GOVERNMENT RESPONSE TO THE REPORT OF THE SENATE STANDING COMMITTEE ON COMMUNITY AFFAIRS

BREAST CANCER SCREENING AND TREATMENT IN AUSTRALIA

DECEMBER 1994

MINISTER FOR HUMAN SERVICES AND HEALTH
Minister Assisting the Prime Minister
for the Status of Women

Parliament House
Canberra ACT 2600

Telephone (06) 277 7220
Facsimile (06) 273 4146

- 5 DEC 1994

Senator Sue West
Chairperson
Standing Committee on
Community Affairs
Parliament House
CANBERRA ACT 2601

Dear Senator

Please find enclosed the response of the Government to the report of the Senate Standing Committee on Community Affairs of 9 June 1994 on the above matter.

The report of the Committee is a substantial record of progress and opinion on breast cancer screening in Australia as it was in 1993. It has been a useful exercise in reviewing the implementation of the National Program for the Early Detection of Breast Cancer and in identifying areas for further development.

The Government accepts or supports the great majority of the recommendations.

Yours sincerely

Dr Carmen Lawrence

FORWORD

On 27 May 1993 the issue of breast cancer screening and treatment in Australia was referred to the Senate Standing Committee on Community Affairs.

The terms of reference of the inquiry were to examine:

Breast cancer screening and treatment in Australia with particular reference to:

(a) the current state of the National Program for the Early Detection of Breast Cancer;

(b) cost efficiency of the screening program;

(c) Commonwealth/State funding;

(d) organisation of screening and treatment services;

(e) the availability of screening; and

(f) Medicare rebate;

with the aim of determining the optimum service for Australia.

The original reporting date of 1 March 1994 was delayed to 9 June 1994 to accommodate the high level of interest displayed.

The Committee made a total of 27 recommendations (listed at Attachment A.)

The recommendations relate to breast cancer screening, workforce issues, the collection of data, research and access to radiotherapy services. Two recommendations are concerned with biopsy and the Government is awaiting the outcome of an inquiry into the management and treatment of breast cancer being conducted by the House of Representatives Standing Committee on Community Affairs in relation to these.

A number of the recommendations relate to areas within the direct control of the Commonwealth. Others would require the co-operation of the States and Territories to implement, or are within their jurisdiction. All State and Territory Health Departments and the Australian Institute of Health and Welfare have been asked for comment on the Senate Committee Report. Discussions relating to workforce issues have commenced between the Commonwealth Departments of Human Services and Health, Employment Education and Training, and Immigration and Ethnic Affairs.

The Government either accepts or supports 24 of the 27 recommendations. The specific response to each recommendation follows. A summary of the responses is at Attachment B.

TABLE OF CONTENTS

Chapter 1

Chapter 2

Chapter 3

Chapter 4

Chapter 5

Chapter 6

Chapter 7

Attachment 1 - Communication Strategy - 1993-94

Attachment 2 - NHMRC-National Breast Cancer Centre - Terms of Reference

Attachment 3 - Policy and Practice in Relation to Symptomatic Women in the Program

Attachment 4 - Australian Cancer Society - Information for general practitioners

Attachment A - Breast Cancer Screening and Treatment in Australia - Recommendations of the Senate Standing Committee on Community Affairs

Attachment B - Summary of Responses to Recommendations

Introduction to Chapter 1

The Commonwealth/State agreements define the functions of the State Co-ordination Units, including:

'Consistent with national strategies, develop and promote programs for education, information and public awareness and disseminate information.'

The States and Territories therefore have primary responsibility for recruitment, education and information as they are intricately linked to the provision of services. Expertise and knowledge at the local level is considered important in fulfilling these functions.

The States are also required to ensure that each service has a recruitment plan which is consistent with the National Accreditation Requirements.

The allocation of funds for recruitment at the State level is directly linked to the number of women screened. The Commonwealth/State agreement for the second phase of the Program includes a component, 17% of the amount per woman screened, for recruitment, information and education at the State and Service level.

Based on the number of women which the Program estimates will be screened during 1994-95, up to $12 million will be available for recruitment and the provision of information for women and general practitioners. In addition a further $2.4 million has been allocated to national activities.

