

How the national health reform process can deliver a sustainable, evidence-based 'National Cancer Plan'

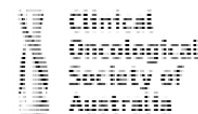
Submission from the Cancer Council Australia/Clinical Oncological Society of Australia to the National Health and Hospitals Reform Commission

June 2008

The Cancer Council Australia is Australia's peak non-government national cancer control organisation. Its member bodies are the eight state and territory cancer councils, whose views and priorities it represents on a national level.



The Clinical Oncological Society of Australia is the peak multidisciplinary society for health professionals working in cancer research or the treatment, rehabilitation or palliation of cancer patients.



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National Health and Hospitals Reform Commission – submission from the Cancer Council Australia/Clinical Oncological Society of Australia

Overview

The Cancer Council Australia and COSA welcome the opportunity to submit recommendations to the Health and Hospitals Reform Commission (the Commission), whose remit addresses the systemic barriers restricting Australia from reaching its potential to control cancer.

The Commission's terms of reference are particularly relevant to cancer control, as cancer is the nation's largest disease burden and imposes a major cost on the health system and the wider community. Moreover, cancer control is subject to cost-shifting and system fragmentation; Australia falls demonstrably short of its potential to prevent cancer; there are stark inequities in cancer care outcomes among population groups (notably Indigenous Australians and people in remote areas); and long-term improvements in cancer control must be underpinned by national systemic and workforce reform.

COAG's commitment to a better coordinated health system, as reflected in the Commission's brief, is in our view an ideal opportunity to bring together the many existing cancer control policies in Australia into a coherent national strategy – with an implementation plan.

National Service Improvement Framework

In making recommendations to the Federal Minister for Health and to COAG, the Commission is urged to observe that the principles of optimal cancer control have already been developed and endorsed by all jurisdictions, through the joint National Service Improvement Framework (NSIF) for cancer. The Cancer Council Australia/COSA therefore recommend that the focus of the Commission's advice be the structural reforms required to convert those agreed principles into practice in a way that improves the efficiency and effectiveness of cancer control services across the health system and minimises inequitable access to optimal care.

National Cancer Prevention Policy

The Cancer Council Australia's *National Cancer Prevention Policy* (NCP) is the most comprehensive policy document on cancer prevention in Australia. It is developed independently on the basis of the best available evidence, peer-reviewed by independent experts from across the wide range of subject areas and edited by the Cancer Council Australia's network of national advisory committees.

The NCP explores the latest evidence in relation to the primary prevention and early detection of all the major cancers in Australia and, in consultation with cancer control professionals from all sectors, recommends optimal policy. It is in our view a particularly useful document in relation to the Commission's work, as it makes evidence-based recommendations relevant to all tiers of government. We see it as a compelling example of quality, comprehensive policy work that requires implementation. The groundbreaking approach to disease control endorsed by COAG and underpinned by the Commission's terms of reference in our view could provide an ideal vehicle for an integrated, whole-of-government plan to implement the NCP's recommendations.

National Cancer Plan

In our view, conversion of the NSIF and NCPP principles* and recommendations into government policy, practice and measurable outcomes could be achieved through the National Cancer Plan, including an implementation strategy built into the National Health and Hospitals Reform process.

The Cancer Council/COSA welcome the \$291 million for items in the 2008-09 budget funded under “the National Cancer Plan”. This substantial funding, some of which is for one-off capital grants, is an enormous net contribution toward reducing the impact of cancer in Australia. We hope the Commonwealth’s reference to a “National Cancer Plan” in the budget statements foreshadows a coordinated national planning process, involving cancer control stakeholders with high-level expertise in public health, clinical care, supportive care and consumer experience. Such a plan would require COAG endorsement, specified funding, measurable targets, mandatory reporting and ongoing evaluation, built into an integrated national approach to cancer control. The recommendations summarised as follows would, in our view, provide the core elements of a strategic National Cancer Plan consistent with the Commission’s brief.

The Commission’s terms of reference, and the long-term objectives of the Rudd Government’s health reform agenda, have great potential to optimise the health system’s capacity to control the unprecedented increase in cancer incidence predicted in Australia over the next 35 years. Our recommendations could all be built into the new health system accountabilities proposed in the Commission’s preliminary report, *Beyond the blame game*.

The Cancer Council Australia/COSA’s recommendations are summarised over the page. The evidence to support these summary recommendations is put forward in the subsequent section, which maps our priorities against the Commission’s terms of reference.

*For copies of the *National Service Improvement Framework for Cancer* and the *National Cancer Prevention Policy 2007-09*, go to:

<http://www.health.gov.au/internet/main/publishing.nsf/Content/pq-ncds-cancer>

www.cancer.org.au/ncpp

Cancer Council Australia/COSA recommendations in summary

Chemotherapy cost-shifting

- Building on preliminary work in Victoria, Queensland and Western Australia, establish a single, integrated, national funding system for cancer pharmaceuticals, with equitable access to public and private patients, inpatients and outpatients.
- Such a system could be an extension of the PBS with additional funds negotiated through the Australian Health Care Agreements, transferring the current piecemeal Commonwealth allocation to public hospital pharmaceutical budgets to the PBS.

Access to radiotherapy

- The 'National Cancer Plan' should include a framework, endorsed by COAG, for implementing the core recommendations of the Baume report, including:
 - Investment in workforce and equipment infrastructure to support the 52.3% of people with cancer who require radiotherapy (see 'Workforce');
 - A national body overseeing accreditation, clinical protocols, benchmarking and coordinating data collection;
 - Resolving the disputes over who should pay for radiotherapy, and tensions between public and private providers, by pooling state, territory and Commonwealth funding for use on a population need basis.
- As part of the 'National Cancer Plan', develop and implement a fully funded, integrated Commonwealth-state plan to build radiotherapy infrastructure in large regional centres according to population need.

Cancer prevention (general)

- It should be noted that Australia's demonstrated under-investment in cancer prevention effectively "shifts" (and substantially increases) a health system cost from the Commonwealth to the states, with a significant net increase in taxpayer costs;
- Cancer prevention requires the integration of research, social marketing, policy reform and government programs. Coordinated prevention strategies, with clear jurisdictional responsibilities, targeted funding, performance measures and mandatory reporting, should be built into the Australian Healthcare Agreements as outlined in the Commission's preliminary report, *Beyond the blame game: accountability and performance benchmarks for the next Australian Health Care Agreements* and foreshadowed in the ALP election policy documents *Fresh ideas future economy – preventative health care* and *New directions in Australia's Health*;

Bowel cancer screening

- The National Bowel Cancer Screening Program should be fully implemented by 2012 as an ideal vehicle for COAG in the context of the Commission's terms of reference;
- The program should be built into the Australian Healthcare Agreements, underpinned by a quality assurance framework (including a communications strategy and biennial re-screening) as indicated by the Federal Minister for Health and Ageing;
- The framework should include all measures necessary to meet a performance benchmark of 70% screening participation rate. This would require jurisdictions agreeing to delineated areas of responsibility, consistent with the Commission's general recommendations on clarifying jurisdictional accountabilities;
- The framework should include building workforce capacity to ensure waiting times for colonoscopy for people with a positive faecal occult blood test are less than 30 days;
- The National Health and Hospitals Reform Commission should recommend that these core requirements for the National Bowel Cancer Screening Program are priority considerations for the Minister for Health and Ageing and the Council of Australian Governments in improving long-term health outcomes in Australia.

Multidisciplinary care

- In consultation with the states, Cancer Australia should develop standard models of multidisciplinary care based on the *National service improvement framework*;
- The National Cancer Plan should include performance indicators to benchmark optimal care according to agreed care standards (as above). Flexibilities should be built into the system to facilitate different models in different environments;
- In consultation with the states, Cancer Australia to establish a national system of accreditation for cancer centres and credentialing of individual practitioners based inter alia on clinical practice guidelines;
- In consultation with professional and consumer groups, the current piecemeal approach to funding some elements of multidisciplinary cancer care through Medicare should be streamlined to foster greater efficiency and maximise professional participation in multidisciplinary teams.

'Comprehensive cancer centres'

- As part of the National Cancer Plan, the benefits of one-off government investments in cancer 'super centres' should be exported to other taxpayer-funded cancer treatment centres through improved teaching, mentoring and data linkages;

Mammography

- A national, coordinated approach to introducing and managing digital mammography as a core element of boosting breast screening participation and improving workforce efficiency;
- The Commission should factor the Commonwealth Department of Health and Ageing's evaluation of the BreastScreen Australia program into its recommendations, to ensure that the national integrity of the program is sustained in the context of the Commission's terms of reference.

Tobacco control

- The next National Tobacco Strategy should be shifted from the Drug Strategy into the healthcare system, consistent with the Government's position on tobacco control as integral to the "Health and Hospitals Reform" process;
- COAG/AHMC should set a target for reducing smoking prevalence by 5% over five years from the commencement of the next National Tobacco Strategy, to help ensure the strategy is supported by a funded implementation plan with mandatory reporting through the healthcare agreements;
- The Commonwealth should seek additional funding for the next National Tobacco Strategy (e.g. through jurisdictional contributions, abolition of duty-free tobacco sales, increases in tobacco tax).

Obesity control

- A comprehensive obesity control strategy be built into the Australian Health Care Agreements/Preventative Health Partnerships;
- Such a strategy should integrate all interventions shown to reduce obesity, including:
 - Social marketing – mass media campaigns, community-based communications programs promoting healthy weight
 - Research – build the evidence base on what works best to reduce obesity; continue to monitor behavioural trends;
 - Policy – marketing reform, e.g. restrict children's exposure to junk food advertising; regulate food labelling to prioritise public health by facilitating more informed choice and preventing deceptive claims; with state and local government, fostering residential and working environments conducive to physical activity
 - Program interventions – support for the primary care sector to encourage healthy weight among patients.

