

Britain against Cancer Conference 2007

The 9th Britain Against Cancer Conference organised by the All Party Parliamentary Group on Cancer was held in Westminster on 4th December 2007, and was opened by **Dr Ian Gibson MP** (Chair of APPG on Cancer) with the news that the Cancer Reform Strategy had been launched the previous day (available on the internet: dh.gov.uk/publications). The good news is that the government is now committed to funding **world class cancer services**, but also expects the NHS to deliver value for money. There will be greater emphasis on cancer prevention as it is thought that over half of all cancers could be prevented by lifestyle changes, action has, at last been taken against smoking and efforts will be made to reduce their availability of cigarettes to children. The relationship of ultraviolet radiation from sun beds to skin cancer needs to be clarified and guidance given regarding safety, particularly with reduction in the exposure of young adolescents. Obesity is now well recognised as an important factor in causing some cancers, as is the excessive use of alcohol. Vaccination against the human papilloma virus (HPV) is now available and will be offered to adolescent girls to reduce their risk of cervical cancer in later life. Steps will also be taken to increase the public awareness of these cancer risk factors.

One of the reasons our survival rates are lower than other comparable countries is thought to be that cancer is still often diagnosed late when the cancer has progressed, so existing screening programmes have been extended and bowel cancer screening is being introduced. There are plans to study the feasibility of using low dose CT scans for screening lung cancer. The treatment of cancers should be improved by reduction in waiting times, further training of surgeons in laparoscopic (keyhole) surgery and further provision of radiotherapy equipment and staff. In future new cancer drugs will be referred to NICE at the same time as they are considered for licensing, this should help to make approved new drugs more speedily available.

It is now recognised that as cancer survival improves (it has doubled from 25% to 50% in the last 30 years) more people are cancer survivors but some of whom may still have problems relating to their cancer or its treatment. It is now realised that patients may need continuing support during their cancer journey and the role of the clinical nurse specialists and the many cancer charities is seen as crucial. Inequalities in cancer services and results are a constant source of irritation and annoyance. This has been recognised and should be addressed by the National Cancer Equality Initiative. We were told that this strategy comes with some additional money, but I don't think we were told how much! However additional funding clearly improves the chance of real improvement; there is a big difference between saying what should happen and its actual implementation.

Vivienne Parry (Health Journalist) gave a review of the cancer events of the year both nationally and internationally, she covered many of the points mentioned above but made the point that cancer charities are liaising better with the government and the media, but issues need to be kept simple for the media, who still have a tendency to trash the cancer services suggesting that things are worse than they are, and still giving the impression of hopelessness. She pointed out that with a new prime minister who is making health a priority we also have a new health minister in Alan Johnson MP and now a minister for cancer in Ann Keen MP a former oncology nurse. However the access to new cancer drugs is still worse than France, Germany or Spain, but Prof. Mike Richards (National Cancer Director) has produced a report on "Getting it right for people with cancer". The problem of quality control in cancer surgery is being addressed as surgery is still the most important curative modality, and radiotherapy facilities are being improved as it is the second most important curative modality. There will be expansion of the number of clinical nurse specialists involved in working with and supporting men with prostate cancer. The government's "End of life strategy" will be published soon.

Ann Keen MP (Minister for Cancer) Pointed out that as cancer affects one in three of the population at some time it is now recognised as top priority, she mentioned the extension of the screening programmes and outlined preventative measures and suggested greater availability of Nicorette and other measures to help people overcome tobacco addiction. Greater public awareness of the signs and symptoms of cancer is thought to be important, as is addressing the inequalities of care and treatment delivery. There will be a National Cancer Equality Initiative, and the role of the specialist nurses is recognised as important as well as continuing support following treatment, including efforts to make employers better informed and more sympathetic to the needs of cancer patients willing and able to continue working.

Prof. Mike Richards (National Cancer Director) pointed out that cancer mortality was improving and more people were living long after cancer treatment. However it is estimated that about half out cancer cases could be prevented if people were more aware of the lifestyle factors involved and who are prepared to take the necessary action in not smoking, avoiding obesity, taking adequate exercise, reducing alcohol consumption and guarding skin from excessive ultraviolet light exposure. Because the poorer survival in the UK is attributed to late diagnosis the co-operation of the Royal College of General Practitioners is being sought in conducting an audit of primary care. Total spending in England is now 4.35 billion pounds but there is enormous variation in the cancer spending of primary care trusts. The good news is that following initial doubts the new Cancer Reform Strategy does have additional money accompanying it.

Breakout session (1)

There were six breakout sessions (workshops) and I chose **The latest developments in cancer screening and prevention**. The first speaker was **Julietta Patnick CBE** Director of the NHS Cancer Screening Programme. In the UK screening is currently available for breast, cervix and bowel, but screening for prostate, ovary and lung cancers is still in the experimental stage. The **breast screening** programme is enormous, dealing with two and a half million invitations each year. The positive predictive value (chance of a positive result) is increasing in that they are finding more cancers (*but she did not say what the proportion of in situ cancers was relative to invasive cancers*). The programme is to be extended to age 75 (currently 70). High risk groups have been identified: those with a strong family history (following the NICE familial breast cancer guidelines), those who previously had treatment for Hodgkin's disease and received radiotherapy to the breast. MRI scanning is being selectively introduced, and there is likely to be a change to direct digital mammography to reduce the problem of storage space for the film mammograms currently in use, and it has better sensitivity for younger women. Efforts are being made to reduce the waiting time for results, but they are struggling to meet the 36 month deadline for repeat screening.