Adequate funding has been allocated for national communication activities over the 5 years commencing 1994-95.

Recommendation 1

That representations be made to the Victorian Electoral Commissioner to obtain access to the Victorian Electoral Roll for the purposes of the screening Program in Victoria.

The Government accepts this recommendation.

The Victorian Electoral Commissioner has now granted BreastScreen access to the Victorian Electoral Roll.

There is also a broader issue of access to the Commonwealth Electoral roll.

At present some access is possible with the gazettal of Regulations to the Commonwealth Electoral Act and Guidelines for the Conduct of Public Health Screening Programs in December 1993. However, the information cannot be provided by gender without an alteration to the Commonwealth Electoral Act itself.

The Minister for Human Services and Health has recently written to the Minister for Administrative Services requesting that the Commonwealth Electoral Commissioner be approached to consider amending the legislation as a matter of urgency.

Recommendation 2

That the Commonwealth Government, in co-operation with the States and Territories, undertake a national education campaign promoting the National Program for the Early Detection of Breast Cancer and that the educational campaign:

- **emphasise the importance for women of the early detection of breast cancer and the services currently available;**
- **clarify the limitations of the screening program, emphasising that mammographic screening is an aid to the diagnosis of breast cancer but will not prevent the disease;**
- **provide information to women and the community generally as the why the Program specifically targets women aged 50-69 years;**
- **provide information to women, the medical profession and the community generally on the difference between diagnostic and screening mammography;**
- **disseminate culturally relevant information about the Program to Aboriginal and Torres Strait Islander women; and ensure that this information is widely disseminated through Aboriginal and Torres Strait Islander organisations, especially through the network of Aboriginal Health Services; and**
- **disseminate information to women on non-English speaking backgrounds and women in rural and remote areas.**

The Government accepts this recommendation.

The first four points of this recommendation have been addressed in the National Program's National Communication Strategy, copy at Attachment 1.

The identified target audiences are women aged 25 years and over - with women over 50 years the main target group and women aged 40-49 years and 25-39 a secondary target- and health professionals with an emphasis on general practitioners.

The communication objectives are consistent with this recommendation. They are to increase awareness that:

- breast cancer is a major health issue for women;
- the risk of breast cancer increases with age, particularly from age 50;
- mammography screening does not prevent breast cancer but is the most effective method of detecting the cancer at an early stage when treatment is most effective;
- mammography screening has been shown to reduce deaths from breast cancer among women aged 50 years and over;
- there is insufficient evidence of benefit in population mammography screening for women aged under 50 years;
- there is a National Program for the Early Detection of Breast Cancer; and
- the general practitioner has a major role in a screening program.

The Program is currently in the process of appointing an advertising agency to undertake a major information campaign, which is to be launched mid February 1995 with television and print advertising aimed at women and the general community. This will be supported by various public relations activities.

Recent research with general practitioners has shown that they have a poor understanding of the difference between screening and diagnostic mammography; have concerns about the effectiveness/accuracy of the procedure and radiation risks; and need information about the appropriate screening age and interval.

A separate strategy will be developed by a small reference group within the Program with general practitioner and program management representatives. The aim of the group will be to formulate a strategy which will provide information in a way which is acceptable to general practitioners, will motivate them to encourage women to be screened and will enhance their standing within the Program.

It is expected that the strategy will use general practitioners and other clinicians who support the Program. It may also be feasible to work through the professional Colleges and General Practice Divisions.

The communication objectives listed above also form the basis of the information provided at the State and service level. A local approach is often more appropriate, as information can be linked to the launch of a service in an area. It also enables the use of local networks and, if necessary, the provision of material which is culturally acceptable.

Experience in the Program has also found that if general practitioners are approached with information on an individual basis when a service goes into an area they are more likely to support the Program.

The development of information for Aboriginal and Torres Strait Islander women at a national level is considered inappropriate. The State and Territory Governments support this position.

These materials need to be culturally relevant and acceptable to the community. This can only be achieved if the material is developed in close collaboration with the local community. The Aboriginal Health Service and Aboriginal women's services, where these exist, are often closely involved in this process.

