The Role of Cancer NGOs in Primary Care Policy and Practice for Early Cancer Diagnosis in LMIC settings: A Malaysian Case Study

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# Primary Health Care in Malaysia

<table>
<thead>
<tr>
<th>Public Primary Care</th>
<th>Private Primary Care</th>
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<tbody>
<tr>
<td><strong>Administration</strong></td>
<td>- Stand-alone clinics, group practice clinics or chain clinics.</td>
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<tr>
<td>Part of Ministry of Health structure-staffed by MOH</td>
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<tr>
<td><strong>Structure</strong></td>
<td>- Has one/more permanent General Practitioners- some are family physicians/ many are post medical degree/ 4years government service -no formal referral system</td>
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<tr>
<td>Rural clinics-staffed by nurses</td>
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<tr>
<td>Small Health clinics –staffed by medical officers</td>
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<tr>
<td>Large Health Clinics- staffed by medical officers/family physicians</td>
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<tr>
<td>(Referral system between them)</td>
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<tr>
<td><strong>Geographic spread</strong></td>
<td>Largely centred around urban centres</td>
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<td>Well-distributed all throughout Malaysia-urban and rural</td>
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<tr>
<td><strong>Financing mechanism</strong></td>
<td>Largely Out-of-Pocket, ~20% employer coverage or personal medical insurance</td>
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<tr>
<td>Subsidised, US$ 0.25 per visit to Medical Officer, US$ 1.25 per visit to Family Physician</td>
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# Challenges in Early Cancer Diagnosis in Primary Care

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<th>Private Primary Care</th>
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<tbody>
<tr>
<td>Crowded, Long waiting times</td>
<td>Difficult to convince patients as need to pay for screening tests/regularly</td>
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<tr>
<td>Not often seen by the same HCP</td>
<td>Patients ‘shop’ to different HCPs</td>
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<tr>
<td>Long waiting times for certain screening tests – e.g. colonoscopes</td>
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<tr>
<td>Patients dislike doing screening tests</td>
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Opportunities Arising in the Landscape

Mandatory Continuous Medical Education points for Annual Practising Certificate renewal

Growing awareness and interest in medical-based CSR

Collaborative willingness from industry stakeholders

Engagement with social/community organisations on the ground

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Seizing Opportunities

**Public Primary Care**
- Ministry of Health Partnership

**Private Primary Care**
- Private Hospital Partnerships
- Nationwide GP training programme
Two components: Education and Service Provision

State level- divided at health district levels-
Pilot project at 2 health districts in Federal Territory of KL

**Education:**
-slots for CME in cancer screening & prevention
-delivered to medical officers, primary care physicians & nursing staff
-cover screenable cancers
-School Doctors Programme

**Service Provision**
-fast-track referral service for mammograms/ultrasounds (screening) for primary care patients under health clinic follow-up
-working with community partners

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Private Hospital Partnership

- Win-win situation/ Marketing & Branding versus Education
- Focused on providing education to GPs-source for feeding into the system
- Utilise NCSM’s branding and reputation
- Sessional- Saturday mornings /driven by attendance- CME points –monthly-themed on cancer of the month
- Speakers: NCSM and hospital clinicians
5 workshop sessions in 8 regions all across Malaysia = 40 workshops

- Run by NCSM working together with the Malaysian Medical Association and the Public Health Society

- Over 1 year, speakers= local experts + NCSM

Content: Primary Care Screening and Management of Cancer- tailored for GPs to carry out in their own practice - supported by education materials on web
The role of NGOs in promoting earlier diagnosis and treatment via primary care

Session chair: Sara Hiom
Director of Early Diagnosis and Health Professional Engagement
Cancer Research UK
Background – Non-Communicable Diseases are changing

“Governments and NGOs must take measures to scale up prevention, early detection and diagnosis, treatment, and care services.”

The engagement of Primary Care is therefore increasingly important, with prevention and early diagnosis key.
Evidence demonstrates the importance of the way we diagnose and the stage of diagnosis on survival.

