AHHA Submission to the BreastScreen Australia Review

Submission

20 February 2024

OUR VISION

The best possible healthcare system that supports a healthy Australia.

OUR PURPOSE

To drive collective action across the healthcare system for reform that improves the health and wellbeing of Australians.

OUR GUIDING PRINCIPLES

Healthcare in Australia should be:

Outcomes-focused
Evidence-based
Accessible
Equitable
Sustainable

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INTRODUCTION

The Australian Healthcare and Hospitals Association (AHHA) welcomes the opportunity to contribute to the BreastScreen Australia Review.

This submission builds on consultation undertaken with health system leaders in developing a blueprint for health reform towards outcomes-focused, value-based health care, and AHHA's operating model of continuously listening to and engaging with the experiences and evidence from our members and stakeholders, as we contribute to the evolution of our health system.

ABOUT THE AHHA

For more than 70 years, AHHA has been the national voice for public health care, maintaining its vision for an effective, innovative, and sustainable health system where all Australians have equitable access to health care of the highest standard when and where they need it.

As a national peak body, we are uniquely placed, in that we do not represent any one part of the health system. Rather, our membership spans the system in its entirety, including – public and not-for-profit hospitals, PHNs, community, and primary healthcare services.

Our research arm, the Deeble Institute for Health Policy Research connects universities with a strength in health systems and services research, ensuring our work is underpinned by evidence.

In 2019, AHHA established the Australian Centre for Value-Based Health Care, recognising that a person's experience of health and health care is supported and enabled by a diverse range of entities, public and private, government and non-government. The Centre brings these stakeholders together around a common goal of improving the health outcomes that matter to people and communities for the resources to achieve those outcomes, with consideration of their full care pathway.

Through these connections, we provide a national voice for universal high-quality health care. It is a voice that respects the evidence, expertise, and views of each component of the system while recognising that siloed views will not achieve the system Australians deserve.

OUR RESPONSE

Q1. What are the biggest opportunities for breast cancer screening in Australia? What are the biggest challenges?

To achieve a healthy Australia supported by the best possible healthcare system, services must reorient their focus from volume to value in the provision of care to ensure the right care is provided in the right place, at the right time.

Value-Based Health Care (VBHC) is an evidence-based framework for health system reform, focused on facilitating improvements in the outcomes that matter to people and communities for the cost of achieving these improvements, across a full pathway of care. It presents a person-centred approach to support healthcare decision-making and system transformation linked to desired outcomes at the level of the individual (micro), the care pathway (meso) and the population (macro).

VBHC can inform the design and provision of risk-based screening services, identified as an area of opportunity for BreastScreen Australia within this Review and the Roadmap for Optimising Screening in Australia – Breast Project (ROSA Project) Summary Report. By personalising care and prioritising those at high-risk of breast cancer, risk-based screening can not only reduce illness and death from this form of cancer among a larger part of the population, but also reduce the unnecessary use of clinical resources, prevent the limited cancer workforce from being further strained, and minimise unwarranted, low-value care[1].

As identified in the Roadmap for Optimising Screening in Australia – Breast Project (ROSA Project), transitioning a well-established national program like BreastScreen Australia from an aged-based model with limited risk-based screening variations between States and Territories, to a nation-wide risk-based screening model is a major undertaking[2]. To ensure success and open up opportunities for innovation and quality improvement, the biggest challenges we must counter include:

- Supply and readiness of the health workforce;
- Effective collection of standardised data on evidence-based, fit for purpose and suitably chosen indicators of risk, outcomes and costs of care;
- Interoperability of health record systems; and
- Development of linked data.

Recent research can help inform efforts to overcome the challenges of data linkage[3] and protect against data breaches[4]. Linked data on risks, outcomes, and costs of care between the providers, services and sectors that interact with consumers across the care pathway can help to inform the design and delivery of future screening programs. For instance, the future opportunities data linkage can enable include:

- Benchmarking to inform quality and safety improvements.
- The use of artificial intelligence (AI), perhaps in the form of a 'proactive, national, artificial intelligence-powered, real-time patient outcome monitoring system'[5].
- Better care pathway integration and coordination between BreastScreen Australia, primary care, family cancer clinics and other related services.