Specific information about the Program for women from non English speaking backgrounds is also available. BreastScreen Victoria has made available to the Program at no cost the translation of the Victorian pamphlets into 10 languages. The pamphlets have been developed in close association with the ethnic communities, including extensive focus testing of the translations. The languages are; Italian, Greek, Macedonian, Chinese, Vietnamese, Spanish, Arabic, Serbian, Croatian and Turkish.

Most States now have pamphlets available in other languages and have also translated the consent forms and information sheets. In addition, translators are available at the screening service if required. Ethnic radio and the ethnic press are used to disseminate information, as well as addresses to women's groups.

At a national level, the Program has sponsored an episode of the SBS program 'English at Work' on breast cancer. This was screened twice during 1993 in English and five other languages - Spanish, Greek, Arabic, Vietnamese and Italian. All States have copies of the program and it is used at the local level when specific groups are being targeted.

To assist the States in disseminating this information to women from non English speaking backgrounds and Aboriginal and Torres Strait Islander women, additional unmatched Commonwealth funding totalling $300,000 has been offered to the States/Territories in 1994-95 for special recruitment initiatives.

Recommendation 3

That the State and Territory Co-ordination Units provide data collected relating to the screening Program to the National Breast Cancer Centre for further analysis and research.

The Government accepts the recommendation that data collected about the screening program be supplied to the National Breast Cancer Centre for purposes which fall within their terms of reference, but wishes to propose that it be provided by the National Co-ordination Unit rather than the State and Territory Co-ordination Units.

The Government would ensure the utmost co-operation in collaborating with the National Breast Cancer Centre. The National Program would be able to provide, on a routine basis, aggregate data based on its regular data collection and respond to other requests as required.

Data collected within the National Program for the Early Detection is being collected for the purpose of monitoring and evaluating its performance. Consent forms which clients sign within the Program inform women of the purpose for which the data is collected.

The collection and use of data within the Program has been an evolving process. Considerable effort has gone into negotiating the terms and conditions for the transfer and use of data. Only aggregate data is collected nationally as privacy and other legal constraints prevent the transfer of unit record data.

Tables containing non-identifiable, aggregate data are supplied on a regular basis from the State Co-ordination Units to the National Co-ordination Unit. The data is used to ascertain compliance to Commonwealth/State funding agreements; for quality control which is linked to the Accreditation process; and to feed back comparative data to the services within the Program. The feedback of information from the national and state levels to services is considered integral to quality control within the Program. Equally important is the national function to report to Parliament, to women and to the public.

The terms of reference for the National Breast Cancer Centre (see Attachment 2) do not include research. It is therefore considered inappropriate for the State Co-ordination Units to supply data to the Centre for the purpose outlined in the Report.

Further, it is possible that such a process would result in the duplication of administrative effort if data was to be supplied from State Co-ordination Units to both the National Co-ordination Unit and the Breast Cancer Centre. States would need to deal with an additional body with potentially different data requests, timeframes and personnel.

Chapter 2

Recommendation 4

That the supply of radiographers be regularly monitored by Commonwealth and State and Territory Governments.

Recommendation 5

That the supply of radiologists be regularly monitored by Commonwealth and State and Territory Governments.

In the context of this Report, recommendations 4 and 5 have been interpreted to relate to the supply of radiographers and radiologists in relation to breast cancer screening and treatment.

The Government supports Recommendations 4 and 5, but notes that they are essentially State issues.

The Commonwealth/State agreement for the continuation of the National Program for the Early Detection of Breast Cancer, which has recently been offered to all States, lists as a State responsibility the monitoring of work force supply within the State and encouragement of the availability of adequate numbers of appropriately skilled personnel.

However, as the lack of availability of radiographers and radiologists is becoming an increasingly serious problem, efforts are also being made at the national level which go beyond monitoring the problem.

It was noted in the report that there is often conflicting evidence on the availability of radiographers in Australia. A survey of services within the Program is planned to quantify the extent and nature of the problem. Strategies will be developed in full consultation with the States and Territories.

Officers of the Department of Human Services and Health and the Department of Immigration have met to discuss possibilities for dealing with the problem at a national level. Approaches will also be made to the Department of Employment, Education and Training if appropriate.