Skin cancer prevention

- The Commonwealth should fund a recurrent commitment to a national skin cancer awareness campaign, consistent with its proposed role as a public health funder in the Preventative Health Partnerships, to invest in the demonstrated positive health, economic and social returns of skin cancer prevention;
- The Commonwealth should continue to show leadership in ensuring all jurisdictions have met their obligations to endorse a nationally consistent regulatory scheme for the operation of solariums in Australia by mid-2008, as announced at the Australian Health Ministers' Conference in April.

Cervical cancer prevention

- Through a re-energised PHOFA process, develop a strategy to ensure Australian women fully understand the importance of Pap testing, irrespective of the HPV immunisation program;
- Explore opportunities to reduce screening costs by reviewing evidence on screening interval in relation to vaccine uptake, age at first screen and the emergence of new technologies; boost education and support to healthcare professionals to reduce early re-screening;
- Increase screening participation rates among under-screening populations, through targeted social marketing and better tailored approaches to service provision;
- Improve the collection of data on the screening of Indigenous women, to evaluate program effectiveness;
- Expedite a whole-of-government strategy to fast-track HPV immunisation to Aboriginal and Torres Strait Islander girls.

Cancer Council/COSA recommendations – onco-geriatrics

- Cancer Australia should work closely with COSA, key stakeholders in onco-geriatrics and health systems design experts to develop linkages between clinical cancer care and aged care services;
- Such approaches should be built into other measures proposed by the Commission to improve the interface between aged care aged care and clinical care in the elderly;
- Cancer Australia and COSA should develop specific cancer care plans for the elderly and establish a recognised subspecialty in geriatric oncology, and scope options to build speciality centres into hospital cancer departments.

Frontline care

- Develop a strategy to integrate cancer-related components of the Commonwealth's general practice agenda (e.g. Super Clinics, simplified Medicare rebates) and Cancer Australia's professional development program into a framework for supporting improved cancer prevention and early detection in the primary care sector;
- This could be boosted through a pilot project, supported by the Cancer Council, NBOCC and AGPN, to further enhance professional support for cancer prevention and early detection in general practice.

Rural/remote oncology

- Whole-of-government recognition of the severity of the disadvantage, particularly among people in remote locations;
- A joint national reform program for rural cancer care built into the health care agreements, with the Commonwealth and the states jointly funding a network of regional cancer centres of excellence in regional cities;
- A joint national approach to improving patient travel and accommodation support, substantially increasing the subsidy, agreeing to national minimum standards and joint measures to reduce cross-border inefficiencies;
- A joint national approach to promoting technical innovation consistent with the Government's 'broadband revolution', such as telemedicine.

Cancer in Indigenous people

- A national strategy developed in consultation with Indigenous groups and built into the Commission's accountabilities;
- A national plan to reduce smoking in Indigenous people, building on the Commonwealth's \$14.5 million budget commitment;
- Increased research to better understand cancer control in Indigenous communities and develop more culturally appropriate responses;
- Fast-tracking of cervical cancer immunisation to girls in Indigenous communities;
- Strategies to increase Indigenous participation in cancer screening programs;
- Strategies to reduce hepatitis infection in Indigenous communities to prevent liver cancer;

Cancer workforce

- As recommended by the Productivity Commission, COAG should invest more in prevention to reduce chronic disease workforce costs;
- The Commonwealth should directly fund training places from a national pool, according to an evidence-based assessment of population healthcare needs;
- Introduce a system of accreditation and credentialing, based on standard competencies and designed to facilitate career paths and staff movement across the system;
- National professional and/or registration bodies to act as accrediting agencies, with models of care approved by Cancer Australia;
- Expand credentialing to include epidemiology, encouraging a whole-of-workforce approach to understanding complex diseases, and to facilitate wider use of clinical practice guidelines;
- Implement The Cancer Council Australia/COSA oncology curriculum model and the National Framework for Cancer Nursing (EdCaN) for skills development in cancer management;
- Continuously review competency standards and scope of practice in training curricula to reflect progress in service models such as multidisciplinary care;
- As recommended by the Productivity Commission, complement lengthy traditional education with streamlined options;
- Expand and support existing training services rather than create new small and dispersed centres;
- Explore innovative and flexible models for clinical training/competency development, such as virtual centres;
- Evaluate and promote cost-effective interventions and new models of care for the delivery of less-complex services (e.g. care coordination, nurse practitioners and nurse-delivered services such as colonoscopy);
- Develop national guidelines on safe and acceptable patient numbers according to workforce capacity matched to population need;
- Foster long-term improvements in the clinical care of Indigenous Australians with cancer by recruiting greater numbers of Aboriginal and Torres Strait Islander people into the medical workforce.

Addressing the terms of reference

a) reduce inefficiencies generated by cost-shifting, blame-shifting and buck-passing;

Overview

The extent of cost-shifting, blame-shifting and buck-passing between Australia's two-tiered health system is well-documented.¹ It is particularly relevant to cancer control, as:

- Cancer is the largest cause of disease burden in Australia, and its control involves all sectors of the health system;
- The majority of health system costs for cancer occur in the hospital system, where “perverse incentives” encourage cost-shifting among administrators, particularly between the states* and the Commonwealth;
- Cancer treatment involves high-cost pharmaceuticals, which are subsidised by the Commonwealth for discharged patients but funded by state hospitals for inpatients;
- Cancer treatment involves specialised imaging and diagnostic services, which are often shifted to the community to attract Medicare subsidy or outsourced to the private sector at higher cost due to staff and infrastructure shortages in public hospitals;
- Cancer prevalence is projected to increase significantly over the next 40 years, along with the emergence of expensive new therapies and heightened patient expectations, suggesting that the systemic problems of controlling cancer are set to be magnified;
- Blame-shifting and buck-passing have characterised the inaction in addressing social inequity in cancer treatment outcomes, particularly the well-documented and unacceptable disadvantage experienced by people in remote locations and Aboriginal and Torres Strait Islander people; and
- Cancer prevention is demonstrably under-funded, in effect shifting the costs of preventable illness from the Commonwealth, which is responsible for national public health programs, to the states, which pick up otherwise avoidable and substantially higher treatment costs through the hospital system.

A probable 30% increase in cancer incidence in Australia every decade until population ageing peaks in the middle of this century suggests that the nation will be unable to afford the current level of systemic dysfunction in cancer control. Eliminating cost-shifting, blame-shifting and buck-passing in cancer control would also improve efficiencies in other disease control.

* The term “states” throughout this submission applies to states and territories.

Eliminating chemotherapy cost-shifting

A well-documented example of cost-shifting is public hospital patients being directed to obtain essential medicines through a GP prescription instead of using hospital supplies. This shifts the cost from the hospital, which receives no direct Commonwealth funding for its pharmaceuticals, to the Commonwealth's Pharmaceutical Benefits Scheme, which subsidises drugs for eligible patients prescribed by GPs. Increase in this practice has coincided with a growth in the use and cost of expensive cytotoxic chemotherapy.²

Under the current Australian Health Care Agreements, the states are also responsible for the cost of drugs for admitted day patients receiving chemotherapy. Cost shifting around these drugs also occurs.

The problem of pharmaceutical cost-shifting is particularly dysfunctional in cancer treatment, as most cytotoxic chemotherapy is high-cost and integral to the length and quality of a patient's life. As well as being inefficient, such cost-shifting leads to sub-optimal care and misuse of medical services, with patients consulting a GP for urgent access to pharmaceuticals at a time when a check up may otherwise not be required. It is also poor use of the doctor's time, with two scripts – one for hospital pharmacy and one for an external pharmacist – written unnecessarily.

In response to widespread recognition of the problem, governments in Victoria, Queensland and Western Australia have undertaken pilot programs to evaluate improving access to the PBS for hospital inpatients, with encouraging results. Victoria was the first to introduce PBS access to patients in a number of participating hospitals in 2001, with a 2004 report showing a generally positive response from stakeholders, with particularly high-level support from oncologists.

The Cancer Council Australia/COSA recommend that these local schemes be built on, through the establishment of a single, integrated, national funding system for cancer pharmaceuticals, with equitable access to public and private patients, inpatients and outpatients. Such a system could be established as an extension of the PBS with additional funds negotiated through the Australian Health Care Agreements, transferring the current piecemeal Commonwealth allocation to public hospital pharmaceutical budgets to the PBS, on the condition that public patients have automatic access to PBS subsidy while inpatients.

Cancer Council/COSA recommendation – chemotherapy cost-shifting

- Building on preliminary work in Victoria, Queensland and Western Australia, establish a single, integrated, national funding system for cancer pharmaceuticals, with equitable access to public and private patients, inpatients and outpatients.
- Such a system could be an extension of the PBS with additional funds negotiated through the Australian Health Care Agreements, transferring the current piecemeal Commonwealth allocation to public hospital pharmaceutical budgets to the PBS.

Improving radiotherapy access

Radiotherapy for cancer is one of the most important examples of an opportunity to reform Australia's health system along the lines of the Commission's terms of reference to improve access to services for those most in need. While radiotherapy is shown to be integral to cancer treatment, inefficiencies throughout the system impede patient access to essential treatment.

As well as being a central modality for more than 40% of successfully treated cancer patients,³ radiotherapy is by far the most cost-effective cancer treatment once a capital investment in infrastructure has been made.⁴ There is strong evidence that 52.3% of all cancer patients should receive radiotherapy at some stage during their treatment.⁵ However, only 34% of cancer patients currently receive radiotherapy, leaving a 40% undersupply. And a significant number of those accessing radiotherapy services experience lengthy delays in starting treatment.^{4,5}

A major Commonwealth review (the Baume report) in 2002 found that around 10,000 people in Australia who required radiotherapy each year did not receive it.⁶ An inadequate supply of radiation oncologists, radiation therapists and medical physicists, along with the problems of using antiquated equipment, continue to cause long waiting times for radiotherapy.⁷ Poor access in regional areas induces some patients to decline treatment altogether or to make choices that may reduce their quality of life (e.g. women in rural areas with breast cancer choosing mastectomy instead of lumpectomy).⁸

Fixing the unacceptable delays in radiotherapy treatment is an ideal service model to demonstrate the effectiveness of the new, more cooperative approach to healthcare reform endorsed by COAG. This will require a cooperative, whole-of-government commitment to genuinely invest in both workforce development and equipment infrastructure.

