



A new model for Cancer Care in New Zealand

An ageing population, earlier diagnosis and advances in oncology treatment are contributing to a rising number of cancer survivors in New Zealand.* This is placing an unsustainable pressure on oncology services, which has led to the announcement of a new national framework for managing people with cancer. The new model of care focuses on a wider level of involvement in cancer care, for a more diverse range of clinicians, using a tiered approach to treatment, based on patient needs. It is likely that primary care clinicians will play a significant role in this new framework, which is to be implemented within the next three to five years.

The changing face of cancer care

Cancer care centres in New Zealand are under pressure due to limited resources and the increasing need for their services. Over the next 15 years it is predicted this demand will increase significantly.¹ Despite a decrease in age-standardised cancer incidence rates, the need for cancer services is increasing due to an ageing population, earlier diagnosis, improved survival rates and the availability of newer, more targeted chemotherapy medicines. Two-thirds of people diagnosed with cancer can now expect

to live beyond five years, and 80% of people with prostate and breast cancer will be long-term survivors.² The result is that more people are living with a diagnosis of cancer and requiring ongoing treatment, surveillance and support.

Medical Oncology National Implementation Plan

To ease the burden on oncology services, and ensure that services are sustainable for the future, a plan has been devised to set a new national framework for managing cancer treatment and follow-up.³ The plan is to be implemented over the next three to five years.

The plan is separated into three main activities:

1. Devise a four-level service centre model, i.e. set up a system where patients can be directed to one of four types of cancer care service, depending on the complexity of their treatment
2. Establish the workforce needs, i.e. determine the requirements for staffing of the cancer service centres, which will involve oncologists, other clinical and non-clinical roles
3. Define a framework for assessing cancer treatment needs, i.e. formulate a consistent approach to directing patients to the appropriate level of cancer service centre, based on tumour type

Establishing the workforce

In the next 12 months, work will be undertaken on identifying cancer care services that can be devolved

* Survivorship is the term widely used to refer to the period after a patient has completed their cancer treatment, until either recurrence of the cancer or death.

to other clinicians (i.e. non-oncologists). This means defining the scope of practice, training and qualification requirements of the clinicians involved, as well as establishing support and supervisory systems. It is hoped that these clinical roles will be implemented in 2013/14.

A tumour specific approach

The five most common cancers in New Zealand (colorectal, breast, prostate, melanoma and lung) account for 90% of cancer treatment volumes, and an estimated 70% of oncology treatments are considered routine.³ In order to stratify cancer treatment from routine to complex, eight tumour types have been identified. The treatment that a patient with cancer receives, and therefore the place that this treatment is undertaken, will be determined by nationally consistent protocols, based on tumour type.

Cancer service centres

It is proposed that four levels of cancer care service centres are established, to meet the differing treatment needs of patients. General Practitioners and other primary care clinicians are most likely to be involved in Level 1 and 2 centres.

Level 1 cancer care service centres will offer non-complex, low-risk, day-based chemotherapy treatment, as well as education and support for patients and their families/whānau, and follow-up services. In some cases, it is possible that these centres would be part of an integrated general practice clinic, with General Practitioners and nurses involved in provision of treatment and follow-up management. Clinicians would receive appropriate post-graduate theoretical and practical training in order to deliver these services.

Level 2 cancer care service centres will offer all the Level 1 services, plus outpatient clinic care by Senior Medical Officers and Medical Oncologists. In addition, a complex needs co-ordinator will provide support for primary care clinicians caring for patients with cancer.

Level 3 and 4 cancer care services centres provide more complex day-treatment and inpatient (hospital) care.

A streamlined referral process

Although not all primary care clinicians will be a part of delivering specific cancer treatments, all will continue to play a key role in surveillance and detection of cancer, and referral to cancer services.

Improved diagnosis and referral standards will lessen the workload of clinicians providing cancer care. National standards will be devised to ensure that referrals are appropriate, timely and directed to the correct pathway, and clinicians will be given guidance on what supporting information and investigations should accompany the referral.

Roles within the referral pathway will be defined, based on treatment needs. The First Specialist Assessment of patients with cancer categorised as “non-complex” or standard, may potentially be carried out by a General Practitioner or nurse (with training in oncology). Primary care clinicians may also be involved in counselling, education and pre- and post-clinic follow-up, e.g. additional investigations and referrals.


Follow-up after cancer treatment

It is anticipated that General Practitioners (with training in oncology) will have a key involvement in follow-up of patients after cancer treatment, and monitoring for recurrence or other adverse effects of treatment. Protocols will be established for delivering this care and referral pathways and additional support put in place.

Where to now?

The exact specifications of the Medical Oncology National Implementation Plan will unfold over the next 12 months and beyond. The Ministry of Health has set aside funding to support the national and regional infrastructure required to establish and deliver these services. Written communication and face-to-face meetings will take place to discuss and inform key stakeholders of the progress of the implementation plan.

In the meantime, cancer care services will continue to be delivered throughout New Zealand by the six major cancer networks, and primary care clinicians should continue to provide cancer detection, referral and follow-up support as required.

 For further information see: “Medical oncology implementation plan 2012/13”, available from: www.health.govt.nz Keyword search: oncology

The role of primary care in the management of people with cancer

The requirements for the care of people with cancer fit well within the strengths of primary care, and have many similarities with the management of long-term conditions. A systematic review found no difference in patient wellbeing, psychological morbidity or satisfaction between primary and secondary care follow-up of people with breast cancer.⁴

Primary care practitioners are well placed to:

- Provide education and psychosocial support to patients and their families/whānau, which may include referral to community support agencies, e.g. Māori health providers, hospice care, counselling services
- Help to monitor patients' haematological and biochemical status during chemotherapy
- Manage medicines and common chemotherapy and radiotherapy adverse effects
- Perform surveillance to detect cancer recurrence, both local and metastatic
- Anticipate and manage transitions, e.g. from the curative to palliative phase

What are the specific challenges for primary care?

Continuity of care and effective communication are both critical in establishing a partnership between providers for cancer management. Care plans must be established to ensure agreed understanding of

surveillance programmes for individual patients, and criteria and pathways for re-entry back into cancer care services when required.

Information technology will play an important role in managing patients with cancer within the practice. Decision support tools can improve interpretation of cancer markers, and practice based cancer registers can enable pathways of care for surveillance and follow up.

Disparities in cancer-related health outcomes already exist for Māori and people in lower socioeconomic groups.^{5, 6} There is evidence that Māori males have a decreased incidence of cancer (all types), yet have increased mortality from cancer, greater than all other ethnicities in New Zealand.⁷ It is important that the implementation of a new framework does not further compound the problem. Although the Medical Oncology National Implementation plan does not make specific recommendations for reducing disparities, the nationally consistent guidelines for care that will be developed and implemented have the potential to help to address this problem and ensure that the right level of treatment and follow-up is available to every patient with cancer. Primary care clinicians have an important role in ensuring that, in particular, Māori and people in lower socioeconomic groups access cancer care services and that appropriate support is provided to them and their whānau.

References

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