The supply of both radiographers and radiologists to the National Program is not simply a function of their numbers. Issues of location, conditions of work (especially on the mobile services) and the payment the Program is able to make will also need to be studied. This includes the possible impact of the monopoly effect on cost per woman screened where the supply (especially of radiological services) is limited or withheld.

The Commonwealth inquiry into the supply of, and requirements for, medical specialist services in Australia reported to the Minister for Human Services and Health on 30 September 1994.

The inquiry report was provided to the October meeting of AHMAC. The aim of this inquiry was to identify factors influencing the availability, quality of, and access to specialist services. It was also intended that the inquiry examine current approaches to specialist training including: the number of training places; selection procedures for trainees; training methods and assessment; and length and location of training. While the focus of the inquiry was on the surgical specialties, the recommendations arising from the inquiry are likely to be of relevance to medical specialties generally.

The Medical Workforce Data Review Committee (MWDRC), which is a subcommittee of the Australian Health Ministers Advisory Council (AHMAC), and is comprised of representatives from Commonwealth and State Health Authorities, the Australian Medical Council and peak organisations representing various components of the medical workforce, is responsible for monitoring specialist workforce and training post numbers, including those for individual specialties such as radiology. Should the MWDRC identify a shortage of radiologists, it can make recommendations to AHMAC on how to address such a shortage.

Recommendation 6

That breast cancer support and counselling services be encouraged and expanded.

The Government supports this recommendation but notes that the funding of such groups is primarily by community fundraising not from government sources.

The community based cancer support groups provide a significant function within the cancer field, and it is appropriate that they are operated by community members.

Within the National Program there is considerable importance given to the counselling function. It is a requirement of accreditation that it be available for all women at the assessment stage.

Many of the Services have direct links to community based cancer support groups, and these are encouraged at the State and local level by Services within the National Program.

The establishment of the National Breast Cancer Centre will enhance the operation of the cancer support groups through its function to provide information to doctors and to women and the role it could serve to let women know of the availability of the cancer groups.

Government support of events such as the National Breast Cancer Day assists in the support of the community for such groups.

Introduction to Chapter 3

The issue of access for women to the National Program for the Early Detection of Breast Cancer is critical to the success of the Program and considerable effort has been made to ensure that the Services are as widely available as possible, and that the information is appropriate. In June 1994 a national telephone number (13 20 50) was established and is being widely publicised. Women anywhere in Australia can be connected to their nearest service for the price of a local call.

Because the program is a population based screening program which aims to have an impact on mortality rates from breast cancer, it aims to reach the maximum number of women possible in the target age group. This has meant as rapid an implementation as possible consistent with good planning and the maintenance of quality.

The infrastructure to reach such large numbers has been established first in those areas where there is a sufficient population base to enable efficient operation and in which recruitment activities will most likely be effective.

The recruitment of women in the harder to reach groups and regions has required the development of specific materials and strategies, and has drawn upon the more general experience. Resources for such recruitment are more readily available in the later stages of the five year implementation period.

Recommendation 7

That Strategies be implemented to improve access to the Program in rural and remote areas and that these strategies involve, where appropriate, the provision of financial assistance to encourage women to participate in the Program.

The Government supports this recommendation.

The Program recognises that women in rural and remote areas may have some difficulty in accessing screening services and has set up a number of mobile services to extend the Program into these areas. As at 30 September 1994, there were 17 mobile services operating from fully equipped vans.

In some States, where mobile vans are not available special buses are provided to transport women to the fixed screening sites. In some States, limited financial assistance is available for the small number of women who may need to travel longer distances to attend for further assessment.

Several States are also using relocatables to reach rural and remote women. This service involves transporting and setting up a mammography machine at an appropriate venue, such as a community health centre. Women in the surrounding area are invited to attend during a specific period. The machine is then moved to the next town. This is a more cost effective way of providing a mobile service and it is expected that more will be put into operation. Strict quality control measures are undertaken to ensure the service remains of high quality by recalibrating the machine after each move and ensuring that all safety standards are met.

The Breast Cancer Screening National Costing Study considered the costs of providing screening services to rural women and concluded that the additional real cost of a rural/remote area service is between $20 - $30 per woman screened. As a result, additional funding of nearly $2 million has been offered in 1994-95 for the screening of women who reside in rural and remote areas. The States will assess the various ways these funds can be used to assist women in rural and remote area to access the Program.

