Thoracic Oncology Group Australasia

AUSTRALIAN CANCER PLAN SUBMISSION 2023-2033

16 December 2022

We congratulate Cancer Australia on the rigorous consultation process undertaken to develop the First Australian Cancer Plan for implementation over the next 10 years. We agree with the 6 strategic objectives used to describe transformative cancer care and thus have allocated our feedback to each objective in turn.

1. **Maximising Cancer Prevention and Early Detection**

   Predominant focus on modifiable risk factors

   While eliminating racism is important, it is not an objective every Australian can be accountable for cancer control, nor one that will maximise cancer prevention in all Australians. In contrast, every Australian can participate in addressing poor lifestyle habits including smoking (and vaping) cessation, UV exposure, weight management and exercise.

   At a national level, we would support more stringent anti-tobacco campaigns, tighter regulation on vaping and a concerted effort to address weight management than have been outlined in the Australian Cancer Plan.

   No described action due to effects of climate change

   The impact of the environmental change and climate control does not feature in the Australian Cancer Plan. Increased air pollution due to emissions and bushfires have been associated with lung cancer, with the IASLC now encouraging health organisations to meet lowest levels of air emission targets and to advocate for clean air and reduction on fossil fuel emissions.[1] Other leading organisations have classified outdoor air pollution as a Group 1 carcinogen.[2]

   In addition, catastrophic weather events can lead to accidental carcinogen exposure from damaged chemical plants, and, in the short term, can markedly disrupt access to health services for both screening and treatment services, contributing to poorer outcomes in cancer. These impacts are likely to disproportionately affect those in lower socioeconomic status (SES) populations and regional, rural and remote areas.

   With regards to the impact of the environment and addressing modifiable risk factors to prevent cancers, we find that the Australian Cancer Plan statements are not ambitious enough.

2. **Enhanced Consumer Experience**

   Navigation of the healthcare system

   We support this objective as we find health literacy is the greatest determinant of health inequity. However, to overcome this and change the model to patient-centred care will require funding and significant change. In order to drill down to the critical points, it may be worth identifying points in the Optimal Care Pathways where those of low health literacy or from vulnerable communities are most at risk and implementing culturally appropriate navigation aids at these points. For minority groups, consideration should be given to virtual, national 'hubs' where culturally appropriate but specific information can be accessed for each cancer.

3. **World Class Health System for Optimal care**

[1] https://www.iaslc.org/iaslc-news/press-release/air-pollution-and-lung-cancer-iaslc-position-statement#:~:text=IASLC%3A,and%20for%20clean%2C%20sustainable%20energy

[2] https://monographs.iarc.who.int/list-of-classifications

Networked comprehensive cancer care

The development of a national framework for comprehensive cancer care is multi-faceted and includes education, virtual connectivity such as telehealth and teletrials, sharing of resources and expertise where gaps exist in smaller centres and maintaining currency of clinical guidelines. Any networked national framework should first isolate all the networked areas in each cancer that already exist, the gaps and build upon this existing infrastructure. Accountability should be in place for centres who do not avail themselves of infrastructure that provides access to expert care e.g virtual MDT consultations. Maintaining currency of clinical guidelines should be a dedicated, accountable and appropriately resourced role in healthcare.

- A specific action that can be undertaken to ensure accountability includes formal accreditation of sites according to levels of care in the same way Intensive Care Units are accredited for complexity of patient care. This will ensure sites formalise networking links to fill gaps in their service eg Thoracic Surgery, while emphasising their strengths in remaining areas. Thus a top tier comprehensive unit in a particular tumour stream must demonstrate fulfilment of all categories to be accredited at that level. An example of a well-defined excellence standard with independent external accreditation of units is the ENETS Centres of Excellence program [https://www.enets.org/coe.html]. While this model sets a high bar and would be costly and onerous to apply to all cancer centres, its governing principles could be applied for site accreditation and for specific tumour sites seeking accreditation for excellence in specific tumour steams. The OCPs could perhaps be extended to define criteria for minimum standards versus excellence and these criteria could be included as part of hospital/site accreditation.

Reporting quality care indicators as a driver of change

It is well known that collecting and reporting on quality care indicators provides the impetus for hospitals to lobby for funding to improve performance. In order to drive the change to address the current inequity in cancer care, the Federal Government must provide funding for the national collection of quality care indicators (at a minimum those defined in the optimal care pathway, but excellence in care should also encompass diagnostics and treatment that are aligned to world class clinical guidelines) and commit to publishing and providing these to state governments and individual hospitals.

Coordinated survivorship services to feature as an integral component of optimal healthcare systems

We congratulate Cancer Australia on the inclusion of coordinated survivorship services. As our treatment and diagnostics improve the outcomes for cancer patients, it is critical that we implement appropriate models and resources for the unique needs and coordination of survivorship care.

Collection of data, provision of funding and accountability are the key drivers that will deliver optimal cancer and excellence in outcomes. We find that the goals and activities are not ambitious or specific enough to produce transformative change in these areas.