With more than 50 reviews of radiotherapy in Australia over the past two decades, but very limited progress in addressing the structural impediments to adequate service delivery,⁹ the Commission is well-placed to provide recommendations that would convert policy into practice and fix a longstanding systemic problem.

Baume report

One outcome of the Baume report, *A vision for radiotherapy*, was the formation of the Radiation Oncology Jurisdictional Implementation Group (ROJIG) and, later, the Radiation Oncology Reform Implementation Committee (RORIC).

The Cancer Council Australia/COSA welcomed the establishment of these groups, however their capacity to effect a cohesive, whole-of-government response to the Baume report was restricted. Radiation oncology professionals saw ROJIG and RORIC as a buffer between those who coped with system inadequacies at the coalface and those who made funding decisions. The groups also limited the extent of their consultation with the professions, colleges and consumers. They were also viewed as examples of intergovernmental advisory instruments without a strong mandate to make policy or funding decisions.

As an indication of the gap between policy and implementation, while AHMC endorsed all of the Baume report's major recommendations, fewer than half were funded or built into the system. Notably, a lack of coherent planning and an *ad hoc* approach to funding continue.

Of particular relevance to the Commission, the core problems with radiotherapy access are workforce (see 'Workforce' section) and a lack of central planning. The Baume report states:

'Radiation therapy has suffered most seriously from the fragmentation of responsibilities between different organisations and governments. In itself, this is not unusual in the health care industry, but its effect has also been serious, as this fragmentation of responsibilities is to blame for the lack of action in the past 20 years — even though all parties are in general agreement about what problems need to be addressed.'

The specific problems of radiotherapy access for cancer patients are documented in greater detail in Royal Australian and New Zealand Faculty of Radiation Oncology's submission, which the Cancer Council Australia/COSA support. In the context of our submission, we provide some general recommendations on improving radiotherapy access in accordance with the Commission's remit to provide advice.

A cohesive, national approach to reforming the health system as foreshadowed in the Commission's terms of reference provides an unprecedented opportunity to reduce radiotherapy waiting times for cancer patients in Australia and improve access for rural/regional communities.

The keys are long-term reforms to workforce (see 'Workforce') and a cooperative approach to planning and service delivery, including an intergovernmental commitment to building radiotherapy capacity in regional areas. The Commonwealth's budget commitment of \$15.3 million to increase radiotherapy capacity in Lismore and Cairns, in partnership with the NSW and Queensland governments, is a welcome initiative on which to build.

Cancer Council Australia/COSA recommendations – radiotherapy

- The 'National Cancer Plan' should include a framework, endorsed by COAG, for implementing the core recommendations of the Baume report, including:
 - Investment in workforce and equipment infrastructure in order to provide timely services to the 52.3% of people with cancer who require radiotherapy (see 'Workforce');
 - A national body overseeing accreditation, clinical protocols, benchmarking and coordinating data collection;
 - A targeted approach to improve access to radiotherapy in rural and regional Australia (see 'Regional cancer reform');
 - Resolving the disputes over who should pay for radiotherapy, and tensions between public and private providers, by pooling state, territory and Commonwealth funding for use on a population need basis.
- As part of the 'National Cancer Plan', develop and implement a fully funded, integrated Commonwealth-state plan to build radiotherapy infrastructure in large regional centres according to population need.

Cancer prevention

Cancer prevention is an important example of cost-shifting. While under-resourced and fragmented prevention programs differ from the operational cost-shifting discussed elsewhere in this submission, they are clearly relevant to the Commission's remit: cancer prevention is funded through a disjointed array of federal and state programs, yet the preventable cost of cancer is largely borne by the hospital sector. Under-investment and program fragmentation in one part of the health system causes unnecessarily high costs in another.

Although a third of cancer burden in Australia is attributed to modifiable risk factors,¹⁰ funding for primary prevention accounts for less than half of 1 per cent of overall cancer expenditure. Of the \$2.9 billion spent on cancer in 2000-01 (the most recent national data), only \$130 million was allocated to "non-MBS public health programs".¹¹

In effect, the cost of Australia's under-investment in cancer prevention is "shifted" – and substantially magnified – to hospitals (\$1.9 billion of cancer expenditure in 2001), outpatient medical costs (\$343 million) and pharmaceuticals (\$183 million).

Importantly, the health system's most costly cancer, non-melanoma skin cancer, is almost entirely preventable, while the costs of Australia's second, third and fifth most expensive cancers – breast, bowel and lung cancer respectively – could also be significantly reduced through primary prevention. (An effective approach to preventing the fourth-most costly tumour type, prostate cancer, has not been identified.¹²)

Therefore, in our view there is a clear case for the Commission to recommend increased funding and better targeting of cancer prevention programs in the Australian Health Care Agreements/Preventative Health Partnerships as a way to reduce cost-shifting and overall expenses across the broader health system. This is consistent with the new approach to comprehensive healthcare funding committed to by the Council of Australian Government, the Australian Health Ministers' Conference (in recent communiqués) and foreshadowed by the Commonwealth through the definition of funding streams in the 2008-09 federal budget.

This submission makes specific recommendations for cancer prevention against terms of reference b), c), g) and h). We will provide additional to the National Preventative Health Taskforce. In our view the core policy work on cancer prevention nationally has already been undertaken, through the Cancer Council Australia's *National Cancer Prevention Policy 2007-09*.

Cancer Council/COSA recommendations – cancer prevention (general)

- It should be noted that Australia's demonstrated under-investment in cancer prevention effectively "shifts" (and substantially increases) a health system cost from the Commonwealth to the states, with a significant net increase in taxpayer costs and the social cost of unnecessarily poor health outcomes met by the whole community.

* Mammography is the major program for preventing breast cancer mortality in Australia, accounting for 39% of overall breast cancer expenditure. However, it should be noted that post-menopausal women who are obese or overweight have a 30% increased risk of breast cancer. Investment in obesity control therefore has the potential to complement the investment in mammography to reduce the \$72 million in annual hospital costs for breast cancer.

- Cancer prevention requires an integrated combination of research, social marketing, policy reform and government programs; coordinated prevention strategies, with clear jurisdictional responsibilities, targeted funding, performance measures and mandatory reporting should be built into the Australian Healthcare Agreements as outlined in the Commission's preliminary report, *Beyond the blame game: accountability and performance benchmarks for the next Australian Health Care Agreements* and foreshadowed in the ALP election policy documents *Fresh ideas future economy – preventative health care* and *New directions in Australia's Health*.

Bowel cancer screening

This submission outlines a detailed case for the National Bowel Cancer Screening Program to be a priority recommendation for the Commission, against terms of reference b) and c).

We also advise that delays in the screening program – which was shown to be effective more than a decade ago and was a 2004 Labor and Coalition election commitment – were in part caused by the absence of a joint national approach. There was a delay of almost two years between the previous Commonwealth Government's election commitment to phase in the program (Oct 2004) and the provision of the first screening test (Qld, Aug 2006). This and subsequent delays were in part perceived to be caused by concerns of cost-shifting – i.e. the Commonwealth establishing a national screening program, without committing to support the substantial flow-on costs to state public hospitals (colonoscopy for people with positive tests).

While the current Commonwealth Government has indicated it will contribute to building state colonoscopy capacity, the historical context further emphasises the National Bowel Cancer Screening Program's relevance to the Commission's remit. Failure to fully establish the program by 2012 would be a salient example of cost-shifting, as it has been shown to be cost-effective and delays in its implementation would cause otherwise avoidable hospital costs for the treatment of advanced disease.

Generic examples

Due largely to the inefficiencies and politicisation of Australia's two-tier health system, cost-shifting, blame-shifting and buck-passing to some extent characterise all aspects of sub-optimal cancer control in Australia. Particularly prominent in this context are:

- Multidisciplinary care – there is no structured, national approach to ensure equitable access to multidisciplinary cancer care, despite its provision (on an ad hoc basis) in most state public hospitals and its listing on the Medicare Benefits Schedule;
- Diagnostic/imaging procedures – infrastructure and workforce shortages in public hospitals encourage administrators to shift patients out of the hospital system to receive Medicare-subsided services or to purchase services at higher cost from private providers;
- Specialist services – *ad hoc* joint Commonwealth and state funding for services such as radiotherapy, with the Commonwealth funding capital grants and the states providing recurrent funding for staff, result in blame-shifting when population need is not met;

- New technology – Australia trails comparable economies in the adoption of important new technology such as Intensity Modulated Radiotherapy (IMRT), tomotherapy and brachytherapy, in part because of the Commonwealth/state divide – the states have a clear need for such technology, but lack infrastructure funding due to time lags in acquiring Commonwealth grants. Australia needs an integrated national approach to implementing cutting edge technology if it is to keep pace with other developed nations;
- Cancer Council/COSA advocacy over a number of years for improved treatment outcomes for Indigenous and remote communities has fallen through the divide, with the Commonwealth asserting that cancer treatment is entirely a state issue, despite the need for national leadership; and
- Cancer workforce – workforce shortages underpin all the systemic issues addressed in this submission and are caused in part by an array of inefficiencies associated with the Commonwealth-state divide.

Systemic problems directly relevant to these examples will be addressed against the terms of reference that relate specifically to each.

b) better integrate and coordinate care across all aspects of the health sector, particularly between primary care and hospital services around key measurable outputs for health;

Bowel cancer screening

As shown throughout this submission, the National Bowel Cancer Screening Program is an ideal “fit” for the Commission’s terms of reference and remit, as it will require a joint Commonwealth/state commitment and the integration of a number of health sectors.