The National Advisory Committee will be asked at its next meeting to consider establishing a subcommittee to look at implementation issues in rural and remote areas and to assess and develop strategies.

Access by women from rural and remote areas to screening services will be closely monitored by the Program.

The matter of financial assistance is a State responsibility. It is noted, however, that such assistance needs to be equitably distributed across all needs and all sectors of the population.

Recommendation 8

That strategies, sensitive to Aboriginal and Torres Strait Islander cultural values, be implemented to increase the access of these women to the Program, and the these strategies involve:

- **close liaison with Aboriginal and Torres Strait Islander community-based health organisations, especially the Aboriginal Health Services; and**
- **the dissemination of culturally appropriate information about the Program throughout the Aboriginal and Torres Strait Islander community.**

The Government accepts this recommendation.

The implementation of strategies to increase the access for Aboriginal and Torres Strait Islander women to the Program at a national level is considered inappropriate. The State and Territory Governments support this position. Strategies to ensure these women have access need to be culturally relevant and acceptable to the community. This can best be achieved with strategies that focus on the local community. The Aboriginal Health Service and Aboriginal women's services, where these exist, are closely involved in the development and implementation of these strategies.

Recommendation 9

That strategies, sensitive to the cultural backgrounds and values of women on non-English speaking backgrounds be implemented to increase the access of women from these groups to the Program.

The Government accepts this recommendation.

Each State and the ACT has implemented separate strategies in an effort to increase the number of women from non English speaking backgrounds participating in the National Program.

The recently revised National Accreditation Requirements require the States to have a recruitment plan which details their specific plans to recruit women with non English speaking backgrounds and to ensure access to the Program for a significant number of this population.

Recent research conducted on behalf of the Program indicates that women from non English speaking backgrounds are more likely to attend if they receive a referral from their general practitioner. A number of cultural requirements, such as minimal physical contact, minimal use of the word cancer and female radiographer were identified. These issues will be address in the recruitment strategies. The research also found that women in this group are less concerned about cancer and have a lower level of knowledge about cancer than women from English speaking backgrounds. They are more likely to attend if they can be screened via their community groups so women can support one another during the process. Women from this group often congregate in particular localities and a local, flexible campaign is more likely to achieve results. The research concluded that women from this group are just as likely to attend as the rest of the target group.

Therefore, as with Aboriginal and Torres Strait Islander women, it is felt that local level recruitment strategies are most appropriate and effective. The Government notes that witnesses appearing before the Committee supported the use of local community networks in encouraging women to attend. The Commonwealth Government's role is to support these activities and undertake national advertising in the national ethnic press as planned during the advertising campaign.

To assist the States in implementing their strategies and disseminating information to women from non English speaking backgrounds and Aboriginal and Torres Strait Islander women, additional unmatched Commonwealth funding totalling $300,000 has been offered to the States/Territories in 1994-95 for special recruitment initiatives.

Further information on the effectiveness of strategies aimed at women from non English speaking backgrounds and Aboriginal and Torres Strait Islander women will become available during the second phase of the Program through national reporting of results and the accreditation process.

Other Special groups

It is noted that the report does not comment on access to the Program for women with disabilities. This point has been raised by one of the State programs in response to the Report. The issue has been discussed in national meetings and every effort will be made to ensure appropriate access.

Chapter 4

Recommendation 10

That the focus of the Program remain women aged 50-69 years, but that mammographic screening continue to be available to women aged 40-49 years and 70 years and over.

The Government accepts this recommendation.

This recommendation is consistent with current Program policy. This policy position was devised on the basis of scientific research at the time the Program was established and for reasons of practicality. There are obvious difficulties associated with attempts to use more complex eligibility criteria.

Women aged 40-49 years will continue to have access to the Program, however, States advise women that mammography screening has only been proven to be beneficial among women over 50 years of age.

The Government will monitor data from the National Program for the Early Detection of Breast Cancer and overseas trials in relation to screening women aged 40-49 years. The policy will be kept under review.

Recommendation 11

That recognising that the Program is for well women, that symptomatic women inquiring or phoning for appointments be advised why the Program is not appropriate for them; and be provided with specific advice and information regarding the availability of other medical services;

Recommendation 12

That should symptomatic women present for mammographic screening they be screened under the Program; and be provided with advice and information regarding the availability of further medical services.