4. Strong and Dynamic Foundations

Supporting research to advance healthcare

Clinical trials should be considered essential to the provision of high-quality cancer care. They should be considered by Local health Districts (LHDs) and Cancer Services Networks as essential to providing high quality care. As such they could be included in site accreditation and performance evaluation (see suggestion above under Item 3: Networked comprehensive cancer care). States and institutions should be mandated to provide minimum core funding to establish and maintain clinical trial unit workforce. Moreover, philanthropic funding and other support obtained to

maintain clinical trial unit activity and financial viability should remain sacrosanct from general hospital funds.

Identifying and allocating resource to the areas of high unmet need to promote equitable care
Collection of quality control indicators as described above will identify geographical areas of unmet need in cancer care. We recognise the inclusion of PROMs to identify individual patients who are experiencing high levels of unmet need so resource can be approportionate and tailored within a hospital, but we feel that this should be implemented within 2 years, not 5 years. We acknowledge that allocating resource between cancers and between aspects of the cancer care journey is difficult, and eagerly await the exploration and testing of innovative approaches to pool and redirect funding to address areas of need in cancer care as outlined in the 5 year activities.

5. Workforce to Transform the Delivery of Cancer Care

Cancer workforce modelling to assess current and predict future areas of workforce undersupply

Collection of quality control indicators will likely highlight areas of inadequate resource that are leading to current low-quality care.

Adoption of research outcomes into routine care is often slow and fragmented and could be enhanced by better focus on implementation research.

Clinical research participation at centre level can and should considered under the proposal for site accreditation, as can maintenance of data and audit as suggested under point 3 above.

At a national level there remains an ongoing unmet need to formally establish a career structure for those entering clinical trials research careers. Currently it is dichotomous and based on either nursing pathways or research pathways (science or other non-nursing graduates) without a specific uniform pathway that encourages career advancement and promotion. Too many clinical research staff are trained within hospital clinical trial units to then be poached by industry. The establishment of a National framework/guidelines for a career in clinical trial research would encourage new members and hopefully enhance staff retention.

Appropriately support primary care as the hub that keeps the spokes together

Primary care plays a key role in survivorship and coordination of referrals to allied health during all stages of treatment. The primary care provider is also the best-positioned healthcare provider to maximise cancer prevention and early detection, which is still the area of lung cancer care that will have the most significant impact on cancer outcomes.

6. Achieving Equity in Cancer Outcomes for Aboriginal and Torres Strait Islander People

Embed culturally safe care within cancer-related services
As a 5 year goal, we feel that this is not ambitious enough. The Optimal Care Pathway for Aboriginal and Torres Strait islander people with cancer has been available since 2018[3]. The guide to implementation of this Optimal Care Pathway has been available since 2020[4]. There are numerous resources, handbooks and communication tips to provide a culturally safe workplace [5].

[3] https://www.canceraustralia.gov.au/publications-and-resources/cancer-australia-publications/optimal-care-pathway-aboriginal-and-torres-strait-islander-people-cancer

[4] https://www.canceraustralia.gov.au/publications-and-resources/cancer-australia-publications/guide-implementing-optimal-care-pathway-aboriginal-and-torres-strait-islander-people-cancer

[5] https://www.canceraustralia.gov.au/culturally-safe-communication-skills-tips-for-non-Indigenous-health-professionals

The NSQHS Standards User Guide for Aboriginal and Torres Strait Islander Health was published in 2017[6], following the adoption of the NSQHS Standards (second edition) the same year[7]. These standards required institutions to have policies, implementation strategies and continual monitoring to address the needs of Aboriginal and Torres Strait Islander People, strategies for a culturally competent workforce, provision of a welcoming and respectful environment and continuing partnerships with Aboriginal and Torres Strait Islander People.

The focus within the next two years needs to already shift to implementation and embedding, with consultation at the local healthcare network level and continuing data collection and stakeholder interviews to optimise implementation. All healthcare professionals and hospitals have a responsibility to provide a culturally safe workplace, and accountability should be pursued through the existing quality standards in healthcare.

We thank Cancer Australia for the opportunity to submit a feedback response and look forward to providing similar input on how many of these activities are best achieved. A commitment to resourcing and agreed activities is integral to the success of the Australian Cancer Plan.

About the organisation making the submission:

The Thoracic Oncology Group of Australasia (TOGA) Ltd is the leading thoracic cancer collaborative trials group in Australia and New Zealand comprising clinicians, health professionals, researchers and patient advocates with an interest in thoracic cancers who collaboratively design and conduct clinical trials in lung cancer, thymic cancers and mesothelioma https://thoraciconcology.org.au/

https://www.canceraustralia.gov.au/affected-cancer/atsi/resources-health

[6] https://www.safetyandquality.gov.au/sites/default/files/migrated/National-Safety-and-Quality-Health-Service-Standards-User-Guide-for-Aboriginal-and-Torres-Strait-Islander-Health.pdf

[7] https://www.safetyandquality.gov.au/sites/default/files/migrated/National-Safety-and-Quality-Health-Service-Standards-second-edition.pdf