Prevention and management of cancer in primary care

Presentation + interactive discussion with DoHA 11am
Wednesday November 7th 2012

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Overview

• Cancer control: why consider primary care?
• Primary prevention
• Screening
• Early diagnosis
• Management and survivorship
• Cancer policy
• Conclusions
Primary care – some key features

- directly accessible, first contact care for unselected health problems
- offers preventive, diagnostic, curative, rehabilitative and palliative services
- holistic approach
- key role in management of multi-morbidity
- emphasises co-ordination and continuity of care
International Cancer Benchmarking partnership: Survival data
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Primary prevention and GPs

• Australians visit a GP five times per year
• Patients expect to receive information and assistance regarding preventive health issues from their primary care providers
• Yet few primary care encounters in Australia involve risk-factor assessment and intervention.

• In 2005–06:
  – 34.6% of general practice encounters were with overweight patients (22.2% being obese)
  – 25.9% with those who drank alcohol at risky levels
  – 17.1% with daily smokers
  – less than one in five patients are routinely asked about their drinking
  – two-thirds are asked about their smoking
  – only up to a third are asked about exercise and physical activity
  – about 15-30% of patients get some form of dietary advice

Centre for Primary Health Care and Equity, UNSW
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Engagement of primary care in cancer screening

• Direct involvement
  – identification and recruitment
  – provision of testing
  – co-ordination of follow-up

• Complementary roles, with centralised programme
  – sharing of tasks
  – endorsement of screening invitations
Improving CRC screening uptake: potential roles for primary care

• Some evidence that primary care can improve uptake – largely from North America
• Endorsement of invitations
• ‘Local Champion’ role
• More extensive feedback on their patients’ participation
• Primary care-based facilitators
• Practice-based promotion of FOBT screening
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## Primary care cancer epidemiology

<table>
<thead>
<tr>
<th></th>
<th>Individual GP</th>
<th>Group Practice</th>
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<tbody>
<tr>
<td>(population)</td>
<td>(1,600)</td>
<td>(10,000)</td>
</tr>
<tr>
<td>New cases p.a</td>
<td>7-8</td>
<td>50</td>
</tr>
<tr>
<td>Patients with cancer diagnosis</td>
<td>30-40</td>
<td>200</td>
</tr>
<tr>
<td>Deaths from cancer p.a</td>
<td>4</td>
<td>25</td>
</tr>
<tr>
<td>Home deaths from cancer</td>
<td>1</td>
<td>6</td>
</tr>
</tbody>
</table>
National Awareness and Early Diagnosis Initiative – key elements

- Achieving early diagnosis by public and patients
  - Raising awareness of cancer, symptoms, importance of early presentation
  - Reducing barriers to early presentation (fear, difficulty accessing GP)
  - Reducing barriers to screening

- Optimising clinical practice and systems
  - Raising awareness of cancer symptoms amongst GPs and other health workers
  - Promoting optimal referral by GPs
  - Optimal screening services

- Improving GP access to diagnostics eg ultrasound, MRI, colonoscopy

- Research, evaluation and monitoring
Barriers to symptomatic presentation

Unpublished findings from ICBP Module 2: Data for England only
Supporting primary care

• Practice visits supported by GP practice profile discussions
• Use of Risk Assessment Tools (7 networks; 165 practices; over 600 GPs)
• Significant Event Audit
• Improved access to diagnostics
### GP Practice Profiles

**Cancer indicators in (X46332) Dr Smith's Surgery, Another PCT (SXX)**

These profiles provide comparative information for benchmarking and reviewing variations at a General Practice level. They are intended to help primary care think about clinical practice and service delivery in cancer and, in particular, early detection and diagnosis. They are not for the purpose of performance management and there are no ‘right or wrong’ answers.

<table>
<thead>
<tr>
<th>Practice population (2008/09):</th>
<th>10,121</th>
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<tbody>
<tr>
<td>PCT population (all practices):</td>
<td>188,907</td>
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#### Demographics