The Government accepts recommendations 11 and 12.

In all States women with symptoms are actively discouraged from attending for screening in all information available to women. In some States women are discouraged when they attempt to make an appointment. This latter practice has ethical and resource implications in that appropriate clinical staff must be available to assess whether the woman does have symptoms, and to recommend appropriate action.

It is a condition of Accreditation under the Program that all units within Screening and Assessment Services meet minimum standards and requirements.

The following minimum requirements for Accreditation relate to protocols for dealing with women who present for screening with breast symptoms:

- All units within the Screening and Assessment Service will use and adhere to written protocols for women presenting with symptoms of breast disease.
- A protocol will exist to ensure the assessment of women in whom symptoms are identified at the screening visits.
- All women in whom symptoms are identified at the screening visits will be offered clinical assessment or referred for a clinical assessment regardless of the result of the screening mammogram.
- The woman and her nominated general practitioner will be notified in writing of any significant symptoms that may require further investigation.

The Program's Policy and Practice on the Screening of Women with Symptoms is attached at Attachment 3.

The existence of such protocols does not indicate that the Program encourages women with symptoms to be screened, but is a reflection of the Program's responsibilities to these women.

Chapter 5

Recommendation 13

That information about the screening Program be more widely disseminated to the medical profession, and in particular to GPs; and that the further education of GPs in relation to all aspects of the Program be given priority.

Recommendation 14

That the role of GPs in their recruitment and support roles be recognised and encouraged under the Program.

The Government accepts Recommendations 13 and 14.

In September 1992 a direct mailing was made to all GPs in Australia informing them of the National Program and providing information about breast cancer and breast cancer screening.

Specifically, the National Program for the Early Detection of Breast Cancer is planning to undertake the education of GPs in the context of a broader national communication strategy that targets both the importance of screening for women as well as the education and support role of all the relevant health professionals.

This will be conducted in addition to numerous strategies to inform and involved GPs,which are routinely employed at the state and local levels of the Program.

Also, see response to Recommendation 2.

Information about the National Program was recently provided for GPs in conjunction with other communication initiatives on Australia's Breast Cancer Day which was funded by the Government. A copy of the material developed for General Practitioners is at Attachment 4.

Ad hoc support in the form of briefings and slides, provided by the National Co-ordination Unit to clinicians who conduct presentations about the Program. This type of approach, i.e. the presentation of material from medical practitioners to other medical practitioners, is considered a highly appropriate and effective communication method.

Recommendation 15

That Fellows of the Australian Society of Breast Physicians may be employed as second film readers under the Program, on condition that indemnity is provided by the employing authority.

This recommendation is consistent with current Program policy in that the requirement for film reading does not preclude the use of an appropriately qualified medical practitioner as one reader.

The issue of indemnity is a State one, as clinicians in Screening and Assessment Services are not Commonwealth employees. Advice from State managers is that indemnity relates equally to all salaried clinicians regardless of the specialty to which they belong.

This issue has been referred to the States.

Both Queensland and the Northern Territory strongly support this recommendation in light of the shortage of radiologists available to the Program in some parts of those States.

An error of fact was noted by the Queensland Department of Health in page 64 of the report that states "Whilst in all states except Queensland film reading is done by radiologists alone." Film reading by non-radiologist readers occurs in NSW both in the Program and in private sector screening and diagnostic services.

Chapter 6

Recommendation 16

That the Program avoid any duplication in the provision of screening services, but that it utilise both the private and public sectors in the provision of screening services subject to all services meeting the guidelines for accreditation established by the National Program.

The Government accepts this recommendation.

Decision making in relation to the location of services either geographically or whether services will be in the private or public sectors is the responsibility of the State and Territory Governments.

There has been a considerable effort to utilise the expertise and the mammographic capacity which already existed in the community. Many of the Services have incorporated private sector providers.

However, the basis of service delivery within the Program is the Screening and Assessment Service which is based on a multidisciplinary assessment centre. The establishment of this centre has not been a duplication as very few such centres existed. In several instances, where a private practice has operated in a mode consistent with Program policy, the whole service has been contracted to a private provider e.g. Geelong, Wagga, Cairns, and Launceston.

