Cancer care urgently needs a real reform engine

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DECLARATIONS

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Introduction

The 2007 Cancer Reform Strategy (CRS)¹ is a bold plan for improving cancer services in the UK. There is much that is positive about it – but can it be achieved in practice? Here we provide a reality check of achieving its goals in the changing NHS landscape. Ageing populations, the increasing incidence and prevalence of cancer, technological acceleration in drug and radiation therapy, and an informed, demanding clientele provide considerable challenges.² The CRS document sets some very clear positive directions – but will there be the drive and funding required to really make it happen? The strategy outlines a model of care building on the 15-year-old hub and spoke model first proposed by the Expert Advisory Group on Cancer in 1993³ and amplified in the NHS Cancer Plan of 2000⁴. It creates a much broader framework incorporating prevention, screening, access to care and survivorship. What are the changes needed to ensure this happens?

The current situation

This year over one-quarter million Britons will be diagnosed with cancer. Today 1.3 million are living with the disease but this could rise to 3 million or more by 2028.⁵ Molecular diagnostics are emerging which will predict cancer risk, pick up early pre-malignant change and provide signatures of response to guide treatment in a personalized manner. Cancer is likely to become a chronic disease, joining conditions such as diabetes, heart disease and asthma. Long-term survival will be normal even for patients with cancers that have spread from their primary site. The political salience of cancer will increase even further, as voters perceive it as the most pertinent issue in health

today.⁶ Continuing progress is likely in surgery, radiotherapy and chemotherapy leading to increased cure but at a price. The completion of the human genome project will bring sophisticated genetic risk assessment requiring careful integration into screening programmes. And excellent palliative care to relieve pain and suffering is now a basic right. The next 20 years will be a time of unprecedented innovation.

It will also be a time of great social change, driven by access to information. People are no longer passive recipients of care but active, empowered partners. At present, 60% of the world's cancer drugs are sold in the United States, home to less than 5% of our population.⁷ But all healthcare systems are struggling to keep up with the burden of ageing populations, novel technology and a much better informed and demanding public.

The short-term outlook for success of the NHS Cancer Plan is mixed. Access to diagnostics, delays in starting treatment, an over 90% under-capacity in radiotherapy provision and a huge problem funding novel drugs used routinely across Europe create massive tensions between doctors, patients and commissioners. No other country actually aspires to a wait of 62 days from referral to treatment – in most it is already less than a week. The EURO-CARE survival figures only go up to 2002 so it is too early to know how successful the Plan has really been.⁸ But there are hints that although we're catching up, British patients are still disadvantaged in terms of survival and yet we are spending comparable amounts per head on cancer compared to neighbouring countries. Clearly there has been some progress in the last few years in terms of improved outcomes.

The relative results are least good for patients with the common cancers – lung, breast, colon and

prostate. For most difficult and rare tumours our results are world-beating suggesting that there's no problem with our skills and technology. Our interpretation is that the common cancer results reflect very deep and generic problems within the NHS. Many are let down by its blind alleys, lack of IT, serial delays and the inequity of decision-making. It's clear that for these cancers the poor have worst results. This is puzzling in a system that is free at the point of delivery. The educated middle class knows how to use the NHS effectively. Their survival advantage is greater than that from any of the high cost drugs that cause so much anxiety. The statistics are clearly desperate in deprived Spearhead Primary Care Trusts⁹ by any standards. Some of the worst results are for patients with lung cancer where the five-year survival rate of 8% compares very poorly with the 12–14% being achieved in most other countries.

A recent study from northern England showed clearly that the number of treatment episodes given to a patient with both radiotherapy and chemotherapy correlated inversely with the distance of their home to a cancer centre. This relationship did not apply to social class one patients who received the highest levels of interventions wherever they live.¹⁰ Again this highlights the huge current inequity of cancer care.

Content of the Cancer Reform Strategy

The model of care set out is highly positive. Key components include:

Prevention: The Report presents evidence that over half of all cases of cancer could be prevented through changes in lifestyle and of the low public awareness of these risks. It aims for stronger programmes for prevention and for vaccination where possible as with HPV virus.

Screening: Extension of the screening programmes in breast and colorectal cancers are suggested although the low compliance rate of either, especially in deprived areas, is not addressed.

Early detection: This is seen potentially as the most effective area in improving outcomes particularly through joint programmes between primary and secondary care. Poor outcomes in lung, colorectal and ovarian cancers can be improved only if they are detected earlier. Yet there are still no agreed programmes for actually

doing this either in the UK or anywhere else even now.

One stop diagnostics: The CRS proposes much quicker and more accessible diagnostics with more joint use with primary care. Presumably this would dovetail well with the polyclinic concept. Many GPs are still sceptical that this is really the way forward.

More intensive treatments in the outpatient setting: The aim is to shift treatment away from inpatient admissions to new kinds of programme in which most patients would have treatment on a day basis with use of hotels for overnight stays. The move is vital to release funding for the other components in the strategy.