Cervical screening is changing to liquid based cytology and this should be complete by October 2008, it is thought to give better results than the older smear test, and it can be linked with tests for the human papilloma virus (HPV), one of the causes of cervical cancer. Interestingly she claimed that she did not know how many cervical cancers were picked up by screening. **Comment:** *this is not surprising in that cervical screening is not a cancer test, although it does pick up the occasional invasive cancer, it is designed to pick up pre-cancerous changes (cervical intraepithelial neoplasia, CIN grades i, ii, and iii). By treating these precancerous changes the development of cancer is prevented. The success of this programme is shown by halving both the incidence and mortality of cervical cancer between 1988 and 1997, making it the most successful screening programme so far.*

Bowel cancer screening is being introduced gradually and should be available nationwide by December 2009 for people aged 60 – 69, and extended to 74 later. As the test shows bleeding from the bowel, a positive test carries a 10 – 15% chance of having a bowel cancer confirmed by endoscopy.

Prostate cancer screening is under evaluation in some European centres and the results will not be available for some years. The problem is that the PSA test (prostate specific antigen), although a useful marker for following the course of disease, is not a very reliable screening tool, and so far screening with PSA has not been shown to reduce mortality from the disease. Despite much effort, a suitable alternative has not yet been found. There is however a prostate cancer risk management programme in progress.

Ovarian cancer screening is being investigated by a combination of a blood test (CA125) and an ultrasound scan, so far 200,000 women aged 50 – 74 years have been recruited but the study will not be reported until 2012/13.

Lung cancer screening is being studied in Belgium/Netherlands and the USA, smokers are at a high risk and under Health Technology Assessment the feasibility of using a low dose CT scan is proposed for the UK.

The second speaker was **Gwynne Lyons** Director of Chem Trust reviewed the known potentially preventable causes of cancer. However she pointed out that not all chemical carcinogens (cancer causing chemicals) have been identified and not all chemicals have been tested for carcinogenicity. Chemical exposure at work has been particularly important in bladder cancer, and asbestos is known to be a cause of the rare chest tumour mesothelioma. It was pointed out that carbon microtubules have a structure very similar to asbestos and probably have carcinogenic potential. Breast and prostate cancers are known to respond to treatment with certain hormones or anti-hormones (drugs that block hormone receptors in the tissues and prevent the hormones from having their usual effect). There are chemicals which mimic the effects of the female sex hormone oestrogen, and it is the synthetic hormone stilboestrol that has been responsible for causing rare vaginal tumours in young women who were exposed to it while still in the womb (It was given to their mothers who had a threatened miscarriage).

Only one in twenty breast cancers is thought to be related to the breast cancer genes BRCA1 and BRCA2, and the search continues for environmental causes of breast cancer. A clue to likely environmental causes is a rapid rise in the incidence of a particular cancer. Possible causes are chemicals encountered at work, home, garden or recreation. Exposure to the insecticide DDT before the age of four is thought to increase the risk and exposure to stilboestrol in the womb may also affect the risk from the BRCA genes and chemical carcinogens. Testicular cancer is rapidly becoming more common implying that there may be an environmental factor involved. However not all chemicals are bad and there is a danger of causing widespread chemophobia! It is important to eliminate or control substances shown to be carcinogenic but she concluded that scientific uncertainty should not delay precautionary action.

Comment: *Her last statement needs to be modified by considerations of risk. We and everything around us are composed entirely of chemicals, and the distinction between 'natural' chemicals and man-made chemicals is entirely false. A substance may both exist in nature and be made synthetically. Life could become more difficult if we banned all chemicals that **might** be implicated as subsequent experience may well show that our doubts were unfounded. Clearly carcinogenesis is very complex, and likely to become more complex as we learn more about it, there is a fine line to be drawn between over-reacting to supposed threats and negligently ignoring an early warning.*

Breakout session 2

For the second session I chose **Cancer in the developing world**, having worked in a developing country in SE Asia for nearly five years, I was interested in an update on progress. However the discussion was entirely on Africa but nevertheless was absolutely fascinating. **Prof. David Kerr CBE** from the Department of Clinical Pharmacy at Oxford University described his involvement with **AfrOx**, collaboration between the medical faculty in Oxford and centres in Africa. There were estimated over seven million deaths from cancer in sub-Saharan Africa in 2002, this compared with six million from tuberculosis, HIV and malaria combined. The cancer problem in Africa makes our problems pale into insignificance! Cancer deaths are reckoned to reach 16 million by 2020 if present trends continue, by which time 70% of the world's cancer will be in the developing world. Radiotherapy is available in only 21 of 53 countries, that is to less than 20% of the population. Two hundred and fifty million people have no access to cancer care – not even to effective pain relief when they are dying. To deflect criticisms of 'cultural imperialism' he emphasised that African politicians have said that they **want** help in confronting this problem. Kenya has a population of 35 million and an annual gross national product of \$1400 per head (approx. £700) priority for palliative care for cancer patients is well below that for HIV/AIDS which is top of the political agenda. Nephroblastoma (a kidney cancer in children) in Nigeria has a five year survival of 38% compared with 90% in UK, part of the problem is that ineffective traditional medicine is tried as the first option, resorting to the hospital only when this has clearly failed, and then finding that they cannot afford the necessary drugs if they are available.