In other instances, the States have established the Screening and Assessment Service itself within the public sector, with the assessment provided in the public sector, and the screening being contracted to private sector providers.

In all services the reading of the films is done at the assessment centre usually by radiologists who are sessional and practice primarily in the private sector.

Recommendation 17

That the funding of screening mammography under the Program continue to be independent of Medicare fee-for-service schedules.

The Government accepts this recommendation.

The Commonwealth has provided funding for a further five years and a special purpose contract is being negotiated with all States and Territories.

The Commonwealth and States are currently developing a framework for the collection of uniform financial data. to facilitate the measurement of the cost-effectiveness of the Program. This data base will be supplemented by economic and costing analyses as necessary to measure and evaluate the cost-effectiveness of the Program.

Chapter 7

Recommendation 18

That open biopsy not be included as part of the screening Program.

Recommendation 19

That action to implement the above recommendation await any recommendations that the House of Representatives Standing Committee on Community Affairs, which is currently inquiring into the management and treatment of breast cancer in Australia, may propose in this area.

The Government has concerns about Recommendation 18, and supports Recommendation 19.

Open Biopsy is currently included in the National Program for the Early Detection of Breast Cancer as the Government's preferred option. However, States have the option to not provide the Service.

The Government's position has been adopted so that women who are invited for screening may have access to free investigations to the point where they can be told whether a cancer had been detected or not. It is also included for quality control reasons in that it provides a direct link between the identification of an abnormality on the mammogram and surgical removal of the lesion, thus ensuring that the correct lesion is removed.

It is acknowledged that the inclusion of open biopsy has been contentious, including strong opposition from the various professional colleges. This view is not shared by all practitioners in the Program.

Currently open biopsy is included as part of the Program in New South Wales, Victoria, Western Australia and the Australian Capital Territory. It will also be included in the Northern Territory when their Program begins.

Responses to the Senate Inquiry Report from the Northern Territory, the Australian Capital Territory and New South Wales offer support for the Government's position on this issue.

One State response contends that all successful international programs promote the concept of the 'multidisciplinary' team. The surgeon has an integral role in the multidisciplinary approach in clinical assessment as well as an operative role.

Breast surgery is increasingly seen as a speciality in its own right, shifting from the general surgery field. This specialisation allows adequate internal auditing to maintain the high level of skills required in the early detection of breast cancer.

The Commonwealth/State agreement for the continuation of the National Program for the Early Detection of Breast Cancer, which has recently been offered to all States, includes funds totalling 5% of the cost per woman screened for histological diagnosis. Payment for open biopsy will be made only on the basis of procedures performed. The method of payment for histological diagnosis will be kept under review.

The Government is awaiting recommendations from the House of Representatives Standing Committee on Community Affairs, which is currently inquiring into the management and treatment of breast cancer in Australia.

Recommendation 20

That more information be provided to women diagnosed with breast cancer on the various treatment options available to them; and that women be encouraged to participate in decisions regarding appropriate courses of treatment

The Government accepts this recommendation in principle and notes that it will be a major function of the National Breast Cancer Centre.

It is expected that the National Breast Cancer Centre will commence operations on 1 January 1995. A major focus of the Centre will be the development of evidence based best practice guidelines, and education and training programs for professions and the public to ensure that these are understood and implemented.

One of its terms of reference is to develop and implement educational packages for service providers across the health spectrum, women and the public on breast cancer and the best practice for screening and treatment and to undertake such evaluation of education strategies and programs as required to underpin the roles of the Centre.

The extent to which this recommendation is adopted is also largely dependent on a co-ordinated approach by the various medical specialties with responsibility for the treatment and management of breast cancer.

The Medical Workforce Data Review Committee (MWDRC) 1993 Annual Report noted that radiation oncologists are part of a wider group of oncologists which includes medical oncologists and surgeons, and that it is important to develop effective co-ordination between these different specialties. The MWDRC report also stressed that the supply of, and requirements for each of these three specialties will necessarily be interlinked, and in the longer term it would be preferable to recommend oncology workforce requirements incorporating each of these specialties.