Q4. How could BreastScreen Australia be more effective in detecting breast cancer early and saving lives? Do you have any related research or evidence to share?

AHHA proposes that a risk-based screening model of care would not only be more effective in detecting breast cancer early, but more efficient, granted that it is supported through an engaged, person-centred workforce.

The Deeble Institute Perspectives Brief, 'Risk based cancer screening: the role of primary care', explores the potential challenges in transitioning from an aged-based to risk-based screening model without the support of the primary care workforce[6]. It highlights that implementation of a risk-based screening model would be impeded by an already limited cancer care workforce that is inadequately prepared to meet the health literacy demands of consumers who may misunderstand their cancer risk, impeding their acceptance of and engagement in risk-based screening.

Effective risk communication by practitioners in primary care settings is an essential component of transitioning to a risk-based screening process. In its absence, individuals may misunderstand their personal risk and become reactive to changes in the broader screening requirements, or apathetic in their self-assessment of risk[7]. The provision of person-centred care that is respectful of, and responsive to, the preferences and needs of the individual in the communication of risk can only occur when providers work together with a shared focus on a person's needs, and with collective ownership of the goals to be achieved[8].

Q6. What changes would ensure the Program is responsive to future evidence of best practice screening?

Learning health systems are an emerging method of driving innovation and value-based health care, having been identified as 'the next stage in quality improvement' and 'what is required to find a sustainable way out of the current crisis'[9]. They are defined as 'a systematic approach to iterative, data-driven improvement', where a learning community is 'formed around a common ambition of improving services and outcomes'[10].

Learning health systems provide a framework that could guide BreastScreen Australia to be responsive to and anticipate the needs of consumers engaging in screening services, to build a continuous learning environment that enhances efforts to improve screening engagement rates.

While there are many examples of such learning health systems, there is significant variation in approaches. Research in the UK[11] has identified four important areas for achieving tangible progress:

- Learning from data
- Harnessing technology
- Nurturing learning communities
- Implementing improvements to services.

1. *Learning from data:*

Data is a key component of achieving high-quality, high-value, safe and equitable care and is a foundational component of a learning health system. Bringing together information from different sources in a way that is easy to understand and act on is important, particularly for supporting care decisions for people with chronic and complex health needs[12]. It must also be brought together in a way that facilitates an understanding of both outcomes and costs.

2. *Harnessing technology:*

Interoperability among Australia's digital health technologies is immature. This issue, recognised by the Australian Digital Health Agency[13], hinders continuous learning and improvement for teams across full care pathways. While the technology itself may have been available for decades, its effective and sustainable implementation requires sector wide collaboration that blends the necessary national policies (e.g., standards for digital interoperability, education accreditation standards, an evaluation framework) with a place-based approach (e.g., implementation and evaluation for person-centredness and equity).

3. *Nurturing learning communities:*

For a learning health system to be effective, a community of people with different roles and backgrounds must be committed to participating (a 'learning community'), with an ability to reconcile differing views and progress decisions[14].

Nurturing learning communities require: systematic approaches and iterative, continuous learning with implementation contributing to new best-practice care; broad stakeholder, clinician and academic engagement and co-design; a culture of learning and improvement; a skilled workforce; resources with sustained investment over time; and finally, data access, systems and processes[15,16].

4. *Implementing improvements to services:*

Place-based flexibility is important in designing innovative models of care and improving outcomes. Flexibility is needed both in the way funding is used as a policy lever and in how skill-mix changes and workforce reform can support new models of care.

An evaluation model that is outcomes-focused is critical to support the necessary cultural shift in implementing a learning health system, and further in enabling place-based accountability for learning from findings in real time. With this comes agility and responsiveness to continually adapt and improve, with innovation being supported by the best available evidence and real-time engagement with data.

However, there is also a need to facilitate the diffusion of ideas between learning communities through the development of standardised frameworks for evaluating implementation, that not only identify the outcomes achieved, but reflect the processes and contextual factors on which those outcomes were dependent.

The following case studies provide examples of outcomes data being used as part of a learning health system.