<table>
<thead>
<tr>
<th>Domain</th>
<th>Indicator (Rate or Proportion in brackets)</th>
<th>Practice indicator value</th>
<th>Practice indicator rate or proportion</th>
<th>Lower 95% confidence limit</th>
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<th>PCT mean</th>
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<th>Lowest practice</th>
<th>Range</th>
<th>Highest practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Practice Population aged 65+ (% of population in this practice aged 65+)</td>
<td>1493</td>
<td>14.8%</td>
<td>14.1%</td>
<td>15.5%</td>
<td>17.0%</td>
<td>15.6%</td>
<td>10.1%</td>
<td>24.7%</td>
<td>32.8%</td>
</tr>
<tr>
<td>2</td>
<td>Socio-economic deprivation, “Quintile 1” affluent (% of population income deprived)</td>
<td>Quintile 4</td>
<td>19.6%</td>
<td>18.8%</td>
<td>20.4%</td>
<td>19.7%</td>
<td>15.9%</td>
<td>10.2%</td>
<td>235</td>
<td>973</td>
</tr>
<tr>
<td>3</td>
<td>New cancer cases (Crude incidence rate; new cases per 100,000 population)</td>
<td>51</td>
<td>504</td>
<td>375</td>
<td>663</td>
<td>504</td>
<td>412</td>
<td>235</td>
<td>973</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Cancer deaths (Crude mortality rate: deaths per 100,000 population)</td>
<td>26</td>
<td>257</td>
<td>168</td>
<td>376</td>
<td>276</td>
<td>236</td>
<td>66</td>
<td>503</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Prevalent cancer cases (% of practice population on practice cancer register)</td>
<td>158</td>
<td>1.6%</td>
<td>1.3%</td>
<td>1.8%</td>
<td>1.1%</td>
<td>1.3%</td>
<td>0.3%</td>
<td>2.1%</td>
<td>79.6%</td>
</tr>
<tr>
<td>6</td>
<td>Females, 50-70, screened for breast cancer in last 30 months (3 year coverage, %)</td>
<td>837</td>
<td>70.1%</td>
<td>67.4%</td>
<td>72.6%</td>
<td>71.5%</td>
<td>71.8%</td>
<td>49.7%</td>
<td>77.4%</td>
<td>88.5%</td>
</tr>
<tr>
<td>7</td>
<td>Females, 50-70, screened for breast cancer within 8 months of invitation, %</td>
<td>13</td>
<td>28.9%</td>
<td>17.7%</td>
<td>43.4%</td>
<td>65.5%</td>
<td>74.3%</td>
<td>0.0%</td>
<td>35.3%</td>
<td>59.0%</td>
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<tr>
<td>8</td>
<td>Females, 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage, %)</td>
<td>1964</td>
<td>80.2%</td>
<td>78.6%</td>
<td>81.8%</td>
<td>79.3%</td>
<td>75.4%</td>
<td>65.0%</td>
<td>65.0%</td>
<td>64.8%</td>
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<tr>
<td>9</td>
<td>Persons, 50-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)</td>
<td>541</td>
<td>54.6%</td>
<td>51.7%</td>
<td>57.9%</td>
<td>51.6%</td>
<td>40.2%</td>
<td>35.3%</td>
<td>59.0%</td>
<td>64.8%</td>
</tr>
<tr>
<td>10</td>
<td>Persons, 50-69, screened for bowel cancer within 6 months of invitation, %</td>
<td>292</td>
<td>60.2%</td>
<td>55.8%</td>
<td>64.5%</td>
<td>56.8%</td>
<td>55.1%</td>
<td>40.4%</td>
<td>64.8%</td>
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</tbody>
</table>

#### Cancer Screening

<table>
<thead>
<tr>
<th>Domain</th>
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</thead>
<tbody>
<tr>
<td>11</td>
<td>Two-week wait referrals (Number per 100,000 population)</td>
<td>162</td>
<td>160</td>
<td>1364</td>
<td>1867</td>
<td>1417</td>
<td>1610</td>
<td>157</td>
<td>2599</td>
<td>158.6%</td>
</tr>
<tr>
<td>12</td>
<td>Two-week wait referrals (Number per 100,000 population, Age standardised)</td>
<td>162</td>
<td>100.9%</td>
<td>85.9%</td>
<td>117.7%</td>
<td>70%</td>
<td>11.3%</td>
<td>10.0%</td>
<td>158.6%</td>
<td></td>
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<tr>
<td>13</td>
<td>Two-week wait referrals with cancer (Conversion rate; % of all TWW referrals with cancer)</td>
<td>24</td>
<td>14.6%</td>
<td>10.2%</td>
<td>21.1%</td>
<td>14.5%</td>
<td>11.2%</td>
<td>5.7%</td>
<td>50.0%</td>
<td>85.7%</td>
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<tr>
<td>14</td>
<td>Number of new cancer cases treated (% of which are TWW referrals)</td>
<td>48</td>
<td>50.0%</td>
<td>36.4%</td>
<td>63.6%</td>
<td>44.5%</td>
<td>42.9%</td>
<td>12.5%</td>
<td>702</td>
<td>771</td>
</tr>
<tr>
<td>15</td>
<td>Two-week wait referrals with suspected breast cancer (Number per 100,000 population)</td>
<td>47</td>
<td>464</td>
<td>341</td>
<td>618</td>
<td>359</td>
<td>329</td>
<td>0</td>
<td>702</td>
<td>771</td>
</tr>
<tr>
<td>16</td>
<td>Two-week wait referrals with suspected GI cancer (Number per 100,000 population)</td>
<td>38</td>
<td>375</td>
<td>266</td>
<td>515</td>
<td>270</td>
<td>251</td>
<td>0</td>
<td>209</td>
<td>662</td>
</tr>
<tr>
<td>17</td>
<td>Two-week wait referrals with suspected lung cancer (Number per 100,000 population)</td>
<td>7</td>
<td>69</td>
<td>28</td>
<td>143</td>
<td>70</td>
<td>66</td>
<td>0</td>
<td>209</td>
<td>662</td>
</tr>
<tr>
<td>18</td>
<td>Two-week wait referrals with suspected skin cancer (Number per 100,000 population)</td>
<td>10</td>
<td>99</td>
<td>47</td>
<td>182</td>
<td>146</td>
<td>280</td>
<td>0</td>
<td>209</td>
<td>662</td>
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#### Cancer Waiting Times

