Ireland's bumpy road to a world-class cancer service

Peter McIntyre

Having scored a first by extending smoking bans to pubs, cafes and restaurants, Ireland is now grasping the nettle of centralising specialist cancer services. The strategy has met some resistance, but it's hard to argue against a measure that promises up to a 20% drop in mortality.

At the turn of the year the Republic of Ireland will publish its second National Cancer Strategy in a decade. The first Strategy saw a huge increase in funding and staffing for cancer services, and succeeded three years early in its aim of cutting the death rate. The second Strategy promises a revolution in the way that cancer care is delivered to the four million people of the Republic.

With one meeting left of the National Cancer Forum, the shape of the second National Cancer Strategy is pretty well decided. Cancer services will be configured in a pyramid of care, most likely based on four regional networks, two centred on Dublin in the east of the country, one on Cork in the south and one on Galway in the west.

It is a plan to create centres of excellence where the 20,000 new patients diagnosed with cancer each year will receive multidisciplinary care, and be treated by consultants with real expertise in their particular cancer. This time it is unlikely there will be a huge increase in resources, but the Strategy aims to generate a second giant step forward for services that ten years ago were patchy, parochial and non-specialised. This approach has the support of the Government, most professionals and the main cancer charities and patient groups. But it is resented outside the chosen centres, where some patients will have to travel long distances for treatment.

This Strategy has already had a dress rehearsal. In October 2003, an expert group published a report on the development of radiotherapy services in Ireland. This also recommended a national network based on four supra regional centres. It called for a massive increase in the number of linear accelerators, from 10 to 26 by 2008 and to 35 or more by 2013. The Government accepted the report.

This increases the number of radiation oncology centres from two (University Hospital, Cork, and St Luke's Hospital, Dublin) to four (another one in Dublin and a new unit now being built in Galway). However, people in Sligo and Donegal in the north west of Ireland will have to travel to Galway or across the border to Belfast for radiotherapy, while in the

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Demonstrators calling for a radiotherapy unit in Waterford "bombarded" Bertie Ahern, Ireland's Prime Minister, with daffodils

south east a population of 450,000 people will have to look north to Dublin or south to Cork.

Large demonstrations were held in the south-east this year to demand that Waterford Regional Hospital be given its own radiotherapy unit. One demonstrator was Mary Power, who had undergone surgery for bowel cancer at Waterford in April 2001 followed by radiotherapy in Dublin. She told the *Munster Express* how she would leave home at 6.30 am to catch a 7.20 am Waterford train to Dublin, then take two buses and walk to St Luke's where her radiotherapy treatment would last less than five minutes. She would immediately set off again for home. She did this journey five days a week for five weeks. Mary said: "You'd be feeling so rotten from the day before but you knew you had to tear yourself out of the bed and start again the next morning. So many times I was violently ill on that train. I'd arrive home exhausted and then have to start all over again." When she contemplates the possible return of her cancer, it is the journey to Dublin she chiefly dreads.

A local service was a significant issue in local elections in Waterford. Faced with a choice between excellence and local services, many people ask, "Why can't we have both?"

Paul Redmond, Professor of Surgery at Cork University Hospital and chair of the

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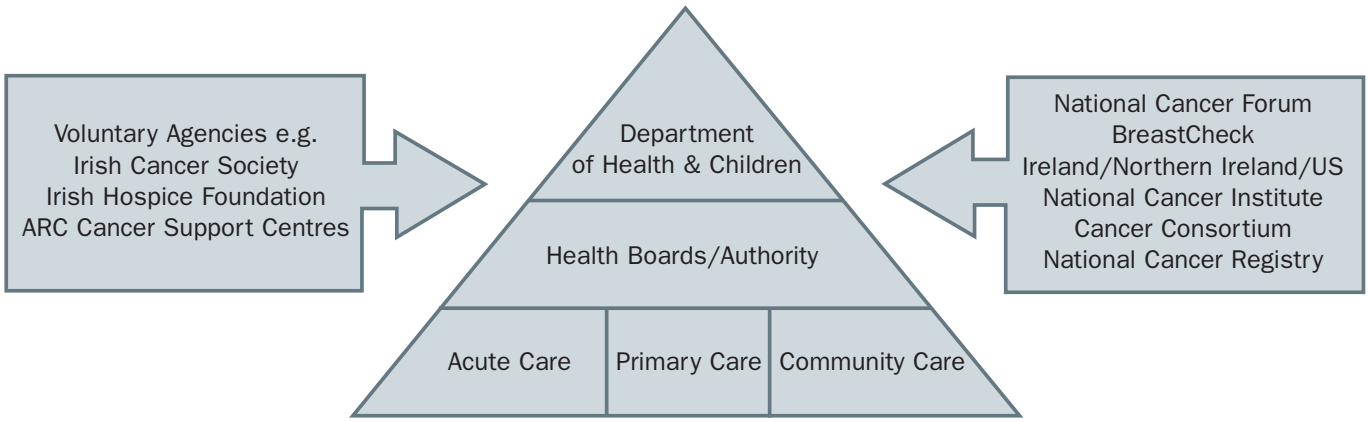
STRUCTURE FOR THE DELIVERY OF IRELAND'S CANCER SERVICES



