Submission to the Draft Australian Cancer Plan Consultation
16 December 2022

Clinical Oncology Society of Australia

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 this final consultation on the draft ACP. COSA acknowledges the work and consultative approach of Cancer Australia in developing the ACP.

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, and the Survivorship Policy Working Group. COSA fully supports each of the submissions.

COSA also supports the submissions from our colleagues at Cancer Council Australia, and Cancer Nurses Society of Australia (CNSA). Whilst COSA does have nurses that are members, we do not have a specific cancer nursing group, therefore we support CNSA as being best placed to focus on cancer nursing workforce specific recommendations for the ACP.

We are pleased that many of the recommendations in our March 2022 submission have been included within the draft ACP. We provide the feedback below to the final draft, in addition to our online survey responses.

Guiding Principles

- ***Person-centred****: The ACP is designed with, and for, all people affected by cancer. This includes people at risk of cancer, people diagnosed with cancer, their families and carers.*

This statement could benefit from the explicit acknowledgment and inclusion of people being treated for cancer and cancer survivors, ie pre-, during-, and post- cancer treatment.

We appreciate the inclusion of "**carers**" in this principle; however, believe carers are underrepresented as a whole in the ACP (further detail is provided below).

Priority Population Groups

COSA supports the focus on priority population groups. This section would benefit from acknowledging that some people affected by cancer may identify with more than one group.

Carers are mostly mentioned for Children, and yet they are obviously relevant to most other populations – one could argue all. Most notably, carers are not mentioned at all in any of the Strategic Objective actions.

COSA is pleased to see **Older Australians** recognised as a Priority Population in the ACP, and we highlight the submission to this consultation by the COSA Geriatric Oncology Group.

Some of the Priority Population goals and actions put the onus on the individual with cancer and seem to remove responsibility from the health systems. This is not in keeping with a person-centred approach as claimed in the Guiding Principles. To address inequities in cancer care, health systems must adapt to better support people with cancer.

Implementing, Monitoring and Evaluating the ACP

COSA recognises that implementation of the ACP is going to be an enormous challenge. As the peak national body representing health professionals from all disciplines whose work involves the care of cancer patients, we are well positioned to provide a leading role in implementation. We recognise the enormous challenges faced in reforming systems and there are going to have to be strong incentives to facilitate this change. Despite our federation of States, the Commonwealth Government is well placed to incentivise change and we suggest that the ACP includes recognition of the need to incentivise large system change and that without the change the ACP will not be a success.

The OCPs form an integral component of the ACP, noting that consistent quality care will be achieved through the integration and evaluation of OCPs as routine cancer care. We recommend further information and actions are required to explain how optimal cancer care will be achieved in cancers and priority populations where OCPs are not established. The aim to extend the suite of existing OCPs to all priority populations and explore the development of new tumour agnostic OCPs is admirable, yet the ACP is silent on how care delivered to these cancers and priority populations will be monitored or delivered prior to the development of an OCP. Systems to monitor OCP compliance must be developed. COSA recommends national review of the existing OCPs to ensure they meet the objective of driving highest quality care. Some of the OCPs are quite generic and fail to emphasise important elements of care including around nutritional support despite their recent update. Some also don't focus on best practice timeframes for commencement of treatments.

We applaud the ambitious objective to eliminate racism; and note that strategies to address and prevent racism should be reflected within the implementation considerations by priority population as well as the accompanying implementation plan.

Key performance indicators will obviously be a key requisite in implementing, monitoring and evaluating the ACP. We would welcome the opportunity to be involved in their development.

