Public consultation submission to

The Australian Cancer Plan 2023–2033

December 2022

Submitted by: Hepatitis Australia Inc.

Hepatitis Australia, incorporated in 1997, is the peak community organisation to progress national action on issues of importance to people affected by hepatitis B and hepatitis C. Our mission is to provide leadership and advocacy on viral hepatitis and support partnerships for action to ensure the needs of the 360,000 Australians affected by, or at risk of viral hepatitis, are met. Our members consist of the eight state and territory hepatitis organisations. Our vision is to see an end to viral hepatitis in Australia.

Contact: Carrie Fowlie – Chief Executive Officer

Introduction

Thank you for the opportunity to contribute to the development of the Australian Cancer Plan. As a peak body representing the interests of people living with hepatitis B and hepatitis C, Hepatitis Australia is acutely aware of the impacts of cancer. In the case of liver cancer, these impacts disproportionately affect vulnerable and often-marginalised population groups. We welcome the development of this important Plan and the opportunity to highlight and address an area of increasing unmet need. Achieving Australia's commitment to eliminate hepatitis B and hepatitis C by 2030 provides a once in a generation opportunity to avert thousands of preventable cancer deaths.

This submission builds on the previous submission that Hepatitis Australia made to the March 2022 consultation process on the Australian Cancer Plan. We acknowledge that the Australian Cancer Plan is tumour agnostic, seeking to address issues relevant to all cancer types. As such, our submission seeks to highlight some minor amendments to existing content and ways that future implementation of the Australian Cancer Plan may help facilitate improved liver cancer outcomes.

Hepatitis Australia supports the Australian Cancer Plan's equity focus

Hepatitis Australia supports the vision and focus of the Australian Cancer Plan on world-class cancer outcomes and experiences for *all* Australians. Liver cancer, of which hepatitis B and hepatitis C are the major drivers, defies positive trends (such as increasing survival rates across most cancer types). With worsening outcomes for liver cancer front of mind, Hepatitis Australia is buoyed by intentions for the Australian Cancer Plan to be equity focused, striving for equitable cancer outcomes across all population groups. See attachment 1 for a summary of the inequities of liver cancer.

Suggested minor additions or amendments

Hepatitis Australia suggests the following minor additions or amendments to the draft Australian Cancer Plan:

Location	Amendment Proposed	Rationale
1.1.1 on p39	Expand explanatory text to read: "Primary prevention activities include raising awareness of healthy lifestyle behaviours that can reduce cancer risk, such as quitting smoking, reducing alcohol consumption, consuming a healthy diet, being physically active, and being sun smart, as well as addressing factors beyond the health system, including social, cultural, commercial, and environmental drivers of cancer risk that influence the adoption of preventive behaviours. *Additionally, because some cancers are linked to viruses like the human papillomavirus (HPV) or hepatitis B and hepatitis C, effective primary prevention*	Hepatitis B and hepatitis C antiviral treatments should be referenced as they are highly effective at preventing liver damage and liver cancer.

	*activities should also improve access to and uptake of immunisation programs (for under-immunised populations) and antiviral treatment for hepatitis B and hepatitis C.***"**	
1.2.2 on p47	Replace 'Third National Hepatitis B Strategy' with 'Fourth National Hepatitis B Strategy (2023-2030)'	The National Hepatitis B Strategy is undergoing a refresh, and the proposed amendment will reference the Strategy with coverage dates similar to Australia's Cancer Plan
1.2.2 on p47	Replace 'Fifth National Hepatitis C Strategy' with 'Sixth National Aboriginal and Torres Strait Islander BBV and STI Strategy (2023-2030).	This section relates specifically to immunisation with a focus on Aboriginal and Torres Strait Islander people. As hepatitis C is not vaccine preventable, we suggest referencing the National Aboriginal and Torres Strait Islander BBV/STI Strategy is more appropriate.
1.2.2 on p47	Replace 'recognising the risk factor associated with cancer due to liver disease, damage and inflammation from Hepatitis' with 'recognising that hepatitis B and hepatitis C are the leading causes of liver cancer and pursuing the elimination agenda of these strategies, alongside community, could be Australia's next biggest cancer prevention success, saving thousands of preventable cancer deaths by 2030.'	The draft National Hepatitis B and Hepatitis C Strategies 2023-2030 frame the elimination agenda as liver cancer prevention. The proposed change in language better reflects the community-centred approach being taken and concords with the elimination as prevention framing.
Other relevant national policies on p136	Include a row with the National Hepatitis B Strategy; National Hepatitis C Strategy and National Aboriginal and Torres Strait Islander BBVSTI Strategy. Year: 2023-2030 (pending publication while undergoing consultation) All jurisdictions Author: Department of Health and Aged Care	These three national strategies set the vision for the elimination of hepatitis B and hepatitis C in Australia by 2030. Key outcomes are sought in relation to liver cancer prevention and improvements in early detection, treatment and liver cancer mortality.

