

Recognising the role of primary care in cancer control

The World Health Report 2008 Primary Health Care (Now More Than Ever) states that, in addition to effectiveness and safety, features of healthcare systems to ensure better health and social outcomes include:

*'...person-centredness, comprehensiveness and integration, and continuity of care, with a regular point of entry into the health system, so that it becomes possible to build an enduring relationship of trust between people and their health-care providers.'*¹

General practice is predicated on these qualities. Against this background, the recently-published *Lancet Oncology* Primary Care Commission report, entitled *The Expanding Role of Primary Care in Cancer Control*, is a welcome and timely initiative.² It presents broad, thorough, and compelling arguments for the recognition and strengthening of engagement of general practice with cancer control, from prevention through post-treatment follow-up and into survivorship or end-of-life care. The Commission report is authored by a distinguished group of primary care clinicians and researchers who have built a strong evidence base for the centrality of primary care in good cancer control. The Commission report highlights the need for integrated models of care with agreed care pathways; effective primary prevention strategies that target known cancer risk factors such as exercise and obesity; new models of access to facilitate earlier diagnosis; the incorporation of electronic clinical decision support tools into clinical software; and support through appropriate undergraduate and postgraduate training.

PRACTICAL IMPLEMENTATION

Implementing the Commission report recommendations will require recognition that health care is a complex system that is continuously adapting to changing environments. There are times when transformational change is possible as multiple reasons for change coincide. This is currently the case in cancer control. Governments and service planners know that common risk factors for many cancers, such as obesity, physical inactivity, and harmful alcohol consumption, are increasing in many communities. They are also acutely aware that the lifetime incidence

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and prevalence of cancer is growing due to ageing populations. Healthcare costs have become unsustainable. The traditional 'capture and no release' approach of specialist cancer services is no longer tenable. As the report states:

*'Health services striving for affordable cancer care seek optimal models of care delivery, which may require the re-engineering of some deeply held socio-medical cultural practices.'*²

In addition, patients and their families seek the best possible care that will maximise their chance of survival and improve their quality of life. They also want care that is affordable and convenient, provided by competent health professionals they trust and who can provide them with the information and support required, from the difficult time of receiving a cancer diagnosis to the years ahead filled with follow-up and various degrees of morbidity and uncertainty.

THE CHANGING ROLE OF THE GP

Simultaneously, there has been renewal of interest in the importance of generalist medical practitioners and the concept of the 'expert generalist'.³ It has been recognised that healthcare systems that have strong primary care as their foundation have better health outcomes and reduced costs.^{4,5} The GP possesses key skills of central importance to cancer control. Generalists work to balance the biotechnical elements of healthcare decision making within the biographical context of each person.⁶ These skills equip the GP for the important role of coordinating care with the patient as the central focus. Why has this role not been realised already? For many patients the GP does play this role, albeit invisibly and without much recognition from specialty services, decision makers, or healthcare

funders. The Commission report sets out the evidence to mainstream this role in cancer control, where the primary care provider ensures whole-person care and is key to smooth transitions between different levels of care.

In addition, primary care has changed dramatically in many parts of the world. No longer is the solo practitioner the norm in primary care; instead, primary care clinics consist of teams of healthcare providers supported by electronic medical records and multidisciplinary care opportunities.

These coinciding factors, driven by both healthcare system and patient need, provide an environment conducive to the development of innovative models of care to improve cancer control. The Commission report places a strong focus on shared care models. Developing these shared care models successfully requires true partnership and will require significant culture change, team work, information management, structured care pathways, and enhanced interprofessional communication. It is useful to look at other areas of health care that have successfully introduced shared care models.

In Australia, a similar problem was successfully addressed in provision of antenatal services. Shared care models had developed quickly in the early 1990s in an attempt to reduce the burden on public hospital antenatal clinics and in response to consumer demand. There had been no systematic approach to the development of the models and while most maternity services offered shared care models, the term 'shared care' meant something different in each location. The Victorian State Government commissioned a review of shared obstetric care and then worked with local health services to develop a more structured approach that was evidence based.⁷ Many lessons were learned from this review that are of direct relevance to

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the introduction of shared care models to cancer control.