Source: An Evaluation of "Cancer Services in Ireland: A National Strategy 1996", Deloitte, 2003

National Cancer Forum, believes that this patient philosophy is starting to change. "There is an attitude in Ireland that we have a right to a Memorial Sloan-Kettering in our back garden so to speak. We have a local hospital and it should be able to do everything.

"People are now more familiar with the whole concept of case volume, evidence-based practice and the centralisation of services for certain aspects of cancer care. People are more accepting of the idea that for certain parts of my care I am going to have to travel, and the likelihood is that it has been done to improve my outcome."

Controversy should not obscure the progress that Ireland has already made. When the first Cancer Strategy was launched in 1996 there were only four medical oncologists in Ireland. Now there are 19. The Strategy has delivered 87 new cancer consultants, including 14 breast surgeons, 6 general surgeons, 19 histopathologists, 12 radiologists and 8 palliative care specialists.

Prior to 1997, nurses working in oncology were not fully recognised. By 2003 there were 245 clinical nurse specialists, 170 appointed in 2001 alone. Half of these nurses are working in palliative home care.

Each new consultant represents a cancer team costing 1–1.5 million euros a year. In 1997 spending on cancer services was 7.45 million euros a year. By 2003 this had risen by 1,477% to 117.45 million euros – a cumulative increase of approximately 400 million euros over the lifetime of the Strategy.

The BreastCheck screening programme was introduced for women aged 50–64 and is being expanded to the whole of the Republic. The first Strategy can also take credit for a 42% increase in patient treatment between 1995 and 2001.

The key goal was to reduce the death rate from cancer in the under-65 age group by 15% in the ten-year period from 1994. In the first few years, Ireland was steadily on target to achieve this. Then 2001 saw a dramatic fall of more than 5% in one year, and the target was achieved three years early.

One factor behind this success was the decline in smoking, and, encouraged by these results, Ireland did what no other country dared. In March 2004 it barred smoking from all workplaces, including pubs, bars, restaurants and cafes. Cigarette manufacturers, Gallagher, reported a fall in sales of 7.5% in the first six months of the ban, suggesting a full year dividend of 500 million fewer cigarettes being smoked by the population of Ireland. Meanwhile, in the UK, Ireland's timid neighbour, sales rose by more than 3%.

An evaluation of the first Cancer Strategy by Deloitte and Touche management consultants, published in 2003, was generally favourable, but concluded that further improvements were needed, without comparable spending increases. Deloitte says the new Strategy will have to rely on "an ability to reconfigure present structures, enhance system co-ordination and interaction and redefine accepted working practices and service management."

This was underlined by a National Cancer Registry report in 2004, which found significant regional variations in treatment and, in the case of breast and colorectal cancer, significant differences in regional survival rates.

Redmond contrasts the second Strategy with the "cluster bombing" of consultants, nurses and new services that came with the first. "This second Strategy will look at putting together a cohesive plan for how cancer care is actually delivered in a more uniform way throughout the country, so that you do not have heterogeneity of care and, ultimately, heterogeneity in terms of outcome. It is not going to cost anything like the first Strategy."