% OF PATIENTS DIAGNOSED

- Via national screening programmes: 6%
- By urgent GP two week wait referral for suspected cancer symptoms: 34%
- By routine GP referral: 25%
- In an emergency, via emergency GP transfer to hospital, as a hospital patient, or via A&E: 21%
- Hospital inpatient or outpatient: 11%
- Unknown data: 3%

STAGE WHEN DIAGNOSED

- EARLY (STAGE I): 63%
- LATE (STAGE IV): 3%
- EARLY (STAGE I): 34%
- LATE (STAGE IV): 22%
- EARLY (STAGE I): 11%
- LATE (STAGE IV): 58%

SURVIVAL BY STAGE AT DIAGNOSIS

= People surviving their cancer for five years or more

DIAGNOSED AT STAGE 1
EARLIEST STAGE

- AROUND 4 IN 10
- EARLY (STAGE I): 34%
- LATE (STAGE IV): 29%
- LUNG: LESS THAN 1 IN 10

DIAGNOSED AT STAGE 4
LATEST STAGE

- AROUND 9 IN 10
- EARLY (STAGE I): 34%
- LATE (STAGE IV): 29%
- BOWEL: LESS THAN 1 IN 10


LET'S BEAT CANCER SOONER
cruk.org

Cancer Research UK’s role in primary care cancer engagement

Dr Richard Roope
Senior Clinical Advisor Cancer Research UK
CRUK/RCGP Clinical Champion for Cancer

Role funded by CRUK
VISION: Transform cancer outcomes via health services to achieve 3 in 4

MISSION: Work with the health system to reduce variation in and accelerate implementation of best practice

OBJECTIVE: Create a supportive environment with providers, commissioners and planners

HOW: Partner to align local, regional and national organisations’ priorities with ours where feasible

OBJECTIVE: Achieve individual professional behaviour change

HOW: Share relevant evidence, insight and intelligence with organisations

OBJECTIVE: Accelerate innovation to support future need

HOW: Co-ordinate and evaluate service innovation

OBJECTIVE: Achieve individual professional behaviour change

HOW: Train, educate and inform about best practice

HOW: Engage health professionals in improvement dialogue
Face to face work in primary care

~75%

Work with local commissioners and planners to influence local plans provide training and drive projects

~20%

Influence regional priorities through strategic relationships

~5%

Independent critical friends

Sustained relationships

Local focus, national connectivity

Bring evidence based and practical learning

work directly with the health system to drive improvement in cancer prevention and diagnosis
Stakeholders attribute our effectiveness to a number of factors…

Impact

Practice outreach

Whole practice approach (Clinical & non-clinical)

Data driven, evidence-based & resource rich

Supportive/non-directive engagement

Staff drive, professionalism and skills

Staff drive, professionalism and skills

Connectedness across the UK

Neutrality/Independence

Data driven, evidence-based & resource rich

Whole practice approach (Clinical & non-clinical)

Supportive/non-directive engagement

Staff drive, professionalism and skills

Connectedness across the UK

Neutrality/Independence

Conclusion of independent evaluation, Healthfocus, 2017

“CRUK Facilitators have played a significant role in introducing and embedding improvement in cancer screening and referral”
CRUK CLINICAL LEADERSHIP PROGRAMME

19 CRUK GPs who deliver real impact

Provide **strategic primary care clinical leadership** and educational resource at regional level

Support SCNs in **improving cancer pathways and reducing variation in care provision** through the sharing of best practice and innovation

Enhance CRUK’s relevance in primary care by **enabling CRUK to engage with and influence primary care** in a systematic way
CRUK strategic partnership with RCGP
‘Cancer as a clinical priority’

- We provide face to face training and education, and e-learning
- We provide position statements and on-line resources
- We ‘influence the influencers’ and input into consultations relating to general practice

How we do it:

- Cascade and Faculty workshops
- E-cigarette position statement
- E-learning modules
- Primary Care Cancer Toolkit
- National Cancer Diagnosis Audit
- RCGP and medical school curriculum
- QI in cancer
- Primary care prevention research
- Conference and posters

www.cruk.org/rcgp
National Cancer Diagnosis Audit 2014

The NCDA combined primary care data with data from the Cancer Registry for patients diagnosed with cancer in 2014 across England to understand pathways to cancer diagnosis.