The clearest indication that the program will be implemented as part of the Commonwealth Government’s health reform agenda is an announcement from the Minister for Health and Ageing, the Hon Nicola Roxon, that funding for bowel cancer screening will encompass “a national framework that includes workforce planning, training and support; and ensures quality assurance mechanisms are in place... The Government will work with state and territory Governments through the Australian Health Care Agreements to ensure all necessary follow-up services are in place”.¹³ These requirements are directly aligned with the Commission’s remit.

The National Bowel Cancer Screening Program should also be built into the Commission’s recommendations as it:

- is a standing item on the Australian Health Ministers’ Conference agenda;
- is in development and attracted \$87 million in new Commonwealth funds in the 2008-09 budget;
- requires the Commonwealth and state governments to work cooperatively through a national framework;

- links the primary care and hospital sectors; and early detection, early intervention and acute care;
- requires additional workforce and may include flexibilities such as the use of specialist nurses for colonoscopy;
- is shown to be cost-effective;
- has ostensibly been delayed (it was a bipartisan 2004 election commitment) due to lack of clarity between jurisdictions on roles, responsibilities and Commonwealth support for additional colonoscopy services; and
- the Minister for Health and Ageing has announced that the Commonwealth Government is working towards full implementation of the program through the Australian Healthcare Agreements.

Australia's need for an effective national bowel cancer screening program, built on an inter-jurisdictional, quality-assurance framework, is well-documented.¹⁴ Bowel cancer claims more than 80 Australian lives each week¹⁵ and its impact will increase significantly as our population ages. Screening prevents more than a third of bowel cancer deaths among the screened population.¹⁶

Early detection through screening significantly reduces hospital expenditure for bowel cancer. For example, removing a precancerous polyp costs around \$1250, while treatment at a public hospital for cancers that develop from polyps can cost more than \$23,000 per case.¹⁷ In addition, state hospital research shows that up to a quarter of colonoscopies currently performed – at a taxpayer cost of \$120 million per annum – do not follow evidence-based NHMRC guidelines. In the absence of a screening program targeting all Australians aged 50 and over with biennial faecal occult blood tests, colonoscopy is to some extent being misused as a screening tool.

Most importantly, conclusive scientific evidence has been available for more than 10 years showing that population-based bowel cancer screening significantly reduces mortality and morbidity;⁷ recent research also shows bowel cancer screening in Australia would be cost-effective.

The Cancer Council/COSA's core position on the National Bowel Cancer Screening Program is that it should be fully implemented (i.e., biennial screening available to all Australians aged 50 and over) by 2012. This would be 15 years after conclusive evidence of bowel cancer screening's effectiveness was published, 10 years after initial pilot programs in Australia supported that evidence and eight years after the Labor and Coalition parties committed to phasing in the program.

Cancer Council/COSA recommendations – bowel cancer screening

- The National Bowel Cancer Screening Program should be fully implemented by 2012.
- The program should be built into the Australian Healthcare Agreements, underpinned by a quality assurance framework (including a communications strategy and biennial re-screening) as indicated by the Federal Minister for Health and Ageing.

- The framework should include all measures necessary to meet a performance benchmark of 70% screening participation rate. This would require jurisdictions agreeing to delineated areas of responsibility, consistent with the Commission's general recommendations on clarifying jurisdictional accountabilities.
- The framework should include building workforce capacity to ensure waiting times for colonoscopy for people with a positive faecal occult blood test are less than 30 days.
- The National Health and Hospitals Reform Commission should recommend that these core requirements for the National Bowel Cancer Screening Program are priority considerations for the Minister for Health and Ageing and the Council of Australian Governments in improving long-term health outcomes in Australia.

Multidisciplinary care

Evidence shows a multidisciplinary approach to cancer care leads to improved patient outcomes. The value of multidisciplinary care features prominently throughout the National Service Improvement Framework (NSIF) for cancer, endorsed by all jurisdictions in Australia in 2005.¹⁸

According to the NSIF, standards that should be built into a flexible, national, multidisciplinary model should include:

- Case-conferencing for agreement on options for treating each patient;
- Audit systems for collecting information about the care of people with cancer, ensuring care is based on evidence and protocols. Results could be used to develop continuous quality improvement programs;
- Pathways for patients to be invited to participate in clinical trials;
- Protocols for exchange of information among all team members, including general practitioners and community service providers;
- Opportunities for patients to provide feedback about the care received from all team members;
- People with cancer having the opportunity to contribute to the planning of cancer services;
- Protocols to ensure patients can discuss their concerns openly with their treatment team or individual team members;
- Access to an individualised written treatment and follow-up plan;

- Provision of culturally appropriate care; and
- Access to supportive care services including psychologists, psychiatrists and social workers.

Access to some of these services is already provided, but with stark inequities. For example, while most large public hospitals have capacity to provide multidisciplinary care, there is no mechanism to ensure the same level of access is available. While Medicare reimburses the patient for some of these services in the private sector, access remains limited. And people in remote areas and Aboriginal people have severely limited access to this model of care.

Multidisciplinary approaches to cancer care are also recommended throughout the range of clinical practice guidelines developed and endorsed by the National Health and Medical Research Council, the Cancer Council Australia/COSA Australian Cancer Network and the National Breast and Ovarian Cancer Centre.

One option for facilitating multidisciplinary care and the application of clinical practice guidelines is an accreditation/credentialing system, as recommended by the Productivity Commission.

The new health and hospitals reform agenda provides a timely opportunity for all jurisdictions to build on their joint endorsement of the NSIF for cancer and agree to national standards for cancer care developed in consultation with state health departments by Cancer Australia, through its Strategic Forum.

Cancer Council/COSA recommendations – multidisciplinary care

- In consultation with the states, Cancer Australia to develop standard models of multidisciplinary care based on the *National service improvement framework*.
- The National Cancer Plan should include performance indicators to benchmark optimal care according to agreed standards (as above). Flexibilities should be built into the system to facilitate different models in different environments.
- In consultation with the states, Cancer Australia to establish a national system for accreditation of cancer centres and credentialing of individual practitioners based on clinical practice guidelines.
- In consultation with professional and consumer groups, the current piecemeal approach to funding some elements of multidisciplinary cancer care through Medicare should be streamlined to foster greater efficiency and maximise professional participation in multidisciplinary teams.

‘Comprehensive cancer centres’

The Commonwealth’s \$50 million budget commitment to establish a ‘comprehensive cancer centre’ at Sydney’s Royal Prince Alfred Hospital (RPA) is a substantial net contribution to advancing cancer care. In our view this investment has the potential to not only introduce a

range of state-of-the-art technology to RPA, but to also benefit other cancer hospitals, provided the centre at RPA is appropriately networked.

The difficulties accessing optimal cancer care experienced by tens of thousands of Australians (see 'Regional cancer reform') demonstrate the importance of networking cancer treatment centres throughout Australia more effectively. (Such an approach is also in line with the Commonwealth's 'broadband revolution'.)

Consistent with the COAG reform agenda and its focus on better cooperation and integration, benefits from substantial one-off grants such as this should as a matter of course be exported to other taxpayer-funded treatment centres. Building improved teaching, mentoring and data linkages nationwide should be essential to the National Cancer Plan.

Cancer Council/COSA recommendations – 'comprehensive cancer centres'

- As part of the National Cancer Plan, the benefits of one-off government investments in cancer 'super centres' should be exported to other taxpayer-funded cancer treatment centres through improved teaching, mentoring and data linkages.

Digital mammography

The Cancer Council Australia and COSA welcome the Commission's example of 70% breast cancer screening participation as a potential performance benchmark in the Australian Health Care Agreements.

A uniform national approach to phasing in digital mammography, led by the Commonwealth, has the potential to improve breast screening participation rates, as well as deliver a number of other significant benefits. Conversely, the absence of a national approach to adopting this important new technology could be counter-productive in terms of the Commission's proposed breast screening performance benchmark and remit to advise on "integration and coordination across all aspects of the health sector".

It should be noted that digital imaging is already widespread in diagnostic service both public and private. The rest of the health system is going digital and the continued use of analogue technology will shortly become difficult as well as more expensive.

Benefits of digital mammography

Digital mammography has been shown to improve efficiency and cost-effectiveness, boost screening participation and reduce disadvantage for women in remote areas. Specific benefits include:

- digital images can be transferred to any computer network location;
- instant technical and quality analysis for radiographers;

- efficiencies that would mean reduced travelling time, fewer appointments and less anxiety for women in regional areas (e.g. recall to mobile digital units rather than immobile assessment centres, fewer technical repeats, quicker results);
- flexibility in radiology reading practice to reduce strain on an expensive workforce;
- mammograms can be read off-site and remotely, so radiologists do not have to travel to different locations. This would boost efficiency in a limited workforce;
- digital production of a fully electronic integrated patient record (e-record);
- greatly enhanced data management (no need for space-intensive film storage);
- rapid automated digital transfer of results to GPs; and
- potential improvements in the detection of small cancers

The Commonwealth Department of Health and Ageing is exploring digital mammography as part of its evaluation of the BreastScreen Australia program's infrastructure, with a report due in September 2008. We would expect that this evaluation supports the evidence-based case for digital mammography.

Meanwhile, a number of jurisdictions have already commenced unilateral phase-ins of digital mammography, with significant investments in NSW, Victoria and Queensland and initiatives in other states. While the technology's introduction is welcome, localised and uncoordinated approaches to systemic issues such as networking and data management may compromise the long-term effectiveness of digital mammography on a national level.

National leadership is required to ensure consistency, equity and efficiency in the way digital mammography replaces analogue breast screening throughout Australia.