"The goal will be organisational infrastructure, governance in terms of how we deliver cancer care, audit, and very careful assessment. If you are a dedicated breast centre you will have to be able to show that you are improving outcomes for patients. Of course there will always be investment for cancer care and there has been a promise of that. But I don't think that this Strategy's purpose is to say we want another 250 million euros or whatever."

The National Cancer Forum will propose four networks of cancer services, each covering a population of about one million people. At the heart of each network will be a lead cancer institution or specialist cancer hospital, where radiotherapy services will probably be based. These centres will deliver a full range of cancer care, and will oversee the delivery of cancer services at the other institutions in the network.

Each network will also have regional centres or cancer units, dealing with cancers where a high degree of specialisation is not so important.

A third tier will offer primary care, palliative care, support and less complex chemotherapy.

Redmond is a Dubliner who spent two years doing surgical oncology in Philadelphia before returning to Ireland. He moved to Cork in 1997 as the first Strategy was under way. The three hospitals in Cork have already created departments that cut across the bureaucratic boundaries. Cancer teams meet across the city, audit their cases together and have even drawn up their own clinical guidelines.

Redmond says that most cancer care should be in the hands of multidisciplinary teams specialising in particular cancers.

"For certain types of cancer, breast cancer for example or rectal cancer, it appears that your surgeon needs to be doing a high volume of cases for you to have your best chance of doing well. If you are a breast surgeon you should operate on a minimum of 50 cancers a year. For other cancers it is more about the patient being processed through the system in a multidisciplinary way so that care is delivered objectively, and the case is discussed by all members of the cancer care team.

"It is like flying in a plane. You don't get in with a pilot who says 'I have not flown this for a year but we'll give it a go'. If someone says 'I have not done a breast cancer operation for a year but I read it up last night in the book and I am confident I will be able to do it again,' you are going to run out of the clinic.

"Historically, when you were appointed as a general surgeon you were trained to do bowel surgery, breast surgery, stomach surgery, oesophageal surgery, whatever. Your remit was

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Centres of excellence could cut cancer mortality in Ireland by 20%

to deal with everything that walked through the door. Redefining work practices means not trying to do everything for everybody, probably not as well as you should.

"Individual clinicians need to identify their strengths. You become a disease specific clinician rather than O'Brian or Murphy doing four or five cases of this a year and four or five cases of that. Instead, you work in the breast team or the colorectal team and you go to the multidisciplinary meetings and interrelate with the nurse specialist."

The health structure of Ireland is changing and the tide is in favour of the new Strategy. Ten health boards disappear at the end of the year, probably to be replaced by four health regions, two centred on Dublin, one on the south of Ireland and one on the west. A new Health Service Executive will exert pressure to raise standards throughout the country.

The Strategy will have the backing of the Irish Cancer Society, which says that centres of excellence could cut mortality by 20%. The Society acknowledges concerns of patients in Limerick and Waterford in the south and Sligo and Donegal in the north west, but concludes: "Although services should be delivered as close to the patient's home as feasible, the over-riding priority should be to provide the best, safest and most effective treatment and in doing so to provide the best opportunity for long-term survival."

Redmond believes that most people will welcome the changes. "The evidence for the multidisciplinary approach and the case volume approach is so strong now that nobody can really say it is wrong. It doesn't take a rocket scientist to work out that if you go to a clinic doing a lot of the disease with all the infrastructure and staff and equipment, you are more likely to be alive in five years. So when I go to the National Cancer Forum and sit down with 24 people there are few dissenters and most agree that we need to do it. Everybody argues a bit about the infrastructure but we have almost got those problems ironed out as well."

However, he worries that patients in Ireland may expect too much. "There is no doubt that the delivery of cancer care has hugely improved in this country but so also has patient expectation. We have perhaps an expectation that you will walk through the system and you will be cured, and you can expect nothing to go wrong, and it will be done quickly and be rosy in the garden almost to the point where it is a bit unreal.

"We spend significant amounts of time, much more than in the past, with cancer patients, which is good. My question is where will we draw the line? Where will public expectations be in five or ten years? You are never going to get it perfect."

Ireland is a place where people take decisions with the head and with the heart. The aspirations that Redmond and his team have for cancer services could put Ireland up there with the best of European oncology. Somehow, the Strategy must also deliver an acceptable solution for Mary Power and patients like her.

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