Strategic Objective 1: Maximising Cancer Prevention and Early Detection

COSA recommends the ACP should also focus on preventing comorbidities in people with cancer. Quitting smoking has clear benefits for all people with cancer with regards to survival, cancer recurrence, treatment outcomes, and quality of life (Clinical Oncology Society of Australia Smoking Cessation Working Group, 2020). Similarly, exercise after a cancer diagnosis has been shown to lower the likelihood and severity of side effects such as fatigue, neuropathy, lymphoedema, osteoporosis, and nausea, reduce the risk of depression and anxiety, and maintain mobility and independence (Clinical Oncology Society of Australia, 2020). However, supporting smoking cessation and prescribing exercise programs for people living with cancer is a specific skill set not always readily available in cancer care environments across Australia. The ACP could set the direction for incorporating these important prevention services into multidisciplinary cancer care and survivorship services.

Exercise professionals (exercise physiologists and physiotherapists) are well placed to provide evidence-based exercise programs to the Priority Population Groups identified in the draft ACP. These groups require intervention to modify physical activity, yet, it currently has not been sufficiently addressed in the ACP how they will receive this support.

There is a strong evidence-base supporting the role of exercise for secondary prevention, including reducing the risk of cancer recurrence, mortality, and chronic diseases, yet it is not clear in the draft ACP how Australians with cancer and survivors will receive evidence-based exercise-medicine to manage their risk of secondary prevention.

Action 1.1.5 Strengthen health literacy for Aboriginal and Torres Strait Islander people through co-designed health promotion and lifestyle strategies for cancer prevention, while an admirable action, should be expanded to other Priority Populations.

Strategic Objective 2: Enhanced Consumer Experience

This Objective, its goals and actions could benefit from greater consideration of the impact of the "financial toxicity" of cancer treatment.

COSA Council has endorsed the following definition of financial toxicity

> *"The negative patient-level impact of the cost of cancer. It is the combined impact of direct out-of-pocket costs and indirect costs and the changing financial circumstances of an individual and their household due to cancer, its diagnosis, treatment, survivorship and palliation, causing both physical and psychological harms, affecting decisions which can lead to suboptimal cancer outcomes."*

This issue is relevant to all Priority Populations defined in the ACP, not only people living in low socioeconomic areas (Actions 2.1.1 and 2.1.2). Implementation considerations should be expanded to minimise financial burden and toxicity for all Australians affected by cancer.

Health services need to not only be culturally responsive, but they also need to ensure age friendly cancer care systems (Action 2.1.3). The ACP must ensure it fosters positive attitudes

towards older Australians, to ensure that prejudices and unconscious biases against older adults do not influence diagnosis and treatment recommendations. Significant research supports that the wellbeing and quality of life of older adults are compromised by ageism. Recommendations to combat ageism require public policy which is broad and consistent with the need of older adults, ensuring it is addressed in how we train our workforce, and encouraging intergenerational activities.

We support the strong emphasis on navigation in this Objective. We support the equitable access to navigation and the focus on developing innovative models. It must be recognised there will be many different models that will vary by priority populations, geographic location, disease type and extent. There will need to incentives to implement these. It is important that the proposed focus of navigation involves a range of disciplines, and navigation strategies / activities, covering the whole continuum from pre-diagnosis through to end of life should be explored (which may include both professional and non-professional navigators). This should effectively integrate primary / community-based care with acute / tertiary care. Navigation should aim to reduce fragmented care.

Strategic Objective 3: World Class Health Systems for Optimal Care

COSA supports the supports the 5-year goal in strategic objective 3 to develop high quality comprehensive cancer care systems that deliver optimal care and outcomes. This is so important to ensure equity in our cancer care systems and we have examples of it already working well. It is also fundamentally linked to One of the actions in the ACP is to establish a National Comprehensive Cancer Centre Network (NCCCN). This network is not clearly defined but COSA expects it refers to all care providers that offer comprehensive cancer care not just major metropolitan service that has chosen to call itself a Comprehensive Cancer Centre. Empowerment of large metropolitan centres will entrench inequities and support powerful siloes.

