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The primary care role for people with cancer

The announcement in January 2009 of funding of \$5.6 million for cancer research and a Primary Care Cooperative Cancer Clinical Trials Group to focus on prevention, detection and care of people with cancer comes after the call by a number of commentators for an expanded role for primary health care in the care of people with cancer. Some recent studies have shown that transfer of care from hospitals and specialists to GPs is safe and effective. However recent Australian research on service design to support cancer care in primary health care is limited, with most research focussing on the differences between care in urban and rural areas. The forthcoming evaluation of the Cancer Service Networks National Demonstration Program (CanNET) will fill a much needed gap in our research knowledge.

An increased role for primary care

New Government funding of \$5.6 million for cancer research was announced by the Prime Minister in January 2009 including funding for a Primary Care Cooperative Cancer Clinical Trials Group to focus on prevention, detection and care of people with cancer.¹

While the prevalence of cancer in the population is not changing, the numbers of new cancer diagnoses are growing due to population increase and ageing.² The number of patients surviving cancer is increasing² and 'survivorship'³ is a growing concept, with cancer being seen as a chronic disease⁴ requiring surveillance for recurrence, psychosocial support and management of complications.

Traditionally the role of the GP in cancer care has been in the areas of prevention, screening, early diagnosis and referral, supportive and palliative care, with most treatment and follow up being carried out in hospitals or by specialists. However, these long term trends are prompting change and there have been calls for increased primary care involvement throughout the entire spectrum from prevention to palliative care.²⁻⁷ In a plenary at the 2007 GP & PHC Research Conference, Cancer Australia CEO Professor David Currow estimated that, if everyone received current best evidence care, cancer outcomes could be improved by 10 to 15%.⁷

Comparison of GP and specialist care

There is growing confirmation that transfer of care to GPs is safe and effective. Trials in the UK and Canada have shown that follow up of breast cancer patients by GPs after treatment is a safe alternative to specialist follow up.^{2,8} An Australian study⁹ comparing the follow up of patients after treatment for colorectal cancer by GPs or by specialist has shown similar recurrence rates and similar time till recurrence.

A study of Medicare data has shown that, compared with specialists, GPs' share of excisions and flap repairs for skin cancer (excluding melanoma) is growing.¹⁰ This increasing role in managing skin cancer may be

explained by early detection campaigns.¹¹ Diagnostic accuracy by GPs has been found to be equivalent to GPs working in skin cancer clinics in one study. Another study¹³ found that GPs and skin cancer clinic GPs had similar excision rates but that the skin cancer clinics may have a higher rate of biopsy and complex skin closures.

Variation in roles and outcomes

At present, cancer outcomes achieved among population groups and between rural and urban areas are highly variable.³ Indigenous Australians experience later diagnoses, lower participation in screening programs and higher mortality rates.^{14,15} Women who have experienced partner violence have also lower screening rates.¹⁶ The BEACH program studied presentations for malignant skin neoplasms between 2002 and 2007 and found that clinical treatment decreased as remoteness increased.¹⁷

A series of studies from Western Australia have highlighted discrepancies in lung cancer care and survival in rural and remote areas.¹⁸ A delay in rural patients presenting to their GP after noticing symptoms led to more advanced cancers at diagnosis and reduced treatment options. More rural patients refused treatment; they had less diagnostic testing, less frequent surgery and experienced travel difficulties. Similar themes were found by a study of patients' experience of colorectal cancer treatment in North Queensland.¹⁹

In Western Australia, rural GPs identified procrastination in scheduling appointments around seasonal workloads, the extended travel required to attend appointments in the city, and loss of earnings as factors which delayed or hindered diagnosis.²⁰ There was poor awareness of danger symptoms as well as a tendency to 'save up' health

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concerns and present multiple problems at one consultation. The confounding effect of multiple health conditions was also identified as a factor.

Screening for colorectal cancer is high on government agendas, with a recent Cochrane Review²¹ update confirming that screening using faecal occult blood tests reduces mortality. Beyond screening, a literature review on the role of GPs in colorectal cancer found that GPs in rural and remote areas play a much larger role than urban GPs.²² This was also the finding of a study in North Queensland.^{19,23} While urban GPs referred their patients to specialists and did not have much contact until after their intensive treatment, rural and remote GPs were more likely to follow their patients through the system, act as advocates and thoroughly 'work up' their patients before referral in order to save time waiting for a colonoscopy. They played a greater role in the coordination of care and in providing procedural care, including chemotherapy. The close relationship can have advantages but the palliative care role can be draining and GPs need greater support than currently exists.

Research on systems of care

Recent Australian research on service design to support cancer care in primary health care is limited.^{3,4} In 2004 a scoping exercise was undertaken by the National Cancer Control Initiative to identify priorities, resources, needs and gaps in support for primary health care professionals.²⁴ Respondents were most positive about diagnosis, referral and screening, timeliness of access, palliation and treatment, but less positive about education and training, multidisciplinary care, timely communication, prevention and supportive care.

A recent project¹⁵ addressed a range of barriers resulting in poorer breast and cervical cancer survival outcomes among Indigenous women. It led to improved systems for coordination and access, GPs' cultural awareness, recall and reminder systems and health promotion. Through community participation in planning and delivery, good communication and partnerships the project achieved increased screening participation, GP awareness and better service collaboration.

The Cancer Service Networks National Demonstration Program (CanNET) has been funded by the Australian Government through Cancer Australia with seven demonstration sites operating during the period February 2007 till May 2009. The program has developed regional managed clinical networks, to coordinate cancer care and includes consumer involvement, linkages between health professionals, continuing professional development, communication and data systems, quality improvement activities and multidisciplinary care.²⁵ Their workshop reports show a number of achievements²⁶ and the program is being comprehensively evaluated but, at the time of printing, no evaluation report has been released.

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