Implementing the Australian Cancer Plan to improve liver cancer outcomes

Hepatitis Australia supports the inclusion of hepatis B, hepatitis C and liver cancer within the Australian Cancer Plan, in particular the cross referencing of National Strategies; the inclusion of

hepatitis B and hepatitis C as modifiable risk factors for cancer; and the identification of liver cancer as a cancer type with relatively poor outcomes.

Hepatitis Australia notes that the Australian Cancer Plan sets broad, largely tumour agnostic, priorities for reform under which improvements to liver cancer prevention and outcomes can be achieved. There are several liver cancer specific opportunities or resources, as described below, that should inform the implementation of the Australian Cancer Plan.

National Hepatocellular Carcinoma Policy and Guideline Development

The development of a Roadmap and Clinical Guidelines for Liver Cancer Control is currently underway; led by Cancer Council Australia and The Daffodil Centre with funding from the Australian Government of Health and Aged Care. The Roadmap will identify priority actions to prevent and reduce liver cancer burden over the next five, 10 and 20 years. Additionally, the Clinical Practice Guidelines for Hepatocellular Carcinoma Surveillance for People at High Risk in Australia are pending publication in 2023. Combined, this national guidance will help identify meaningful and systematic approaches to preventing and improving national liver cancer outcomes and should inform actions taken under the Australian Cancer Plan.

Policy alignment between the Australian Cancer Plan and the National Hepatitis B and Hepatitis C Strategies

There are critical strategic alignments between the Australian Cancer Plan and the National Hepatitis B Strategy and National Hepatitis C Strategy. The Department of Health and Ageing is currently refreshing these national Strategies and undertaking consultation in advance of their 2023 release. Hepatitis Australia is strongly advocating that the next National Hepatitis B Strategy and National Hepatitis C Strategy (2023-2030) to:

- Incorporate specific action focused on liver cancer including prevention, vaccination, treatment, diagnosis and HCC surveillance
- Align with and cross reference the Australian Cancer Plan
- Incorporate specific action on population wide offer of hepatitis B testing as a means of reducing the liver cirrhosis and cancer burden from hepatitis B
- Enshrine Australia's commitment to achieving the Global Hepatitis Elimination Goals including, by 2030, to reduce mortality from hepatitis B and hepatitis C by 65%.

Support from Hepatitis Australia

Hepatitis Australia supports the vision of the Australian Cancer Plan and extends its assistance to Cancer Australia and others to ensure meaningful implementation for people impacted by hepatitis B and hepatitis C in Australia. This could include:

- Engaging in planned consultation processes on the National Aboriginal and Torres Strait Islander Cancer Plan, with a particular focus on the inequitable burden of liver cancer for Aboriginal and Torres Strait Islander people;
- Continuing to work with Cancer Australia including providing assistance to implement the Australian Cancer Plan or associated future actions relevant to liver cancer prevention and outcomes;
- Providing assistance to identify and embed liver cancer consumer perspectives into national cancer policy, governance and clinical enhancement processes; and

- Continuing to advocate for an increasing focus on liver cancer prevention and responses as a key priority in national hepatitis B and hepatitis C policy and governance.

In Closing

Hepatitis Australia thanks Cancer Australia for undertaking the development of the Australian Cancer Plan 2023-2033, and for providing this meaningful opportunity to contribute. Should you require additional information from Hepatitis Australia, please contact our office on 02 6232 4257 or via email to the CEO, Carrie Fowlie, at admin@hepatitisaustralia.com