Cancer Council/COSA recommendations – mammography

- A national, coordinated approach to introducing and managing digital mammography as a core element of boosting breast screening participation and improving workforce efficiency.
- The Commission should factor the Commonwealth Department of Health and Ageing's evaluation of the BreastScreen Australia program into its recommendations, to ensure that the national integrity of the program is sustained in the context of the Commission's terms of reference.

Unique patient identifier

The fragmented nature of health data management in Australia and (in some cases) irrational privacy concerns have restricted effective patient monitoring and epidemiological research. The Cancer Council Australia/COSA recommend the introduction of a unique patient identifier for every Australian, with the capacity to continuously monitor their health status (according to strict privacy provisions) and facilitate improved research. This is consistent with the Australian Law

Reform Commission's broad recommendations regarding the current review of privacy law in Australia and the need to make changes in the public interest.

c) bring a greater focus on prevention to the health system;

Cancer prevention: a case for national reform

There are a number of compelling arguments for major systemic change in national cancer prevention policy in Australia. As well as reducing health system costs for cancer (5.8% of total disease expenditure),² improved primary prevention would cut costs elsewhere in the health system, as most behavioural risk factors for cancer apply to other prevalent chronic illnesses such as cardiovascular disease, pulmonary disease, diabetes and kidney disease.

Around one third of cancer burden (measured in disability-adjusted life years) is linked to lifestyle behaviour,¹ yet investment in the primary prevention of cancer accounts for less than half of 1 per cent of total cancer expenditure.²

While Australia is a leader in cancer survival, with more than 60% of patients alive five years after diagnosis,¹⁹ we fall well short of our potential to prevent cancer:

- smoking is the major preventable cause of cancer. A comprehensive approach to tobacco control has been shown to drive down smoking rates, yet almost one in five Australian adults smokes due to demonstrated under-investment in tobacco control;
- obesity and overweight are important preventable causes of cancer. An estimated 7.4 million Australians are obese or overweight, including a quarter of children aged between five and 16.²⁰ Despite the urgent need to reverse the obesity trend to pre-empt a future surge in chronic disease, there is no comprehensive national strategy;
- non-melanoma skin cancer is the most costly cancer for the health system,² while Australia has the world's highest melanoma and NMSC mortality rates.⁷ Both are almost entirely preventable through sun protection, yet there is no national plan to reduce skin cancer incidence in Australia; until 2006, there had never been a national social marketing campaign, and the future of the current skin cancer awareness campaign is not known beyond 2008.
- alcohol is a Group 1 carcinogen,²¹ yet alcohol control policy has historically focused on short-term harm minimisation, overlooking long-term risks such as cancer.

The Cancer Council Australia summarises recommendations for national reform in modifying these risk factors in the context of the Commission's brief as follows. More detail is available in our *National Cancer Prevention Policy 2007-09*, online at www.cancer.org.au/hcpp.

Tobacco control

A Commonwealth Government report released in 2008 estimated the annual social costs of tobacco use in Australia at \$31.5 billion, 56.2% of the total social costs of licit and illicit drug use.²²

Smoking remains the major cause of preventable cancer death and disability, with more than 20% of all cancer burden linked to tobacco. Lung cancer alone accounts for 35% of the total disease burden attributed to smoking.¹

The extraordinarily high cost of smoking and its relevance to the Commission's terms of reference call for a fully funded, national strategy to reduce tobacco use.

National Tobacco Strategy 2004-09

The *National Tobacco Strategy 2004-09* is a quality raft of evidence-based policies. However, despite its endorsement by all jurisdictions the strategy has fallen well short of its potential to reduce the health system costs of smoking, due to the absence of a joint implementation plan, targeted funding and mandatory reporting.

A product of extensive consultation and research, the strategy covers the core elements of effective tobacco control:

- regulation of tobacco
- promotion
- place of sale
- price (through tobacco tax)
- place of use
- packaging
- products
- promotion of Quit and Smokefree messages
- cessation services and treatment
- community support and education
- informing the community
- preventing smoking uptake by children
- addressing social and cultural determinants of health
- tailoring initiatives for disadvantaged groups
- research, evaluation, monitoring and surveillance
- workforce development.

Despite the comprehensive approach supported by COAG through the strategy, an analysis of jurisdictional reporting on the Commonwealth Department of Health and Ageing website²³ shows very limited achievement against these specific goals. Where progress has been made – e.g. policies around place of sale, place of use, addressing social disadvantage – there is significant variation between jurisdictions. Funding for social marketing, pivotal to reducing tobacco use, has also differed markedly, with the Cancer Institute NSW for example showing leadership in that state while a number of other jurisdictions have had no access to media campaigns.

Opportunities outlined in the strategy to reduce tobacco use and generate additional funding for tobacco control programs through increased excise and abolition of duty-free sales have not been pursued. There has been no measurable work done at the national level on product regulation, while reform in areas such as product packaging has gained little traction. A case

could be made that tobacco control policy against every criterion in the strategy has been delayed, overlooked or under-funded.

Emerging opportunities

The Cancer Council publicly commended the Commonwealth Government's budget commitment of \$15 million over four years "to reinvigorate the National Tobacco Strategy".²⁴

With \$12.5 million of this allocation in the forward estimates for the period after the expiry of the current National Tobacco Strategy, we are encouraged by this indication of a down-payment on a future, "reinvigorated" strategy. The strategy's description in the budget statements as part of the "Health and Hospitals Reform" process further indicates a government plan to build tobacco control into the healthcare system, thus removing it from the "Drug Strategy" where in our view it is a poor fit.

We are further encouraged by a government statement in the 2008-09 budget papers that, "the National Tobacco Strategy 2004-09 [is] due to expire in 2009 and significant effort will be invested to evaluate [this strategy] in terms of strengths, weaknesses and the needs of the changing social and economic environment. [The National Tobacco Strategy] exists under the National Drug Strategy, and [is a] cooperative venture between the Australian, State and Territory governments, and the non-government sector".

We will seek opportunities to contribute to this evaluation, in keeping with the strategy's standing as a "co-operative venture" involving the non-government sector. As part of this process, we will also engage with the National Preventative Health Taskforce to promote our detailed tobacco control priorities.

Social marketing

The government's \$15 million allocation to the National Tobacco Strategy over the next four years has the potential to significantly reduce the health system costs of smoking in Australia.

While there is no detail on the government's rationale for the funding schedule (yearly instalments of \$2.5m, \$5m, \$5m and \$2.5m), there is a strong case for seeking additional funds to ensure the taxpayer investment in social marketing yields maximum return.

Research indicates that a \$15 million investment in one year is required to generate sufficient target audience ratings points (TARPs) to significantly reduce smoking prevalence through a media campaign. Increasing the media investment to around \$25 million would buy 700 TARPs per month. A recent US study found that 700 TARPs per month over two years provided better returns on investment in terms of smokers quitting than 400 TARPs per month.²⁵

The Cancer Council recommends that the Commonwealth increases its investment in tobacco control media campaigns as part of its "reinvigoration" of the National Tobacco Strategy, in order to achieve maximum returns. Building the National Tobacco Strategy into the Australian Healthcare Agreements/Preventative Healthcare Partnerships, as foreshadowed in the 2008-09 budget statements, could provide a revenue source by seeking in-kind contributions from the states. As the taxpayer costs of smoking are largely borne by the states through the hospital system,¹² there is a rationale for seeking formal state investment in tobacco control as part of

the strategy. (The recent unilateral investment in social marketing by the NSW Government is an example of how jurisdictional commitments could be integrated into a national approach.)

An additional revenue source for investing in tobacco control media campaigns would be the abolition of duty-free tobacco sales at Australian airports, which would provide an estimated \$25 million per annum.²⁶ Substantially more revenue could be channelled into tobacco control through an increase in tobacco excise, which is also shown to reduce consumption.

Cancer Council Australia/COSA recommendations – tobacco control

- The next National Tobacco Strategy should be shifted from the Drug Strategy into the healthcare system, consistent with the Government's position on tobacco control as integral to the "Health and Hospitals Reform" process.
- COAG/AHMC should set a target for reducing smoking prevalence by 5% over five years from the outset of the next National Tobacco Strategy, with the strategy supported by a funded implementation plan and reporting through the healthcare agreements.
- The Commonwealth should seek additional funding for the next National Tobacco Strategy (e.g. through jurisdictional contributions, abolition of duty-free tobacco sales, increases in tobacco tax).

Obesity control

Obesity/overweight is an important cause of cancer in Australia.¹ It is linked to 11% of colon cancers and 9% of post-menopausal breast cancers.²⁷ These are increasingly prevalent tumour types in Australia due to population ageing.²⁸ A number of rarer cancers are at risk of also becoming prevalent due to their strong association with obesity, notably endometrial cancer (39% attributed to obesity/overweight), oesophageal adenocarcinoma (37%), kidney cancer (25%) and gall bladder cancer (24%). There is also emerging evidence that obesity is associated with increased risk of cancers of the pancreas and liver, and multiple myeloma and non-Hodgkin lymphoma.²⁹

Extrapolating the population ageing trends used by the Australian Institute of Health and Welfare to determine cancer projections beyond 2011 suggests an increase in cancer incidence of around 30% over each decade until the middle of the century.¹⁸ These projections indicate that cancer is set to impose an unprecedented impact on our health system as our population ages – and they do not factor in the effects of a 50% increase in the number of obese or overweight Australians over the past 15 years.¹⁰

A comprehensive national approach to preventing an obesity-related surge in cancer incidence, which is at high risk of compounding the anticipated pressures of population ageing, is urgently required. Moreover, obesity/overweight is an important risk factor for a range of other expensive chronic diseases, with an Access Economics report estimating the health system costs of obesity in 2005 to be \$873 million.³⁰ The total financial costs of obesity were estimated at \$3.7 billion, of which 37% is borne by the Commonwealth. The total health costs from cancer due to obesity were \$107.3 million, with 79% of the costs related to bowel and breast cancers.

