and enhance the structures to support the uptake of effective and sustainable improvements.

We support the principles underpinning the development of the ACP, and the commitment of the Government of Australia to its realisation.

Addressing the Principles

Person centred

A shift to patient priority-directed decision-making is required, particularly for patients who have multiple chronic conditions as well as cancer. This should include a focus on Patient Reported Outcomes and experience to support people with cancer informing their care, and to evaluate quality of cancer care.

Access to care coordination and navigation support will improve cancer experience and outcomes.

Carers should feature as an integral partner in optimal cancer care and be duly recognised in the ACP.

Embedding the Optimal Care Pathways (OCPs) within the ACP as national standards of cancer care and value-based care will improve person centred optimal cancer care.

Equity focussed

The ACP should have the principles of respect, value and dignity embedded to achieve health equity for all Australians with cancer, regardless of their age, gender, geography, culture or other demographics.

All people with cancer should be fully informed of the financial implications of their treatment. This is highlighted in the OCPs, as well as the Cancer Council and collaborators' [Standard for Informed Financial Consent](#).

Tumour agnostic

Whilst we support the embedding of the OCPs within the ACP, we recognise some of these are tumour specific and some agnostic, such as the Optimal Care Pathway for Aboriginal and Torres Strait Islander People. Development of other OCPs in tumour agnostic areas is important, such as an OCP for older people with cancer.

Tumour specific approaches have led to improvements in care and outcomes by integrating research, best practice, consumer advocacy and community support in recent decades, notably in Breast Cancer. Many innovations in breast cancer management have flowed on to benefit other patients, for example the implementation of the multidisciplinary team approach. Nevertheless, it could be argued that “resting on our laurels” may perpetuate inequalities in the oncology sector, where people with less conspicuous cancers and more limited resources may experience minimal to no support outside of their direct treatment team and family caregivers.

Tumour agnostic practices such as navigation, psychosocial care, exercise prescription, lymphoedema care and evidence based Integrative Oncology should be recognised as core components of person centred supportive and survivorship cancer care. Patients with tumour specific supportive care needs, eg those needing stoma care or prostheses, would still require the input of nurses with specialist training and experience.

Encompass whole continuum

Assessment and management of modifiable risk factors can reduce the incidence of cancer and must be a focus for the ACP. The ACP needs to create an environment to improve cancer outcomes for all Australians and should be aligned with the targets and activities of the National Preventative Health Strategy, and other relevant national health care plans and strategies.

As noted in the COSA Exercise and Cancer Group ACP submission, 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). Expansion, methods for flexible delivery such as telehealth, and further funding for exercise services is vital for achieving equitable outcomes for people with cancer.

Future focussed

Building a cancer and aged care workforce (particularly to support geriatric oncology) with skills and competency to meet the current and future needs of all Australians with cancer, including older people, must be reflected in the ACP.

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.

Collaborative

The ACP will require alignment with established Australian State and Territory comprehensive cancer plans and act as a springboard for those who do not currently have effective cancer plans in place.

We agree with Cancer Council that the ACP should detail and utilise a national governance structure and a reference group similar to the former National Cancer Expert Reference Group, to provide oversight of the ACP's implementation and evaluation. It is important for the reference group to comprise of experts in cancer prevention, early detection, treatment and survivorship as well as expertise in policy and advocacy, to ensure all voices are at the table. COSA would be willing and eager to participate in such a governance framework.

Data focussed

To be effective the ACP must have an accompanying monitoring and evaluation framework which describes responsibility and accountability.

National agreement on cancer prevalence data and burden of disease must be established. We need more than just incidence and mortality data. Routine collection of a mix of burden of disease and healthcare outcomes / monitoring performance, e.g. long term treatment side effects, co-morbid disease, prevalence data, premature death (non-cancer causes versus cancer causes), disability, disability on productivity, cost of healthcare delivery etc.

Strengths based

Strengths of the Australian Cancer Workforce include its high level of training, and ongoing multidisciplinary education. The COVID 19 pandemic has however led to burnout, loss from the workforce, and truncated access to educational opportunities, particularly for those in rural and remote settings. The ACP needs to support the flexible ongoing education of cancer professionals, and advocate on their behalf for appropriate workloads, remuneration and continuing professional development.

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?

We would like the Australian Cancer Plan to achieve a health system that addresses the care needs of all Australians with cancer, guided by evidence-based practices that is person-centred, minimises harm, equitably applied, and is consistent with what matters to those with cancer. This will require care pathways that are coordinated and age friendly.