Sincerely,

Carrie Fowlie
Chief Executive Officer
Hepatitis Australia
13 December 2022

Attachment 1: The inequities of liver cancer

Incidence Incidence refers to the number of new cases diagnosed each year. Liver cancer incidence is increasing faster than the increase in incidence of all cancers combined.	
The number of new cases of **liver cancer** is estimated to be 2,599 in 2019. This represents: - a 25% increase from 2,079 in 2015, and - a 51% increase from 1,549 in 2010.	The number of cases of **all cancers** combined is estimated to be 144,713 in 2019. This represents: - a 10% increase from 131,452 in 2015, and - a 21% increase from 119,472 in 2010.
Age-standardised incidence Age-standardised incidence refers to the number of new cases diagnosed each year, presented as age-standardised rates (to remove the influence of age for comparing different populations). Age-standardised incidence of liver cancer is increasing faster than all cancers combined. Liver cancer impacts men significantly more than women and is also disproportionally distributed (per capita) in areas of low socio-economic status and remote/very remote regions.	
The age-standardised incidence rate of **liver cancer** is estimated to be 8.6 cases per 100,000 persons in 2019. This represents: - a 13% increase from 7.6 in 2015, and - a 32% increase from 6.5 in 2010.	The incidence of **all cancers** combined in Australia is changing over time. From 1982 to 2015, the age–standardised incidence rate increased by 21% (from 383.5 to 486.9 per 100,000). However, this includes a slight improvement (of 2.6%) in rate from 2010 to 2015, when the age-standardised incidence rate decreased from 499.7 to 486.9 per 100,000 persons.
In the period 2010-2014, stratified by socio-economic status (SES), the highest age-standardised rate of **liver cancer** (per 100,000 persons) occurred in the lowest quintile (SES 1) where it was 58% higher than the highest quintile (SES 5): - SES 1 (Men) 13.9 - SES 1 (Women) 4.5 - SES 5 (Men) 8.5 - SES 5 (Women) 3.2 - Australia (Men) 10.8 - Australia (Women) 3.6	In the period 2010-2014, for **all cancers** the age-standardised incidence rate was highest in the lowest SES quintile.
In the period 2010-2014, the age-standardised incidence rate of **liver cancer** was 16% higher in remote/very remote regions than major cities: - Remote/very remote (Men) 11.5 - Remote/very remote (Women) 5.1 - Australia (Men) 10.8 - Australia (Women) 3.6	In the period 2010-2014, for **all cancers** (and in contrast with the case for liver cancer) the age-standardised incidence rate was lowest in remote/very remote regions. - Remote/very remote (Men) 530.6 - Remote/very remote (Women) 410.6 - Australia (Men) 581.7

	- Australia (Women) 422.4
Aboriginal and Torres Strait Islander people experienced higher age-standardised liver cancer incidence rates than non-Indigenous persons. In 2009-2013, age-standardised **liver cancer** incidence rates were 142% higher in Aboriginal and Torres Strait Islander people (15.5 per 100,000) than non-Indigenous Australians (6.4 per 100,000).	In 2009–2013, age-standardised incidence rates for **all cancers** combined (excluding non-melanoma cancers of the skin) were 14% higher in Aboriginal and Torres Strait Islander people (501.4 per 100,000) than non-Indigenous Australians (438.6 per 100,000).
In Australia, more than 50% of people with hepatocellular carcinoma (HCC) were born overseas. HCC is the major cause of liver cancer morbidity and mortality and hepatitis B (22%) and hepatitis C (41%) are significant contributors.	
5-year relative survival Relative survival refers to the probability of being alive for a given amount of time after diagnosis, compared with the experience of the general population. The measure '5-year relative survival at diagnosis' refers to the probability that a person will survive their cancer for five years after a cancer diagnosis. Compared with most other cancers, liver cancer has a low rate of survival five years post-diagnosis.	
In the period 2012-2016, 5-year survival was lowest for: - pancreatic cancer (11%) - lung cancer (19%) - **liver cancer** (19.5%)	In the period 2012–2016, 5-year survival was 69% for **all cancers** combined.
Mortality Cancer mortality data refer to the number of deaths in a calendar year for which the underlying cause is cancer. Whilst the age-standardised rate of mortality from all cancers has decreased over time, deaths from liver cancer have increased exponentially.	
In the years from 1968 to 2016, as the Australian population doubled (from 12 million to 24 million): - deaths from **liver cancer** increased 16-fold from 117 (1968) to 1,864 (2016), and - the age-standardised **liver cancer** mortality rate increased from 1.3 deaths per 100,000 persons (in 1968) to 6.6 deaths per 100,000 (in 2016).	In the years from 1968 to 2016, the age-standardised mortality rate for **all cancers** combined has decreased over time: - 199.1 deaths per 100,000 persons in 1968 - 160.0 deaths per 100,000 persons in 2016. In 2019 it is estimated that the age-standardised mortality rate from **all cancers** is 159.0 deaths per 100,000 persons.

In 2019 it is estimated that deaths from **liver cancer** total 2,161 with an age-standardised mortality rate of 7.0 deaths per 100,000 persons.	
Mortality-to-incidence ratio (MIR) The MIR is calculated by dividing the number of deaths from certain cancers in a given year by the number of newly diagnosed cases in the same year. It is a high-level comparative measure to identify inequities in cancer outcomes, including identifying population groups with poorer survival outcomes (such as liver cancer) warranting further investigation.	
In 2016 MIRs were highest (indicating shorter survival) for: - oesophageal cancer (0.90) - **liver cancer** (0.87), - pancreatic cancer (0.86).	In 2016, the MIR for **all cancers** combined in Australia was 0.34.

Liver cancer impacts a diverse range of people however certain population groups are disproportionally affected. There is considerable overlap with Hepatitis Australia's communities of interest (i.e. priority populations of the National Hepatitis B and Hepatitis C Strategies) including:

- People living with hepatitis B and hepatitis C
- Aboriginal and Torres Strait Islander people
- People from culturally, ethnically and linguistically diverse backgrounds
- People in detention settings, and
- People with a history of injecting drug use.