Given the social and psychological consequences of obesity, intangible costs such as impaired quality of life are significant, with estimates for obesity-related cancers at \$218 million.²⁰

Reducing obesity must be integral to the “Health and Hospitals Reform” process.

Australia’s ‘obesogenic’ environment

A number of factors contribute to the recent increase in obesity/overweight in Australia. In the past, Australian lifestyles fostered a higher degree of physical activity and restricted food choices. Today there is access to a wide variety of cheap, energy dense/nutrient poor foods that are marketed powerfully; and the population is encouraged, directly or indirectly, to avoid expending energy through physical activity. This has led researchers to describe the environment as ‘obesogenic’, in that it inhibits appropriate dietary and physical activity patterns and encourages energy imbalance.³¹

The evidence base on how to reduce obesity on a population basis is growing, with researchers recommending a range of measures. Table 1 summarises the best options to prevent weight gain based on a framework for a broad portfolio of actions for tackling weight gain prevention.³² This framework considers the level of potential health gain and level of uncertainty of risk associated with different interventions, and adopts the concept of assessing the level of ‘promise’ to judge the worth of interventions.

Table 1 Best options to prevent weight gain

Target setting	Activities
Best options for families	Reduce time spent watching TV and other sedentary behaviours
Best options for early childhood care	Improve parental knowledge and skills through early childhood care facilities Enhance food service policies in early childhood care facilities Enhance policies in early childcare facilities to promote physical activity
Best options for schools	Establish a network of health promoting schools: policy on food and drinks school physical environment physical activity opportunities health education curricula programs for out of school hours care

Best options for active neighbourhoods	Active transport Safe space for exercise facilities Improve access to food options for families
Best options for workplaces	Increase options for incidental physical activity Reduce passive work environments Improve workplace food service options
Best options for primary care	Improve skills and knowledge of health workers
Best options for industry / food supply	Work with local suppliers to reduce fat in common foods Introduce taxation measures and subsidies to make healthy food options cheaper Develop a simplified food labelling system indicating energy and fat content
Best options for media / marketing	Reduce exposure of children to food advertising Implement social marketing strategies to support improvement of parents as healthy role models
Best options for support structures	Improve monitoring of weight and fitness status Implement 'whole of community' demonstration projects

Source: Gill, King & Webb 2005; reproduced from the Cancer Council Australia's National Cancer Prevention Policy 2007-09

Current approaches

Despite the increasingly urgent need to prevent an obesity-related increase in disease burden and Australia's standing in 2007 as the "fifth fattest nation" in the OECD,³³ there is no integrated national strategy to reduce obesity/overweight in Australia. A piecemeal collection of government initiatives, largely funded and administered at the state level, have been in place over a number of years, with limited national coordination and evaluation.

In 2003, a National Obesity Taskforce, with representation from Commonwealth and state health jurisdictions, developed a four-year national action plan for tackling obesity.³⁴ This was preceded by *Acting on Australia's weight: a strategic plan for the prevention of overweight and obesity* (NHMRC 1997), *Eat well Australia: a strategic framework for public health nutrition*, (SIGNAL 2001), and *Be active Australia: a framework for health sector action for physical activity 2005 - 2010*. None has been comprehensive, sufficiently funded nor mandated to address policy issues such as food marketing reform.

Food marketing in Australia operates under co-regulation system, with the Australian Communications and Media Authority responsible for the Children's Television Standards, which include some regulations for limiting food advertising to children. The Advertising Standards Bureau administers industry codes of practice developed by Free TV Australia and the Australian Association of National Advertisers, which add little to the statutory regulations.

Other food policy levers include regulatory systems for food safety and marketing, including Food Standards Australia New Zealand (FSANZ), which is responsible for setting standards for the production and sale of food in Australia.

ABHI

In February 2006, COAG announced a joint \$500 million commitment to health through the Australian Better Health Initiative (ABHI), with a major focus on obesity control. More than two years later, there is no measurable obesity-related outcome to report in relation to ABHI. It is understood initial work on ABHI focused on governance issues around program management across nine jurisdictions. This is reflected in comments from Federal Labor in 2007, that ABHI was "a positive step, but progress is slow".

The Cancer Council Australia welcomes the Commonwealth Government's subsequent commitment to build obesity control into the "Health and Hospitals Reform" process, with modest 2008-09 budget initiatives under this heading seen as a step towards a comprehensive national strategy supported by all jurisdictions through the Australian Health Care Agreements/Preventative Healthcare Partnerships.

The Cancer Council Australia strongly recommends that a comprehensive approach to obesity control policy be adopted, integrating research, social marketing, policy reform and program interventions to maximise return on investment. We will engage closely with the Preventative Health Taskforce to promote our priorities in greater detail.

Cancer Council Australia/COSA recommendations – obesity control

- A comprehensive obesity control strategy be built into the Australian Health Care Agreements/Preventative Health Partnerships.
- Such a strategy should integrate all interventions shown to reduce obesity, including:
 - Social marketing – mass media campaigns, community-based communications programs promoting healthy weight
 - Research – build the evidence base on what works best to reduce obesity; continue to monitor behavioural trends;
 - Policy – marketing reform, e.g. restrict children's exposure to junk food advertising; regulate food labelling to prioritise public health by facilitating more informed choice and preventing deceptive claims; with state and local government, fostering residential and working environments conducive to physical activity

- Program interventions – support for the primary care sector to encourage healthy weight among patients.

Skin cancer prevention

Australia has the world's highest skin cancer incidence and mortality rates, yet skin cancer is almost entirely preventable through appropriate sun protection.³⁵ The case for an ongoing Commonwealth commitment to national skin cancer awareness campaigns to reduce skin cancer burden in Australia is compelling, for a number of reasons:

- at least two in three Australians will be diagnosed with skin cancer, Australia's most common cancer, in their lifetime;³⁶
- skin cancer is the most expensive of all cancers in Australia to treat, costing the health system around \$300 million per annum;
- UV exposure causes around 99% of non-melanoma skin cancers and 95% of melanoma in Australia;^{37,38}
- more than 1,600 Australians dying from skin cancer each year, the majority from melanoma;³⁹
- skin cancer burden is higher among people in rural and regional Australia;⁴⁰
- 380,000 Australians are treated for skin cancer each year⁴¹ – more than 1,000 people per day;
- Skin cancers account for more than 80% of all cancers diagnosed in Australia;⁴²
- Skin cancer costs the health system around \$300 million annually, the highest cost of all cancers.⁴³
- GPs in Australia have nearly 1 million patient encounters per year for skin cancer;⁴⁴
- Regular use of sunscreen during the first 18 years of life is estimated to reduce skin cancer incidence by more than 75%;⁴⁵
- 1,900 premature deaths could be prevented through the SunSmart program over the next 20 years; and
- SunSmart programs have the potential to reduce the number of cases of melanoma by 20,000 and non-melanoma skin cancer by 49,000 over the next 20 years (based on the success of SunSmart programs since 1998) and are shown to deliver net financial benefits.

Current approaches

Until recent years, skin cancer prevention was driven largely by the non-government sector, with Cancer Councils leading in the development of skin cancer campaigns and promoting skin cancer prevention policy and products. Government contributions have varied markedly and have generally been below requirements for effective intervention.⁴⁶

The main focus of skin cancer prevention activity in state governments over the past 20 years has been legislation, regulation and other instruments that require sun protection measures in schools, workplaces and public environments. The Commonwealth also plays a regulatory role.

In 2006-07 the Australian Government funded the first national mass media campaign on skin cancer awareness, with approximately \$5 million.⁴⁶ It consisted of television and print advertisements, as well as radio commercials aimed at educating Australians about the importance of protecting themselves from skin cancer. This phase of the campaign focused on the risks associated with cumulative sun exposure increasing awareness among young Australians of the seriousness of developing skin cancer, while promoting multiple sun protection behaviours as socially acceptable.

An extension to the campaign, into the summer of 2008-09, was funded in the 2007-08 federal budget by the former Howard Government, with the incoming Labor Minister for Health and Ageing, the Hon Nicola Roxon, confirming the commitment within two months of taking office in January 2008. There is no indication of funding for the campaign beyond 2008-09. Independent evaluation of the campaign has shown it to be effectiveness in influencing attitudes that would significantly reduce skin cancer burden.⁴⁷

Benefits of an ongoing commitment

Based on the effect of SunSmart programs since 1988, a national commitment would prevent 20,000 melanoma cases in Australia in the next 20 years and 49,000 cases of non-melanoma skin cancer. This would translate to the prevention of 1,900 premature deaths.⁴⁶

Based on expenditure since 1988, an ongoing national SunSmart program would have a present value cost of \$52 million dollars and anticipated healthcare cost savings of \$58 million (both discounted at 5% per annum). Therefore, the SunSmart program generates a net surplus of around \$7 million. Maintenance of historic investment levels in the SunSmart program (\$0.18 per capita per annum) will yield \$1.13 saved in return for every dollar spent on the program.⁴⁶

Additionally, production gains in the general economy attributable to a national SunSmart program are valued at \$135 million. These results reinforce that an ongoing national SunSmart program would provide strong value for money, not only from a health sector perspective, but also from a broader societal perspective.⁴⁶

Cancer Council/COSA recommendations – skin cancer prevention

- The Commonwealth should fund a recurrent commitment to a national skin cancer awareness campaign, consistent with its proposed role as a public health funder in the Preventative Health Partnerships, to invest in the demonstrated positive health, economic and social returns of skin cancer prevention.

- The Commonwealth should continue to show leadership in ensuring all jurisdictions have met their obligations to endorse a nationally consistent regulatory scheme for the operation of solariums in Australia by mid-2008, as announced at the Australian Health Ministers' Conference in April.