Keeping people out of hospital is a major goal of the CRS. Indeed an astonishing £750m per year is to be saved by the creation of an 'inpatient management programme', presumably to fund other aspects of cancer care such as better radiotherapy and chemotherapy.¹¹ This is equivalent to the closure of around 5000 secondary and tertiary care beds in English hospitals or an average of 100 for each of the 50 cancer centres in the country. This is almost certainly not politically possible as in order to get the greatest financial benefit whole hospitals would have to close. This is of course strenuously denied by the Department of Health but there is no other forthcoming explanation of how the money is to be saved.

Patients would have more intensive and longer-term programmes in radiotherapy and chemotherapy. The strategy stresses the gains from rapid access to innovative therapies and from a massive expansion of radiotherapy. It accepts the aim set by the NRAG Report¹² of a 91% increase in radiotherapy fractions by 2015. It calls for a 30% expansion in the number of fractions of radiotherapy to be delivered by 2010. It takes at least two years from the creation of the concept to switching the radiotherapy beam on in the NHS. Yet the only active planning applications for new bunkers are in the private sector.

Improving the patient experience: The CRS envisages new programmes to deal with the personal and social effects of cancer and its treatment. In effect the multidisciplinary team will be supplemented by a programme for much wider co-operation between different professionals to support in a holistic way those living with cancer. Such survivorship programmes are widely practised in the US where their take-up rate is greatest

in the white, middle class, educated population and unpopular in deprived areas. The challenge here is to create a British model, which transcends socioeconomic groups and does not simply allow a new subpopulation of the educated worried well to consume even more NHS resources.

Financing the strategy

The NHS Cancer Plan injected in excess of £500m into cancer services year on year by 2005. Improvements in access and quality of care followed but created new pressures in access to downstream pathways. The balance sheet for the current strategy can be found on the Department of Health website.¹¹ Unfortunately we believe this is Garden of Eden accounting. To make it work requires a massive upfront investment in IT, 24-hour dedicated telephone call services, round the clock facilities for patient assessment and a huge shift in staff attitudes and incentives. To get the savings requires the injection of capital well in advance of the bed closures suggested. This has been omitted from the spreadsheet along with inflation, dramatically rising staff costs and the inevitable surge in the costs of new drugs.

Structural reform

These key stages of the model require a great deal of development and investment. They will only become a reality through strengthening key capabilities. The list of essentials is a formidable. Initiatives such as the expanded GP role in early detection, one stop diagnostics and close to home ambulatory treatment centres hardly exist at present. Care programmes to manage decisions over time are not yet common. The development of these concepts into real programmes will depend on a number of key capabilities. The first is in better communication. Cancer services have been waiting on Connecting for Health for a long time but nothing much seems to have happened. Health teams must now develop their own set of requirements and then find ways of using Connecting for Health resources to deliver them. The first priority for better IT is to produce local metrics on survival and the patient experience where cancer services are way behind renal and cardiac services. The IT capability also has to include better communication with primary care and directly with patients.

Secondly there is a great urgency to improve financial management. Cancer services need to have quarterly information about costs and income. The many complex issues raised by service line reporting are important in the long term – but in the short term cancer services need a simple and regular trading statement or profit and loss account. A far more businesslike approach needs to pervade cancer networks, PCTs and provider units. These include:

- Developing new capability in diagnostics with links between secondary and primary care;
- Collaborating on the real use of care pathways and access services to reduce patient admissions and to provide support nearer to home;
- Planning and managing a large increase in radiotherapy fractions so as to improve access especially for older patients who find it hard to travel and so as to minimize serious problems of side-effects which will be the result of more intensive and longer courses of radiotherapy;
- Developing capability to target the increasing numbers of costly new drug and surgical therapies and to monitor outcomes;
- Developing new programmes jointly with the voluntary sector to significantly improve patient experience.

These developments are the essential parts of a strategy for improving outcomes and the patient experience – but how are they realistically going to be managed and financed?

Policy implications

Policy-makers are baffled that despite huge resources there has hardly been any significant change in the trend decline of amenable mortality of cancer over the last decade. The CRS sets out a very positive model but it does not set out a very clear process for making it happen. The much less publicized *Vision for 2012*, available with some difficulty on the Department of Health website, shows little perception of the tidal wave of future technology or clear implementation plan. The CRS badly needs the drive that can only come from use of reform incentives and systems.

Conclusion

The equation of value equals access plus quality divided by cost is familiar to all consumers of

mobile phones, airline travel or high street shopping. Striving for value through competition and choice eradicates inequity – every patient becomes a valued customer. The CRS needs a commissioning process to lead this drive for value. The Cancer Networks need an explicit role in commissioning services, which would contribute to the new model of care. They would draw on a range of providers both from existing NHS providers and from innovators. Plurality of providers, some taking a global stage, will change the quality and access to care for the better. Patients could be offered choice of access to accredited services. The aim over the next three years must be to invest in a service, which can move from referral through diagnostics to treatment in days rather than weeks. Cancer services are currently seen as too complex and politically sensitive so that only monopoly can produce adequate results for patients. There has been much more progress in improving access in elective care than in the even more vital area of cancer care. The CRS also needs to use the new incentives of world-class commissioning, choice and competition, which the government rightly sees as crucial to the future of the NHS. There is an urgent need for an effective reform engine to make it happen for the benefit of future patients.

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