Some specific examples include:

- All people with cancer receive care close to home, including via telehealth
- Geriatric assessment and management alongside oncological care for older people with cancer
- Better integration of oncology services with geriatric medicine services and community-based Aged Care services (especially social support services), with new more flexible and responsive models to meet the needs of older people with cancer and their families
- A greater recognition of the importance of carers and families as care-partners in the patient's cancer experience, thereby ensuring their involvement in communication and decision-making (in line with patient preferences/care requirements). It should also be recognised that many older people with cancer are themselves carers, and care includes recognising and managing the flow-on effects of their illness
- A shift in the language used throughout the cancer care space to put the older person with cancer at the centre of care
- We would like to see primary care playing a key role in the care of people with cancer throughout the cancer care continuum, including prevention, screening, early detection, treatment and survivorship, and palliative care. Such complex care requires appropriate remuneration, such as the use of a cancer specific chronic care plan
- All patients receiving cancer care at public hospitals to have access to an oncology-specialised qualified exercise professional
- Implementation of referral pathways between cancer centres and qualified exercise professionals in community settings
- Partnerships between all cancer centres and universities to engage in exercise-oncology research
- Implementation of national survivorship outcome measures that account for all people with cancer including minority populations, with the use of Patient Reported Outcome Measures (PROMs) to guide clinical care more routinely
- All patients with cancer should have access to evidence informed wellness, Integrative Oncology and Supportive Care programs to reduce symptom burden and enhance wellbeing

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?

- A national advisory group which oversees the delivery of the ACP and evaluates agreed key performance indicators
- Embedding the Optimal Care Pathways (OCPs) within the ACP as national standards of cancer care and value-based care will improve person centred optimal cancer care. One way to ensure integration is to develop key performance indicators related to the OCPs to hold health services accountable. Without reportable metrics it will be challenging to see the impact of the ACP
- Development of an OCP for older people with cancer to provide guidance and resources for organisations on pathways/models integrating oncological and geriatric care, which also links to tumour specific OCPs
- Ensure all older people with cancer have screening for frailty and geriatric needs during their initial assessment and over the course of their cancer treatment using validated tools
- Creation of age-friendly health services
- Increasing resources for older people with cancer and their carers
- Advocacy of terminology which emphasises the older person with cancer's preferences, priorities, and autonomy
- Greater involvement of primary care and integration of primary care teams with specialist cancer services
- Greater investment in cancer survivorship and shared care and systems enabling timely and dynamic communication and teamwork between hospital-based cancer centres and community-based general practices, non-GP specialists, and allied health professionals
- Greater investment is required to promote primary prevention strategies (such as healthy lifestyle), to reduce downstream effects on cancer as well as other comorbidities. This is particularly important in survivors of childhood cancer, who have elevated risk for many serious health conditions. These patients require resources best accessed through primary care settings to foster healthy lifestyle and other preventative measures
- Rebates for exercise therapy need to be increased to remove the out-of-pocket expenses 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. 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
- Establishment of agreed standards for quality cancer survivorship care for health services – this should form an excellence framework or a national accreditation system
- Expanded reportable data to encompass prevalence, burden of disease, timing of relapse after initial treatment and prevalence of metastatic disease. This is vital for service planning and funding of innovative cancer treatments

- Establishment of Centres of Excellence in Cancer and/or Cancer Survivorship, and accreditations for Supportive Care Centres of Excellence, similar to the US National Cancer Institute designated Cancer Centers
- Greater investment in implementation research, so that local solutions can be found in areas where the evidence base for treatment is already strong but it is difficult to deliver equitably

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?

There are significant examples and centres of excellence within Australia, and internationally which can provide learnings to inform the ACP and proposed activities, particularly in geriatric oncology. Geriatric oncology services are well established in some centres and countries. In France, long-standing integrated services are established through Coordination Units in each regional territory. The Units promote screening all older adults with cancer and train health care professionals to complete comprehensive geriatric assessments, promoting organisation of integrated geriatric oncology services, and coordinate, conduct and disseminate research. In Belgium geriatric assessment is widely implemented in routine oncology practice. In the USA, healthcare delivery varies widely, however, a number of centres offer comprehensive integrated Geriatric Oncology services.

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, as outlined in the COSA Exercise and Cancer Group submission. Recent studies have expanded this work to encompass those with metastatic disease, and through remote delivery methods.

The ACP provides an opportunity to commit to sharing our collective expertise in cancer prevention and control with other nations, particularly low- and middle-income countries in our region. The leadership we have shown on the WHO's Global Cervical Cancer Elimination Strategy provides a model that could be expanded to other cancers and issues and would provide benefits to the Australian community as well as those we are working to assist.

There is evidence of steady growth globally of Cancer Centres over the past two decades offering Integrative Oncology programs, providing a wealth of examples and models for consideration. Most National Cancer Institute Hospitals in the US offer some form of Integrative Oncology, including hospitals such as MD Anderson in Texas, Memorial Sloan Kettering in New York and Dana Faber in Boston. In the UK, over 30 "Maggie Centres" have been offering wellness programs with standard cancer care since 1996.

Conclusion

The development and implementation of the ACP provides a unique opportunity for all stakeholders to reflect upon the needs of patients and families, which have evolved significantly over past decades. No longer is it enough to concentrate purely on survival in the few curable cancers, regardless of side effect burden, and to build cancer services around the few medical specialists in a small number of urban ivory towers. Cancer is everywhere, and so are its survivors. Getting back to work or independent living, to having or raising a family, to travelling and contributing to society: these are the goals our patients express now. They expect that cancer treatment will adapt to their individual needs, and if death comes eventually, it will be at a place of their choosing with all available comfort and support. Implementing the knowledge we already have in a systematic way should allow us to achieve these goals over the next five years. At the same time expanding our research capacity will allow us to address the needs of the patients of the future. This opportunity must not be lost.

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