Case study 1 – Palliative Care Outcomes Collaborative (PCOC)[17,18]

Palliative Care Outcomes Collaborative (PCOC) is a national, voluntary program improving patient experiences and outcomes in palliative care through the routine collection and reporting of patient-reported data. Generated data is then sent back to services in deidentified benchmarking reports, enabling services to compare their performance to peers without the risk of penalties if the improvement strategies employed do not show immediate or significant results.

The data is used as iterative feedback, giving services autonomy over the strategies to improve their performance, providing freedom to experiment and adapt to local context via place-based responses. By firmly embedding a culture of quality improvement without judgement through the PCOC program, services can measure and appropriately improve the care they provide, resulting in better patient, family, and carer experiences and improved outcomes in palliative care.

Participation in the voluntary PCOC program is over 80% of all palliative care services in Australia, despite the program not being tied to funding.

Case study 2 – A registry for a population approach to prostate cancer outcomes[19]

Detected early, prostate cancer 5-year survival rates are >95%. However, those who survive often experience a poor quality of life as a result of the treatment they receive.

The Prostate Cancer Outcomes Registry Australia and New Zealand (PCOR-ANZ) is a large-scale prostate cancer registry that collects information on the care provided and the outcomes for men diagnosed with prostate cancer.

Diagnosis and treatment data, including patient reported experience measures, are collected twice a year. They are used to identify population-wide trends in diagnosis and treatment practices, track survival rates and understand what effect different treatments are having on the quality of life for men.

Q8. How could the BreastScreen Australia program improve user experience?

To better understand and capture what matters to people and communities', health services across Australia are increasingly exploring the use of Patient Reported Measures (PRMs). PRM is an overarching term that encapsulates patient reported outcome measures (PROMs) and patient reported experience measures (PREMs). While PROMs capture a person's perception of their own health through reporting on quality of life, daily functioning, symptoms and other elements of health and well-being, PREMs capture a person's perception of their experience of the service provided[20,21].

Patient-reported measures can be used to inform care planning and decision-making, improving communication between individuals and care providers to ensure timely care based on collaboratively identified needs. Trials and implementation of PRMs has already started to occur in various individual programs, by State and Territory governments, as well as individual services and providers (see case studies); however, investment in data infrastructure and linkage will be required to enable this to occur on a national scale.

The following case study highlights the opportunity patient-reported measures hold in capturing and improving the experience of consumers moving through BreastScreen Australia services.

Case study 3 – Performance Information and Reporting: New South Wales experience[22]

PRMs are a critical component of achieving the NSW Health vision for truly integrated, better value care across the state. Direct and timely feedback about patient reported health outcomes and experience of care will help to drive improvements in quality and safety, and to facilitate the integration of health care across NSW.

The key factors that will influence the scalability and sustainability of the Program:

- Infrastructure: Appropriate technology architecture to support PRM collection and use at a statewide level and enable the embedding of PRMs into routine clinical practice with minimal added burden to clinicians, consumers and managers.
- Interoperability: The statewide PRMs IT solution will require seamless integration with existing electronic medical record systems including GP software.
- Standardisation: Statewide consistency in the collection of PRMs to enable system performance reporting and service comparison.
- Support: Adequate resourcing, training and support is available, and services have appropriate inducement and support to change.

Q10. What are your views on the balance between the benefits of early cancer detection and the potential risk of overdiagnosis and unnecessary investigation for women participating in breast screening, and what factors influence your views?

It is estimated that 30% of healthcare globally is wasteful or low value care, and a further 10% is harmful care. Low value, or unnecessary, healthcare is care that provides little or no benefit to patient health, may cause harm, or provides marginal benefits at disproportionately high costs.

Low value health services include, for example, the provision of screening or diagnostic tests that have not been clinically recommended, encompassing the unnecessary investigation of women participating in breast screening.

As explored in response to Question 1, a risk-based approach to breast screening can reduce the provision of low value or unnecessary care by prioritising high-risk consumers, provided it is informed by evidence and the relevant information on outcomes and costs[23].