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<th>Highest practice</th>
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<tbody>
<tr>
<td>19</td>
<td>In-patient or day-case colonoscopy procedures (Number per 100,000 population)</td>
<td>103</td>
<td>1018</td>
<td>831</td>
<td>1234</td>
<td>877</td>
<td>513</td>
<td>302</td>
<td>1419</td>
<td>1419</td>
</tr>
<tr>
<td>20</td>
<td>In-patient or day-case sigmoidoscopy procedures (Number per 100,000 population)</td>
<td>40</td>
<td>397</td>
<td>252</td>
<td>538</td>
<td>324</td>
<td>360</td>
<td>55</td>
<td>682</td>
<td>682</td>
</tr>
<tr>
<td>21</td>
<td>In-patient or day-case upper GI endoscopy procedures (Number per 100,000 population)</td>
<td>203</td>
<td>1324</td>
<td>1109</td>
<td>1568</td>
<td>1374</td>
<td>999</td>
<td>729</td>
<td>2385</td>
<td>1122</td>
</tr>
<tr>
<td>22</td>
<td>Number of emergency admissions with cancer (Number per 100,000 population)</td>
<td>48</td>
<td>474</td>
<td>350</td>
<td>629</td>
<td>583</td>
<td>691</td>
<td>253</td>
<td>187</td>
<td>1122</td>
</tr>
<tr>
<td>23</td>
<td>Number of emergency presentations (% of presentations)</td>
<td>4</td>
<td>14.3%</td>
<td>5.7%</td>
<td>31.5%</td>
<td>33.7%</td>
<td>23.7%</td>
<td>12.5%</td>
<td>100.0%</td>
<td>87.5%</td>
</tr>
<tr>
<td>24</td>
<td>Number of managed referral presentations (% of presentations)</td>
<td>18</td>
<td>64.3%</td>
<td>45.8%</td>
<td>79.3%</td>
<td>46.8%</td>
<td>48.6%</td>
<td>0.0%</td>
<td>90.0%</td>
<td>50.0%</td>
</tr>
<tr>
<td>25</td>
<td>Number of other presentations (% of presentations)</td>
<td>6</td>
<td>21.4%</td>
<td>10.2%</td>
<td>39.5%</td>
<td>19.4%</td>
<td>27.7%</td>
<td>0.0%</td>
<td>50.0%</td>
<td>50.0%</td>
</tr>
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Cancer Risk Assessment Tools
Overview

- Cancer control: why consider primary care?
- Primary prevention
- Screening
- Early diagnosis
- Management and survivorship
- Cancer policy
- Conclusions
Follow up - why?

- detect cancer recurrence
- treatment side effects, new cancers
- other co-morbid health conditions
- incorporate on-going therapy (e.g., endocrine treatments)
- quality of life issues
- psychosocial issues
- empowerment/self management
Involvement of primary care in cancer follow-up: potential benefits

• evidence that strong primary care can lead to better health outcomes in chronic disease management
• cancer patients have multiple health needs, and require holistic, co-ordinated care
• many primary care practitioners want to have a greater role
• many patients want their family doctor to be involved
• potentially:
  – promotes better-integrated care
  – more cost-effective
Involvement of primary care in cancer follow-up: caveats

- many cancer patients prefer to stay closely linked to hospitals/specialist services
- many problems experienced by cancer patients require specialised skills
- primary care practitioners often reluctant to take on these kinds of responsibilities
- may not have sufficient access to services needed
- quality of primary care varies widely
Cancer Survivorship in Australia
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Primary care: why a limited role in cancer?

• Recognised role in:
  – assessing symptoms and diagnosis
  – delivery of some screening programmes
  – palliative care

• Some noteworthy models of primary care involvement, but typically excluded in ‘conventional’ models of cancer care

• Reasons for limited role in many aspects of cancer journey:
  – perception that management of cancer is high technology and hospital-based
  – territorial issues, perceived lack of necessary skills amongst PCPs
  – lack of integration between primary and secondary care services
  – training, education and workforce issues
Why should primary care have a greater role in cancer prevention?

• Broad-based contribution:
  – education/awareness raising of cancer symptoms
  – promotion and delivery of screening
  – co-ordinating care for complex needs of individuals with cancer
  – primary prevention
  – management of co-morbidities
  – advocacy re poor housing, poor nutrition, inadequate water supplies

• Affordability in low-resource settings
Integrating primary care into cancer control

• National cancer plans need to recognise the potential of primary care in cancer control

• This recognition needs to translate into practical strategies in areas including:
  – primary prevention
  – screening
  – early diagnosis

• Strategies need to address:
  – financial, organisational and attitudinal constraints
  – significant gaps in research and evidence
Acknowledgements..

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• NCRI
• PC4
• Cancer Australia
• UNSW
• Australian Primary Health Care Research Institute
Thanks for your attention!

David Weller

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