We agree with our colleagues at Cancer Council Australia and note that as we discussed in Strategic Objective 2 above, addressing financial toxicity for people affected by cancer requires systematic changes as essential elements of the ACP. This includes the implementation of the Medicare Benefit Schedule (MBS) review recommendations, removing out of pocket costs for chemotherapy delivered in the public health system, ongoing review of MBS rebates to ensure they support contemporary practice and have an appropriate fee, ongoing review and reporting of patient out of pocket cost data, increasing MBS rebates and reducing payment gaps for patients, and delivering fit-for-purpose income support programs. Increased cost transparency will elevate these issues to ensure people affected by cancer understand their choices when accessing medical care. Initiatives such as driving the implementation of informed financial consent, embedding screening for risk of financial toxicity and improving access to financial counselling must be addressed by the ACP before financial toxicity becomes the most concerning side effect of cancer in Australia.

As outlined in the COSA Geriatric Oncology Group submission, COSA recommends an Optimal Care Pathway (OCP) for older people with cancer is developed, guided by a national

expert interdisciplinary advisory group inclusive of older people with cancer, and integrated within the Optimal Care Pathways for specific tumour groups (Actions 3.2.1 & 3.1.1).

Networked cancer care must consider the interface and integration with aged care, geriatrics and community services including social services. The ACP also needs to consider how those services can be better equipped to meet the needs of older people with cancer (Action 3.1.2).

Strategic Objective 4: Strong and Dynamic Foundations

It is pleasing to see multiple mentions of Patient Reported Outcome Measures (**PROMs**) and Patient Reported Experience Measures (**PREMs**) in the draft ACP. These need to be inclusive of issues which affect all people with cancer, particularly older people; and should also consider capturing carer reported outcomes and experiences (Action 4.2.1).

The needs Priority Populations, including older Australians must be considered to ensure adequate support for digital literacy and to ensure digital strategies are co-designed with them to meet their needs will be important (Action 4.2.2).

Participation in **clinical trials** is an important factor for equitable cancer care and improved outcomes. Unfortunately, despite continued efforts and improvements disparity still exists in access to and awareness of cancer clinical trials. Many individuals within the ACP Priority Population Groups are ineligible for clinical trials due to strict and sometimes unreasonable eligibility criteria. This is not representative the Australian population, and therefore leads to under-representation, skewed results and drives increasing disparities in outcomes for people with cancer.

Actions within the ACP should look to systemic barriers to trial participation faced by researchers which include but are not limited to funding, governance, and research culture.

A national cancer data framework must build in the variables for national data pertaining to the epidemiology and relevant outcomes for older people with cancer (Action 4.1.1).

Targeted research will be required in both clinical trials and clinical research to address specific questions pertinent to older Australians with cancer. It will also be important to ensure older people with cancer are included as consumer representatives in grant review panels for all major cancer research schemes (Action 4.1.2).

COSA is highly supportive of all actions pertaining to telehealth, yet we note **teletrials** are not mentioned in the ACP despite there being strong evidence to support their success.

The ACP is strangely silent on **metastatic disease**. There is growing concern that we are not capturing data on metastatic cancer, thus not supporting our patients appropriately.

Data collection must move beyond basic incidence and mortality data. We need to know who is living *with* (rather than beyond) cancer. We need to have data regarding recurrence and development / diagnosis of advanced disease. Ideally also, we should have data regarding functional outcomes / disability.

Strategic Objective 5: Workforce to Transform the Delivery of Cancer Care

COSA is very concerned about the risk to implementation and sustaining the actions of the ACP due to existing and predicted workforce shortages across many of the professional groups that make up COSA's membership and are fundamental to cancer care. Workforce challenges in regional Australia are already dire. We fully support the actions in Strategic Objective 5 but there needs to be an emphasis of the urgency of these actions and a strong national commitment from the Australian Government to support this and to do this work collaboratively with the states and tertiary education sector. COSA strongly supports the 2-year goals to train and Aboriginal and Torres Strait islander workforce and suggests that this is emphasised as an urgent priority.

COSA supports Cancer Council's recommendation that the title of this Strategic Objective be amended to include "prevention". This is in keeping with the ACP's Strategic Objective 1.