Cervical cancer prevention

Australia has one of the world's lowest cervical cancer mortality rates,⁴⁸ largely attributed to the success of the National Cervical Screening Program. The program's effectiveness is not, however, equitably shared among population groups, with Aboriginal and Torres Strait Islander women in particular screening at significantly lower rates and having around four times the cervical cancer death rate of non-Indigenous women.⁴⁹

While Pap testing is essential to ensuring cervical cancer mortality is minimised, the inclusion of a vaccine for human papilloma virus, which is linked to more than 99% of cervical cancer cases,⁵⁰ will require changes to, and integration with, the National Cervical Screening Program. The inequities in cervical cancer outcomes between Indigenous and non-Indigenous women in Australia also call for targeted approaches to HPV immunisation and cervical cancer screening.

As the Commission's brief includes reviewing inter-jurisdictional frameworks such as the Public Health Outcome Funding Agreements (through which cervical cancer screening is funded), there is an opportunity to build additional rigour, better targeting and achieve cost benefits in cervical cancer screening, and integrate elements of the screening and immunisation programs.

Cancer Council/COSA recommendations – cervical cancer prevention

- Through a re-energised PHOFA process, develop a strategy to ensure Australian women fully understand the importance of Pap testing, irrespective of the HPV immunisation program;
- Explore opportunities to reduce screening costs by reviewing evidence on screening interval in relation to vaccine uptake, age at first screen and the emergence of new technologies; boost education and support to healthcare professionals to reduce early re-screening;
- Increase screening participation rates among under-screening populations, through targeted social marketing and better tailored approaches to service provision;
- Improve the collection of data on the screening of Indigenous women, to evaluate program effectiveness; and
- Expedite a whole-of-government strategy to fast-track HPV immunisation to Aboriginal and Torres Strait Islander girls.

d) better integrate acute services and aged care services, and improve the transition between hospital and aged care;

Geriatric oncology

The problems of Commonwealth/state buck-passing manifest in accommodating frail aged people in acute hospital beds (states picking up a Commonwealth cost) and young people with disabilities residing in aged care homes (vice versa) are well-documented.

Lesser known is the growing problem of cancer in the elderly and its impact on the health and aged care systems. In 2003, the median age of patients diagnosed with cancer in Australia was 67.8 years,⁵¹ with 44% of patients aged over 70 at diagnosis.⁵² With the ratio of Australians aged over 65 years set to double to one quarter of the population over the next 35 years, and lifetime risk of cancer diagnosis now one in two by age 85 in Australian men (one in three for women), the average age of an Australian cancer patient is set to increase significantly.

Despite this increase in Australia's ageing population and in the growth of aged care services, there is no distinct, standalone service delivery vehicle for older cancer patients. There is also little or no crossover between the disciplines of oncology and aged care.

Given the median age of new cancer patients in Australia, it could be said that that *all* oncologists outside paediatrics are 'cancer in the elderly' specialists by default. Yet despite this elderly patient load, evidence suggests that current care providers lack the resources to handle the complex management of an older patient with cancer.

Managing cancer in the elderly has been a priority in Europe and the USA for some years. Groups such as the International Society of Geriatric Oncology (SIOG) and the Geriatric Oncology Consortium (GOC) in the USA have raised the profile of geriatric oncology, providing a catalyst for research. International taskforces working under SIOG have produced a number of clinical practice guidelines, and a considerable amount of research has been undertaken to examine the use of screening and assessment tools for use in older patients.

The current health reform agenda should include as a priority targeted measures to meet the needs of dramatically increasing numbers of elderly cancer patients.

Cancer Council/COSA recommendations – onco-geriatrics

- Cancer Australia should work closely with COSA, key stakeholders in onco-geriatrics and health systems design experts to develop linkages between clinical cancer care and aged care services.
- Such approaches should be built into other measures proposed by the Commission to improve the interface between aged care aged care and clinical care in the elderly;
- Cancer Australia and COSA should develop specific cancer care plans for the elderly and establish a recognised subspecialty in geriatric oncology, and scope options to build speciality centres into hospital cancer departments.

e) improve frontline care to better promote healthy lifestyles and prevent and intervene early in chronic illness;

Cancer control in general practice

The latest national data on cancer in Australia further demonstrates the pivotal role of primary health care professionals. The most common registered cancers diagnosed in Australia in 2006 are all of great significance to general practice. Prostate cancer (e.g. detection advice), colorectal cancer (prevention, screening), breast cancer (prevention, screening etc.), melanoma (prevention, detection etc.) and lung cancer (prevention, detection etc.) all require a range of important advice from the general practice sector that could significantly reduce the impact of cancer in Australia through primary and secondary prevention.

Our recommendations on the core requirements of improved cancer prevention are outlined against term of reference c), some of which include specific measures to involve general practice in cancer prevention. A number of these GP-based interventions could be strengthened by structural reforms that underpin improved professional support for primary care.

Opportunities for improved cancer prevention in general practice are also documented in the three flagship Royal Australian College of General Practitioner publications, referred to in brief as the RACGP “red book”,⁵³ “green book”⁵⁴ and “SNAP”.⁵⁵

While there is limited available evidence on the effectiveness of health promotion through general practice, with studies showing GP prevention advice most effective among high-risk patients,⁵⁶ there has also been limited professional support. However, the Commonwealth’s groundbreaking approaches to healthcare reform indicate a commitment to enhance a broader approach to chronic disease prevention through primary care.

Consistent with this approach, the Cancer Council Australia, the National Breast and Ovarian Centre (NBOCC) and the Australian General Practice Network (AGPN) promoted a joint proposal to Government and Opposition in 2007 to formally support improved cancer control in general practice. Attached for reference, the proposal includes a focus on primary prevention and early detection of cancer through enhanced, structured support for general practice.

The involvement of general practice/primary care is essential to effective cancer control. As well as the role played by GPs and practice nurses in referral pathways and support for people with a cancer diagnosis, primary health care professionals are integral to cancer prevention, early detection and screening.

Emerging and existing initiatives

Current whole-of-government cancer control commitments could be complemented by a structured approach to underpinning the involvement of general practice. Key examples of emerging or existing initiatives, components of which could be integrated to create a strategy for primary and secondary cancer prevention through general practice, include:

- The Commonwealth’s \$275 million investment in GP Super Clinics;
- The Commonwealth’s commitment to “better integrate primary care and other health

services” as part of its GP Super Clinics program;

- The Commonwealth’s commitment to establish a reform process to “simplify Medicare rebates, shift the focus from six minute medicine, and provide incentives for GPs to practice quality, preventative health care”;
- The critical intervention points in the NSIF for cancer, 11 (out of 19) of which are directly relevant to general practice;
- Ongoing Commonwealth support for Cancer Australia to develop its Cancer Service Networks National Demonstration program (CanNET), including opportunities to link with general practice; and the Cancer Professional Development (CPD) program, developing tools to facilitate cancer professional development in GPs;
- The National Bowel Cancer Screening Program, which includes an important role for GPs.

While the Cancer Australia initiatives focus generally on detection and treatment, their targeting of GPs provides an opportunity to extend their scope to include primary prevention and screening.

Developing a strategy to link elements of these programs to improve professional support for general practice to provide cancer prevention and early detection is consistent with the national health reform agenda. Additional support could be provided by the Cancer Council, NBOCC and AGPN, as promoted in our joint proposal.

Cancer Council/COSA recommendations – frontline care

- Develop a strategy to integrate cancer-related components of the Commonwealth’s general practice agenda (e.g. Super Clinics, simplified Medicare rebates) and Cancer Australia’s professional development program into a framework for supporting improved cancer prevention and early detection in the primary care sector;
- This could be boosted through a pilot project, supported by the Cancer Council, NBOCC and AGPN, to further enhance professional support for cancer prevention and early detection in general practice.

f) improve the provision of health services in rural areas;

Rural/remote cancer outcomes – unacceptable inequities

In our view the challenge of reducing the inequities in cancer care outcomes across the rural/metropolitan divide is an ideal “fit” for the Commission’s remit and the Commonwealth’s health reform agenda more generally.

As submitted by our organisations and a number of others in response to the 2007 Senate

inquiry into Patient Assisted Travel and Accommodation, poor access to cancer care for people in remote locations contributes to unacceptably inferior outcomes. In addition to the well-documented decrease in cancer survival correlated with remoteness,^{57,58,59} there is a litany of anecdotes from patients and their families struggling to cope with a cancer diagnosis and life in geographic isolation. For some cancers, remote patients are up to 300% more likely to die within five years of diagnosis.⁶⁰

In parallel with the epidemiological data equating mortality with remoteness, a COSA study of regional oncology services shows that cancer care is less accessible as geographical isolation increases; quality and availability of services by location correlate to survival rates.⁶¹ Reducing this inequity must be a priority for the Health and Hospitals Reform process.

It is therefore encouraging to see the Commission focus on rural/regional healthcare, through its terms of reference and through the statement:

“... Australia’s geography creates other challenges: ensuring an appropriate mix of health and aged care services in regional, rural and remote locations, the workforce to staff them, the support for remote staff, and programs to assist people who need to travel for care. Access for these communities is facilitated with good retrieval services, support with accommodation close to treating facilities and help with transport for visiting family members.”

We also support the Commission’s recommendation to bring performance benchmarks in rural/remote areas in line with those in metropolitan areas (benchmark 9.3). The Cancer Council/COSA have for a number of years been building community and political support for a rural cancer services reform agenda that would significantly reduce inequity of access across the rural/metropolitan divide, by:

- boosting travel and accommodation support;
- better use of communications technology; and
- as the centrepiece of our model, establishing a network of regional cancer centres of excellence that would dramatically reduce the distances remote patients may need to travel by bringing services closer to them.

Flow-on benefits

The problems of diagnosing and treating cancer in regional Australia reflect disadvantages across the healthcare spectrum experienced by rural and remote communities.²⁻⁴ Geographic isolation, shortage of healthcare providers and a higher proportion of disadvantaged groups are acknowledged as general contributing factors.³ Improved cancer care infrastructure in large regional centres would in our view establish a culture of excellence that would attract additional healthcare professionals to such centres.