Primary liver cancer (hepatocellular carcinoma) is associated with the hepatitis B virus and is common in Africa. It can be largely prevented by vaccinating children against the virus before they have come into contact with it. Also a vaccine is now available against common strains of the human papilloma virus responsible for cervical cancer which is often the commonest female cancer. The priority is to prevent what can be prevented, to cure the curable and provide effective palliative care for the rest. Even this limited objective requires a tremendous effort in providing the necessary training for health workers, and this is at least provided in part by partnerships set up through AfrOx with 34 cancer networks in UK, helped by providing information, e-learning and treatment guidelines available on mobile phones. In Rwanda a completely paper-free health system is in operation – something we can only aspire to!

Website: www.afrox.org

Panel debate: Getting the priorities right

Representatives of the three main political parties: Mark Simmonds MP (Conservative), Norman Lamb MP (Liberal Democrat) and The Rt. Hon. Frank Dobson MP (Labour) discussed the extent of agreement and the differences in the priorities of the three parties, but added little to the overall debate.

Q & A session, officers of the APPG on Cancer

The points I noted from this debate were that NICE guidance on technical appraisals are now mandatory but NICE guidelines are not enforceable in law (*an obscure difference in the interpretation of the meaning of guidance and guidelines*). The NHS currently has a surplus of 1.8 billion pounds (*meaning that we have collectively overdone the cut-backs!*).

The word **rationing** is regarded as unparliamentary language and the term **healthcare prioritisation** is preferred. Public health budgets are often raided for other purposes. It might be helpful to define what is **not** funded.

Comment

The National Health Service aims to make appropriate treatment available to all and free at the point of access, and for sixty years has rightly been regarded as a marker of our civilisation, even as a jewel in our slightly tarnished crown. Alternative arrangements may well provide a superb service for those who can afford to pay, but leave a woefully inadequate service for those who cannot or will not afford the necessary insurance. Our national scheme is paid for from taxation. That latter point is the Achilles heel of any national scheme in that healthcare costs are rising faster than the general inflation rate, and new drugs and technology, especially in cancer medicine are inevitably more expensive than the drugs or equipment they replace because of their development costs and the essential assessments before they can be approved for general use. The Government is responsible for control of healthcare funding via the Department of Health and it faces an immediate dilemma in that any government that provides the total package of care that the people really want is likely to be defeated at the next election because of either the tax increases incurred or the cuts in other government services in order to pay for the improvements. Historically we have therefore ended up with a system of "robbing Peter to pay Paul" in that high profile services get funding at the expense of other equally essential but low profile services. Recent events show that causing personal embarrassment to government ministers can be an effective method of obtaining funding, but it is hardly a rational way to run a health service!

Local inequalities in service delivery often called the 'postcode lottery' are seen as wrong or bad, but they are an inevitable consequence of local autonomy in healthcare decision making. If all care delivery were to be controlled by central government dictat, there would be pressure on government to provide special additional funding to pay for the new treatment, or if this was not forthcoming the local healthcare providers would be left wondering what services they could cut without causing a public outcry. Previous experience leads one to believe that such cuts would probably fall on services for the elderly or the mentally ill. For many years the 'efficiency' argument has been used to provide a smoke-screen to hide this underlying political dilemma. The argument goes 'if we improve the efficiency of the service there will be plenty of money to go around'. However efficiency, like beauty is often in the eye of the beholder, and the public perception often confuses efficiency with convenience. It goes without saying that waste must be eliminated, but recent TV programmes have suggested that the biggest source of waste has been unsuccessful government policies! After a working lifetime in government health schemes, mainly in the NHS I would not like to see our NHS reduced to the service for the impoverished and the improvident while everybody else gets private treatment. In the USA about 40% of the population cannot or will not afford health insurance or has been declined by the insurance companies, usually on grounds of ill-health!

The way forward I see as needing rigorous independent assessment of all new treatments, including their effectiveness, indications (when they should be used) and contra-indications (when they should not be used). Such assessments inevitably include the subjective assessment of 'value for money' which is essential in any publicly funded service. The role of the National Institute for Health and Clinical Excellence (NICE) should be enhanced and it should be adequately staffed to complete its assessments in reasonable time and I applaud the steps already taken. I think it is time that we looked seriously at the possibility of an independent body overseeing the running of the NHS removing it from the endless cycle of reorganisation and political interference. The government would remain responsible for setting budgets, but the service should remain truly national.

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