Workforce to Transform the Delivery of Cancer <u>Prevention and</u> Care

Strategies to support education and training for the cancer workforce to ensure they are better equipped in specific competencies will be required, particularly in the care of older people with cancer, and in cultural safety.

With calls to implement a cancer care workforce that can deliver engaged, capable and culturally safe evidence-based care, we also call for embedding exercise professionals into hospitals to ensure patients are receiving personalised care from the start of their experience, which will optimise their outcomes and response to treatment.

Actions in the ACP rightly refer to building on existing capability of the primary care workforce (Action 5.1.2) and working with the sector to support all cancer care practitioners to practice at the top of their scope (Action 5.2.2) yet the opportunities here are greater than stated. Australia is set to have a shortfall of GPs/Primary Care Physicians of around 10,000 within the next decade. We suggest there may be primary care career opportunities in the cancer and survivorship space, to enhance a generalist career, allowing for special interest and experience. This may make entering general practice training more attractive to junior doctors, plus retain more senior GPs/primary Care Physicians, knowing that a career can be multifaceted, and highlights the benefits to generalist training/practise, as it has potential applications both within GP community practice, academic cancer research, cancer survivorship, in addition to involvement along the cancer continuum and across all ages. Such opportunities will also help to build the cancer/cancer survivorship workforce generally.

We note that, in addition to existing medical, nursing, and allied health workforce, there should be focus on scoping and developing non-clinical roles – these will be essential to support new models of care, for example remote monitoring and shared care between acute / oncology and primary care providers. This Objective 5 may benefit from greater emphasis on development of new roles within cancer care beyond the above traditional (medical, nursing and allied health) roles, for example peer support / navigation, and administrative roles.

The ACP could benefit from more emphasis on frameworks for the integration between tertiary and primary care throughout the cancer journey especially in relation to survivorship. In order to achieve successful implementation, the ACP relies on such integration. This may include IT and communication systems, survivorship clinicians and workforce, establishment of clinics etc. Some of these are mentioned; however, they are not documented in a way that emphasises the integration between systems. These measures allow a conduit between tertiary and primary care, while supporting the various models of possible survivorship care including self-management, and for establishing the capacity of adaptability.

Strategic Objective 6: Achieving Equity in Cancer Outcomes for Aboriginal and Torres Strait Islander People

COSA applauds the strong focus on equitable care and outcomes for Aboriginal and Torres Strait Islander people with cancer throughout the ACP, not just in this objective.

When considering the needs of Aboriginal and Torres Strait Islander people with cancer, it should be noted this population has an increased incidence of frailty and medical and age-related conditions at younger ages, and therefore are eligible to access Aged Care Services from 50 years of age. This should be taken into account to ensure that they receive the appropriate tailored support.

It is also important to note that many Aboriginal and Torres Strait Islander people may also identify with some of the other Priority Populations as outlined in the ACP, such as LGBTQIA+ people, and may often need to favour one identity over another when accessing health services. We support our Cancer Council colleagues and agree that without acknowledging intersectionality, people can feel isolated, and this often leads to them not seeking support and/or the services they require. Like Cancer Council, COSA is supportive of the implementation of each action within the ACP considering the compounding impacts of intersectionality across other priority population groups.

Conclusion

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.

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References

Clinical Oncology Society of Australia. (2020, December 1). *COSA position statement on exercise in cancer care.* Retrieved from COSA: https://www.cosa.org.au/media/0hhhmfnm/cosa-position-statement-v3-dec2020-web-final.pdf

Clinical Oncology Society of Australia Smoking Cessation Working Group. (2020, August 1). *Smoking Cessation in Cancer Patients: Embedding Smoking Cessation Care in Australian Oncology Health Services.* Retrieved from COSA: https://www.cosa.org.au/media/332692/cosa-smoking-cessation-in-cancer-patients-140820-final.pdf