Opportunities for sustainable equity

Regional cancer centres of excellence present the most cost-effective and sustainable way to provide long-term, measurable improvement in regional cancer care. They would provide

multidisciplinary care, improve support and educational services and, by being mentored by major metropolitan centres, establish a vital link to more remote services.

Returns on investment

The best way to roll out a network of regional cancer centres is to build them where a radiotherapy unit is in place. Radiation oncology is essential to multidisciplinary cancer care. And, while it is costly in capital outlays, it is the most cost-effective in terms of operational cost.⁶² Ten non-metropolitan centres already have units (Coffs Harbour, Port Macquarie, Wagga, Wollongong; Albury-Wodonga, Ballarat, Bendigo, Geelong, Latrobe Valley; and Townsville) and units are flagged for Darwin, the NSW North Coast and Orange. The combined population of these centres is more than 1.5 million and an additional 700,000 people live within a 150km radius.⁶

Some of these facilities already have the core elements of a regional cancer centre of excellence; others have only basic services in addition to their established or planned radiotherapy units. A Commonwealth commitment to working in partnership with the states and territories to co-fund multidisciplinary cancer care in these centres according to local need would ensure investments in radiotherapy hardware deliver optimal returns and reduce long-term cancer survival inequity across the rural/metropolitan divide.

A recent expansion of the cancer centre at Albury-Wodonga has delivered benefits that include an increase in the number of new patients treated locally from 150 to 750 a year, an eight-fold increase in chemotherapy day treatments, multidisciplinary clinics and 10% of new patients participating in a clinical trial.⁶³ A pilot project funded by the Australian Government, with support from the Victorian and NSW governments, showed that a modest investment in improved coordination of services would deliver significant additional benefits for a wide patient catchment area.^{64,65}

Travel and accommodation support

Patient travel and accommodation assistance is an instructive example of health inequity cause by cracks in the Commonwealth/state divide. Formerly a national program, "PATs" was devolved to the states by the Hawke Government in 1986, where the schemes became increasingly fragmented, dysfunctional and under-resourced. Apart from recent modest increases in subsidy level in some jurisdictions, for 20 years most state schemes remained tied to late 1980s funding levels, despite continued rises in CPI and other living costs. While advocates called continually for national leadership to fix the program, the Commonwealth maintained it was a state issue; the states appeared reluctant to fund the schemes according to need without an additional contribution from the Commonwealth.

On 20 September 2007, the Senate completed an inquiry into patient travel and accommodation assistance schemes, recommending major improvements through the Australian Health Care Agreements, with national service standards developed by the Australian Health Ministers' Advisory Committee. The Cancer Council Australia supports the Senate's recommendations,⁶⁶ with added emphasis on the need for a substantial increase in the subsidy level commensurate with need and for Commonwealth leadership to set national minimum standards.

Fixing patient travel and accommodation schemes is integral to improving the quality of life of

people with cancer in rural and remote Australia. It is an opportunity for the next Australian Government to show milestone leadership in helping to ensure Australians in regional areas have improved access to potentially life-saving treatment and care.

Innovative approaches

Australia's vast distances and sparsely populated remote communities will always present challenges for health services. The Cancer Council Australia recommends regional cancer centres and improved patient travel and accommodation be complemented by innovative approaches to strengthen regional cancer care, such as a national quality assurance framework (e.g. service accreditation, the use of clinical practice guidelines) and investment in clinical data systems to audit, monitor and plan services. Telemedicine is another flexible model that should be supported, as it has proven beneficial in reducing the impact of extreme distances.⁶⁷ Distance education and mentoring are also proving effective and should be further supported.⁶⁸

Cancer Council/COSA recommendations – rural/remote oncology

- Whole-of-government recognition of the severity of the disadvantage, particularly among people in remote locations;
- A joint national reform program for rural cancer care built into the health care agreements, with the Commonwealth and the states jointly funding a network of regional cancer centres of excellence in regional cities;
- A joint national approach to improving patient travel and accommodation support, substantially increasing the subsidy, agreeing to national minimum standards and joint measures to reduce cross-border inefficiencies;
- A joint national approach to promoting technical innovation consistent with the Government's 'broadband revolution', such as telemedicine.

g) improve Indigenous health outcomes; and

Cancer control in Indigenous Australians: an urgent priority

Evidence shows Indigenous Australians with cancer are twice as likely to die within five years of diagnosis as non-Indigenous Australians with cancer.⁶⁹ While research on cancer in Indigenous people is limited – which reflects the low priority given to cancer control in Aboriginal people and Torres Strait Islanders – there are important indications of why cancer treatment outcomes for Indigenous people are so much poorer those for non-Indigenous Australians. A study published in 2008, drawing on the latest available data, noted that although inadequate identification of Indigenous people in cancer registers precludes reporting for some parts of Australia, “sufficient information is available to identify priorities and inform appropriate remedial action”.⁷⁰

Indigenous Australians smoke at around 2½ times the rate of non-Indigenous Australians (with 80% smoking prevalence in some communities), causing disproportionately high incidence of

the comparatively high-mortality cancers attributed to smoking. Indigenous people also participate at significantly lower rates in screening programs and are far more likely to present for diagnosis with an advanced cancer and to decline treatment.^{71,72}

A national, cooperative approach

In August 2004, the Cancer Council Australia convened Australia's first ever national discussion forum on cancer control in Indigenous Australians.⁷³ Over two days the forum explored the reasons for poor cancer outcomes in Indigenous Australians across the spectrum from primary prevention to palliative care. Leading clinical and public health experts, Aboriginal community leaders and Indigenous people with cancer agreed on a range of measures needed as part of a national strategy to reduce the impact of cancer in Indigenous people.

Cancer Council Australia/COSA recommendations – cancer in Indigenous people

- A national strategy developed in consultation with Indigenous groups and built into the Commission's accountabilities;
- A national plan to reduce smoking in Indigenous people, building on the Commonwealth's \$14.5 million budget commitment;
- Increased research to better understand cancer control in Indigenous communities and develop more culturally appropriate responses;
- Fast-tracking of cervical cancer immunisation to girls in Indigenous communities (see 'Cervical cancer prevention');
- Strategies to increase Indigenous participation in cancer screening programs; and
- Strategies to reduce hepatitis infection in Indigenous communities to prevent liver cancer.

h) provide a well qualified and sustainable health workforce into the future

Cancer control: a test case for sector-wide workforce reform

Almost 90% of newly diagnosed cancer patients in Australia are aged over 45,⁷⁴ which means population ageing poses an unprecedented challenge in cancer care. Australia's obesity epidemic also threatens to cause a major increase in future cancer incidence.

In addition, cancer patients are surviving for longer, have higher expectations and require increasingly expensive treatments. While these developments are the welcome results of improved treatment technology, they also underscore the need to act now to prepare Australia's cancer workforce for the challenges of the future. Population ageing will also reduce the relative number of clinicians further, as the current medical workforce ages and retires.

With 270,000 Australians currently living with cancer – a figure likely to increase by 30% each decade until population ageing peaks in 40 years⁷⁵ – we must urgently address the key barriers to a sustainable cancer workforce. These include system fragmentation across multiple jurisdictions and agencies compromising efficiency of staff recruitment, training and planning; a lack of standards in training curricula; unstructured career paths; and the overuse of high-cost specialists where other professionals could contribute.

A number of studies show significant shortages of cancer clinicians, including patient-to-specialist ratios well below the recommended benchmarks.⁷⁶ Shortages of allied health practitioners are also well-documented, while accessing healthcare professionals can be particularly difficult for people in remote areas or for Indigenous Australians.⁷⁷ A Productivity Commission study into Australia's health workforce published in 2006 further emphasised the increasingly urgent need to address the deficiency of health workers.⁷⁸ The study reported that:

“... workforce shortages and the increasing demands of an ageing community are placing mounting pressures on Australia's health care system. Improving preventative health care, increasing the number of training places and retaining more of those currently employed are all important strategies, but they don't go far enough.”

While government has responded with *ad hoc* grants to increase training places in a number of disciplines, structural reform is imperative if Australia is to cope with the expectations of an increasingly large population of cancer patients. With Australian men and women facing a one-in-two and one-in-three lifetime risk of a cancer diagnosis, workforce reform must also include measures to improve cancer control competency across the health system.

The current health reform agenda provides a timely opportunity for COAG to endorse structural changes to streamline Australia's inherently fragmented health recruitment, training and placement processes and to ensure all governments work together to fund and support a health workforce responsive to population need.

Cancer Council/COSA recommendations – workforce reform

- As recommended by the Productivity Commission, COAG should invest more in prevention to reduce chronic disease workforce costs.
- The Commonwealth should directly fund training places from a national pool, according to an evidence-based assessment of population healthcare needs;
- Introduce a system of accreditation and credentialing, based on standard competencies and designed to facilitate career paths and staff movement across the system;
- National professional and/or registration bodies to act as accrediting agencies, with models of care approved by Cancer Australia;
- Expand credentialing to include epidemiology and use of clinical practice guidelines;

- Implement The Cancer Council Australia/COSA oncology curriculum model and the National Framework for Cancer Nursing (EdCaN) for skills development in cancer management;
- Continuously review competency standards and scope of practice in training curricula to reflect progress in service models such as multidisciplinary care;
- As recommended by the Productivity Commission, complement lengthy traditional education with streamlined options;
- Expand and support existing training services rather than create new small and dispersed centres;
- Explore innovative and flexible models for clinical training/competency development, such as virtual centres;
- Evaluate and promote cost-effective interventions and new models of care for the delivery of less-complex services (e.g. care coordination, nurse practitioners and nurse-delivered services such as colonoscopy);
- Develop national guidelines on safe and acceptable patient numbers according to workforce capacity matched to population need.
- Foster long-term improvements in the clinical care of Indigenous Australians with cancer by recruiting greater numbers of Aboriginal and Torres Strait Islander people into the medical workforce.

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