The most important, yet challenging, requirement was to foster strong leadership from key opinion leaders in both the hospital and GP sectors to build the culture to support the development of workable shared care models as a legitimate model of care. Implementation required specialists to cede defined responsibilities in defined circumstances to primary care practitioners. Famously, during the review of shared obstetric care, one of the interviewers was told that a leading obstetrician referred to shared care as: 'no-care'. Overcoming such deeply ingrained attitudes was one of the biggest challenges to the successful implementation of shared antenatal care.

THE FUTURE OF SHARED CARE

Those developing shared care models for cancer care will need to be willing to openly and honestly assess the views of those in positions of power and influence, in addition to patients and their families, if new models are to thrive. Interventions to build a culture in which shared care models can flourish are just as important as the actual model of shared care to be introduced.⁸ Once health professionals trust each other innovations can be embraced, while, without this trust innovation and implementation will falter.

Other lessons from shared antenatal care, in addition to building the right culture, were the importance of developing a common understanding of the definition of shared care; development of appropriate structures and guidelines for care, including clear protocols that defined who was responsible for what and when in the programme; resourcing a local coordinating body, with institution and shared care provider representation, which was responsible for maintaining the coordination, standards, and evaluation of the programme; and explicit guidance on patients who were not suitable for the shared care model as well as guidance on communication strategies and record keeping.⁹

Often when building shared care models, much effort goes into developing training for primary care providers to be able to offer quality shared care; however, this can be a major distraction. While some level of training will be required, it is more important to ensure that the shared care models are supported by clear processes and robust system changes that use technology, decision support, and communication channels to facilitate care, rather than rely solely on the training of individual GPs. Information needs to be available 'just in time' and will require the developers of shared care models to work closely with software designers and systems engineers, as well as GPs and other stakeholders, to ensure that the systems that support shared care models allow them to be embedded seamlessly into routine care for all members of the care team.¹⁰ The Commission report also highlights the need for clarity around role definition for those in the care team.

GPs are able to play a central role in cancer control. The Commission report provides the evidence to support this view and sets out an ambitious plan for research and system reform. Primary care is ready for the challenge and the technology and information systems exist to make the vision a reality. Being involved in cancer care is important and rewarding, and GPs will make cancer care better, now more than ever.

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REFERENCES

1. World Health Organization. *The World Health Report 2008: primary health care (now more than ever)*. 2008. <http://www.who.int/whr/2008/en/> [accessed 17 Sep 2015].
2. Rubin G, Berendsen A, Crawford SM, *et al*. The expanding role of primary care in cancer control. *Lancet Oncol* 2015; **16**: 1231–1272.
3. Royal College of General Practitioners. *Medical generalism: why expertise in whole person medicine matters*. 2012. <http://www.rcgp.org.uk/policy/rcgp-policy-areas/-/media/Files/Policy/A-Z-policy/Medical-Generalism-Impact-Report-March-2013.ashx> [accessed 17 Sep 2015].
4. Stange KC. The problem of fragmentation and the need for integrative solutions. *Ann Fam Med* 2009; **7**(2): 100–103.
5. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Q* 2005; **83**(3): 457–502.
6. Gunn JM, Palmer VJ, Naccarella L, *et al*. The promise and pitfalls of generalism in achieving the Alma-Ata vision of health for all. *Med J Aust* 2008; **189**(2): 110–112.
7. Brown S, Dawson WJG, McNair R. *Review of shared obstetric care summary report*. Melbourne: Centre for the Study of Mothers' and Children's Health, La Trobe University, 1999.
8. Greenhalgh T, Robert G, Macfarlane F, *et al*. Diffusion of innovations in service organizations: systematic review and recommendations. *Milbank Q* 2004; **82**(4): 581–629.
9. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists. *Policy Statement on Shared Maternity Care Obstetric Patients in Australia*. RANZCOG, 2014. www.ranzcog.edu.au/doc/policy-statement-on-shared-maternity-care-obstetric-patients-in-australia-wpi-09.html&usg=AFQjCNH2gkCjp_gweNgdMvEUCwKtyo-Lg [accessed 17 Sep 2015].
10. May C, Finch T, Mair F, *et al*. Understanding the implementation of complex interventions in health care: the normalization process model. *BMC Health Serv Res* 2007; **7**: 148.