439 practices from 139 CCGs took part in the audit (this is 5.4% of all practices in England)

17,042 patient records were collected (this is 5.7% of all patients diagnosed with cancer in 2014)

1All cancer diagnoses included except non-melanoma skin cancer

Swann et al. BJGP 2018: https://doi.org/10.3399/bjgp17X694169
Health Marketing to Primary Care Health Professionals

GPs, Practice Nurses & Pharmacists
Key features of our approach to primary care engagement and transferability

• Carried out 'simply’ yet effectively
• Independent and in-house evaluations confirm positive impact at individual clinician and system level
• Testimonies from health professionals show we are valued
• Complementary activities at national, regional & local level
• Relatively inexpensive
• Focus on people and communities
• No need for significant investment/complex infrastructure
The role of cancer NGOs in primary care policy and practice for early cancer diagnosis

Dr Anna Bol tong, (previous) Head of Division, Strategy and Support, Cancer Council Victoria; (future) Associate Director, Victorian Comprehensive Cancer Centre (VCCC)
Prof Jon Emery, Herman Professor of Primary Care Cancer Research, University of Melbourne and VCCC.
**Rural Cancer Initiative: A Guide for General Practitioners**

### Colorectal Cancer

**Which symptoms best predict colorectal cancer?**

- Rectal bleeding
- Unexplained weight loss
- Change in bowel habit
- Appetite loss
- Persistent pain

**Implications for practice**

- Findings on a physical examination, including rectal examination, can significantly alter the probability of colorectal cancer.
- Conducts full blood count in people with possible symptoms of colorectal cancer.

**Risk factors**

- Previous history of colorectal cancer or polyps
- Inflammatory bowel disease
- Family history of colorectal cancer
- Smoking
- Increasing age

**Carcinoid Tumors**

- Carcinoid tumors are rare and are associated with long-term survival.

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**Rural Cancer Initiative: A Guide for General Practitioners**

### Lung Cancer

**Which symptoms best predict lung cancer?**

- Cough for ≥3 weeks or change in nature of cough
- Persistent breathlessness
- Unexplained weight loss
- Unexplained fever

**Implications for practice**

- Perform early CR for those with relevant symptoms.

**Diagnostic pathways**

**Initial investigations**

- CRR (lung markings)
- Sputum cytology (multiple samples are more sensitive, but may be negative)
- FCGR ablation or where normal CRR but symptoms are suspicious
- Request CT Chest with IV contrast and Upper Airway including bronchoscopy

**Risk factors**

- Never or ex-smoker
- Increasing age
- Family history of lung cancer
- Exposure to asbestos
- Occupational exposure to cancer-linked chemicals, such as coal tar

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**Turn over to find out more information**
The RAGE Project

Rapid Access G-I Endoscopy - Colorectal Cancer
A GUIDE FOR GENERAL PRACTITIONERS

PREDICTIVE SYMPTOMS
- Rectal bleeding
- Symptoms of anaemia
- Change in bowel habit
- Abdominal pain
- Unintentional weight loss

RISK FACTORS
- Previous history of colorectal cancer or adenoma
- Inflammatory bowel disease
- Family history of bowel cancer (RACGP Red Book² for risk criteria)
- Inactive lifestyle, obesity, alcohol consumption, smoking
- Increasing age

IMPLICATIONS FOR PRACTICE
- Positive FOBT in National Bowel Cancer Screening Program requires urgent referral.
- Findings on a physical examination including rectal examination can significantly alter the probability of colorectal cancer.
- Conduct a full blood count and iron studies in people with possible symptoms of colorectal cancer.
- A low haemoglobin in the presence of symptoms significantly raises the probability of colorectal cancer.
- FOBT is not an appropriate test for people with symptoms.
- Recent onset of symptoms in patients >40yrs should be viewed with a higher degree of suspicion.
- Consider findings and time since last colonoscopy in assessment of current symptoms.

WESTERN HEALTH REFERRAL PATHWAY

Patient with symptoms suspicious for CR cancer
Download and Complete Rapid Access Referral form* Fax Rapid Access Referral form to 8454 7278
Western Health Rapid Access Endoscopy Service

*http://www.westernhealth.org.au/HealthProfessionals/ForGPs/Pages/Endoscopy.aspx

Figure 1 shows the probability of colorectal cancer for individual symptoms and pairs of symptoms, including second presentation of same symptom.¹
For example, the probability of colorectal cancer for rectal bleeding alone is 2.4%, but rectal bleeding combined with an abnormal rectal exam increases the probability to 8.9%. Two separate episodes of rectal bleeding have a probability of 6.8%.