Moreover, a recent perspectives article examining the drivers of inappropriate use of diagnostic testing reinforced the benefits of learning health system approach (explored in our response to Question 6). The article concluded that finding the 'sweet spot' between overuse and underuse required routine, data-driven strategies to facilitate the informed, appropriate provision of care[24]. Formed around the common ambition of identifying this sweet spot in care to optimise consumer experiences and outcomes, learning health systems can provide this critical framework for BreastScreen Australia in advancing towards a national, risk-based screening model of care.

Further still, a VBHC approach provides a complimentary, evidence-based framework to addressing this question of balancing costs (defined broadly) and benefits. For instance, the collection of outcomes and costs data facilitates a VBHC approach to service design and decision-making which is focused on improvements in health outcomes for the cost of achieving these improvements, across a full pathway of care. Therefore, low or no-value care is explicitly considered in care design and delivery.

In navigating this balance, AHHA would like to draw your attention to the following Deeble Institute Issues Briefs, 'Decarbonising clinical care in Australia', which explores the provision of low-value care in Australia[25], and 'Value-Based Health Care: Setting the scene for Australia', which examines the setting for VBHC implementation in Australia and provides a series of recommendations for success[26].

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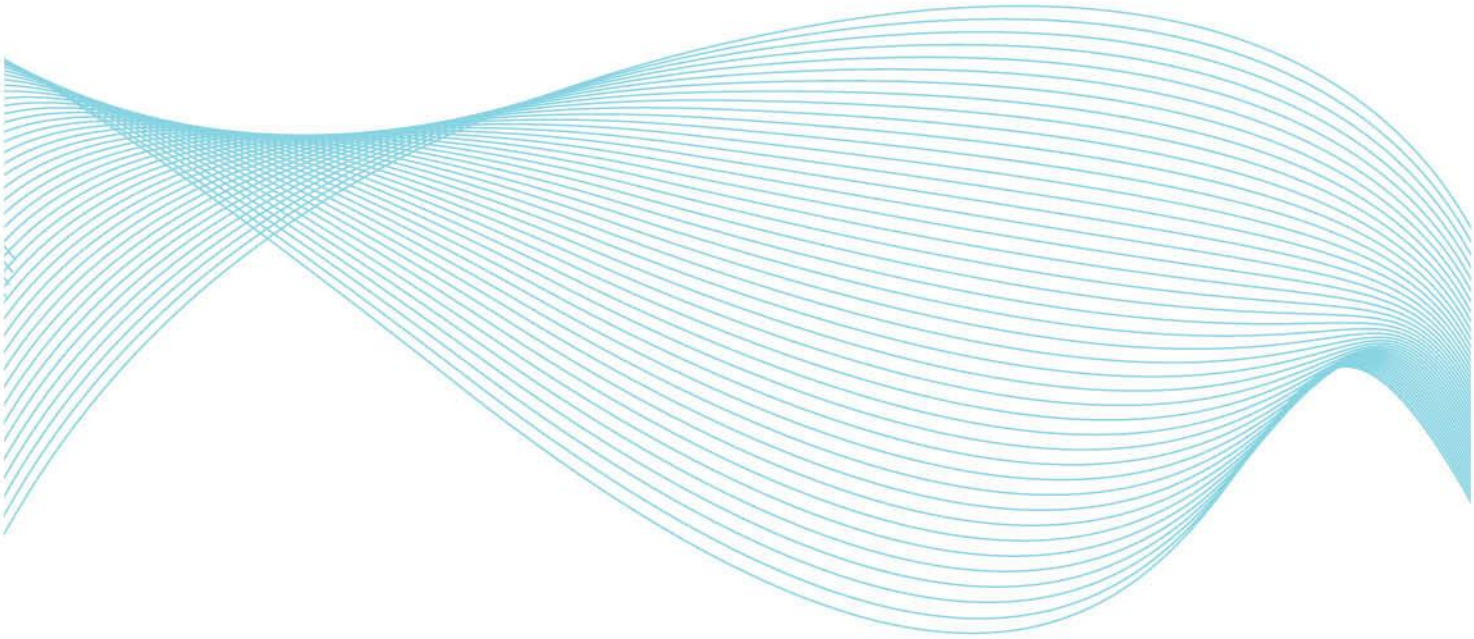

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