References:

PPV – Positive predictive value (%) or probability of Ca if Sx present

<table>
<thead>
<tr>
<th>Constipation</th>
<th>Diarrhoea</th>
<th>Rectal bleeding</th>
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<tbody>
<tr>
<td>0.4</td>
<td>0.8*</td>
<td>1.6*</td>
</tr>
<tr>
<td>0.9</td>
<td>1.1</td>
<td>3.4</td>
</tr>
<tr>
<td>1.2</td>
<td>3.0</td>
<td>6.8*</td>
</tr>
<tr>
<td>1.1</td>
<td>1.5</td>
<td>4.7</td>
</tr>
<tr>
<td>1.1</td>
<td>1.7</td>
<td>4.5</td>
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<tr>
<td>0.9</td>
<td>2.6</td>
<td>8.5</td>
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<td>0.9</td>
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<tr>
<td>2.3</td>
<td>2.9</td>
<td>3.2</td>
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PPV as a single symptom

<table>
<thead>
<tr>
<th>Constipation</th>
<th>Rectal bleeding</th>
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<tbody>
<tr>
<td>1.4*</td>
<td>6.9</td>
</tr>
<tr>
<td>3.4</td>
<td>2.7</td>
</tr>
<tr>
<td>6.4</td>
<td>&gt;10</td>
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<tr>
<td>7.4</td>
<td>&gt;10</td>
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<td>1.3</td>
<td>&gt;10</td>
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<td>4.7</td>
<td>&gt;10</td>
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<tr>
<td>1.7</td>
<td>&gt;10</td>
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Probability of cancer
- >5% 1-2%
- 2.5% <1%
- second presentation
Implementation strategy
RAGE: key findings

- Increase in urgent referrals for cancer over time
- Better patient selection
- RAGE referrals associated with shorter waiting time
- Improvements in quality of referrals (no symptoms reported)
I-PACED- Implementing PAthways for Cancer Early Diagnosis

- Following success with RAGE, we approached State Government to expand the model
- Key success factors:
  - Cancer Council branding has prestige and salience with GPs
  - Specialist oncology nurses respected workforce and trusted sources of information
  - Strong practice engagement
  - Tailored primary care tools and resources

- Opportunity through two, sequential academic detailing visits to:
  1. Operationalise recommendations within the Optimal Care Pathways (OCPs)
  2. Sell a new message at the second, follow up visit

- Aim: Increase GPs awareness about critical primary care points along the colorectal cancer and lung cancer OCP and support facilitation of recommended care
Optimal Care Pathways

• Facilitate consistent care based on best evidence and practice

• Guides to optimal care across 15 tumour types for health professionals, including quick reference guides for GPs

• Have become recognised as a “standard of care”

• Encourage concept of an integrated pathway of care

• High level overview of what, where and who

• Emphasises the importance of communication across care sectors and at transition points for patients and carers

• Tool to assist health services, clinicians, service planners, and others to map, plan and benchmark services

• Inform quality improvement projects by identifying gaps
Is colonoscopy the right screening test?

Outcomes for **average risk** population, **without symptoms** (refer to RACGP Red Book for risk criteria).

100,000 people have a **FOBT**
- 7,300 test positive
- 92,700 test negative
- 260 have bowel cancer
- 46 have bowel cancer
- 12 die from bowel cancer
- 7 die from bowel cancer
- 19 deaths
- 10 bleeds
- 5 perforations

100,000 people have no screening
- 306 have bowel cancer
- 60 die from bowel cancer
- 60 deaths

100,000 people have a **colonoscopy**
- 99,709 test negative
- 291 have bowel cancer
- 15 have bowel cancer
- 13 die from bowel cancer
- 2 die from bowel cancer
- 23 deaths
- 140 bleeds
- 68 perforations
Outcomes

Practice visits
- Appointment setting = 4850 phone calls!
- 320 GP practices visited (40% of total); 1108 practice staff educated by Cancer Council nurses

Change in awareness, use of OCPs, confidence, information and support services
- 50% improvement in general awareness of the OCPs.
- 50% improvement in awareness of the specific practice recommendations contained in the OCPs for colorectal and lung cancer.
- An increased likelihood to use the colorectal and lung OCPs to guide their clinical practice.
- Improved confidence in clinical practice related to all clinical areas outlined in the OCPs
- An increased likelihood to refer to cancer prevention or information and support services
Key benefits and resources

Benefits

✓ Leveraged credibility and neutrality of Cancer Council brand
✓ Defined model for engaging the primary care setting
✓ Strengthen relationships across the cancer landscape
✓ Contribute to improved patient outcomes and cancer care

Resources

• The Optimal Cancer Care Pathways and consumer PDFs can be downloaded from www.cancer.org.au/OCP
• Interactive web portal for consumers (‘What to Expect’ guides) at www.cancerpathways.org.au
• The I-PACED GP resource cards can be downloaded from www.cancervic.org.au/for-health-professionals/optimal-care-pathways