Recommendation 21

That the supply of radiotherapy services be regularly monitored by the National Breast Cancer Centre

This recommendation is not consistent with the Terms of Reference for the National Breast Cancer Centre.

See also the responses to Recommendations 20, 22 and 23.

Recommendation 22

That the geographical distribution of radiotherapy facilities be improved so that women living in areas outside the major metropolitan centres can obtain equitable access to these services.

Recommendation 23

That the Commonwealth Government, in co-operation with the State/Territory Governments, improve the level of travel and accommodation assistance available to women living in areas outside the major metropolitan centres requiring radiotherapy treatment.

In regard to the recommendations involving radiotherapy, the provision of radiotherapy services is primarily a matter for the States, through their responsibility for the planning, provision and administration of services provided through their public hospitals. The concerns expressed in the recommendations will be referred to the Australian Health Ministers' Conference (AHMC).

The National Program has not developed specific strategies in relation to radiotherapy as the provision of treatment falls outside of its area of responsibility. However, the Department of Human Services and Health has a number of strategies which deal with aspects of rural health. It is considered more appropriate to argue for increased access to radiotherapy treatment for women, men and children requiring cancer treatment. See also comments in response to recommendation 20.

Recommendation 24

That hospital based cancer registries be established as a matter of priority

The Government supports this recommendation in principle, noting that it is normally a State responsibility.

Hospital based cancer registries (HBCR) have been proposed as one method by which cancer outcomes information can be collected. In response to resolutions from the Australian National Cancer Network sponsored HBCR conference, calls from health professional groups, the Senate Committee on Breast Cancer Screening and Treatment in Australia and the National Health Goals and Targets Cancer Implementation Committee, a working party has been established to examine HBCRs in Australia.

The Australian Cancer Society and the Australian Institute of Health and Welfare nominated representatives are working together to define the types of data required, by whom, for what purposes and in the event of a registry being set up, provide guidance as to how and when data items should be collected. The development of HBCRs in Australia would require appropriate funding from government and non-government sources, commitment from resident and visiting clinicians and hospital management, a clear set of guidelines for minimal operation and for its expanded use, and good links to State and Territory based cancer registries and other data collection agencies e.g. screening programs.

In order to facilitate this process, a draft document on HBCR minimum data set will be circulated in the near future to interested parties for comment. A study will also be commissioned on the operating costs and structure of HBCRs.

Recommendation 25

That statistics collected by State and Territory cancer registries be collected on a more uniform and consistent basis and that data on cancers generally be provided to the Commonwealth government on a timely and regular basis to ensure that current national statistics on the incidence of cancers are readily available

The Government supports this recommendation in principle, noting that it has limited influence on the performance of State Cancer Registries, and that there may be significant financial implications.

Uniformity in data collection is being addressed by the National Cancer Statistics Clearing House at the Australian Institute of Health and Welfare in conjunction with the State and Territory cancer registries. At present the core set of data and the standards imposed on this data are robust and directly comparable e.g.. age, histology, personal identifiers, country of birth, place of residence. Data collected on additional features of breast cancer, or any other cancers, is less comparable. For example data on tumour size, in situ verses invasive carcinoma, stage, Aboriginal status and node status are all collected on an ad hoc basis by State and Territory cancer registries.

Some of these data items are not amenable to collection at the State and Territory cancer registry level, but rather at the hospital based cancer registry level. For those data items which are amenable, funding is not currently available at the State and Territory based cancer registries to extend their capacity. A potential source of funds for the collection of this data is from the National Breast Cancer Centre.

The timely reporting of national cancer incidence data is dependent on the supply of data from the State and Territory cancer registries. While some cancer registries are able to provide data 18 months after the completion of the calendar year others are not able to supply data for up to four years after completion of the calendar year. The reasons for this delay are the (1) nature of cancer reporting (i.e. compilation of multiple reporting sources) (2) lack of resources (3) volume of case load (4) historical impediments (5) legislation inadequacies.

The Australian Institute of Health and Welfare and the State and Territory cancer registries are attempting to improve the timeliness of the national incidence reporting. As an ongoing feature of the future national cancer incidence data reporting, projections to the current year of the common cancers, of which breast cancer is one, will be undertaken. In the meantime, many of the State and Territory cancer registries have adopted new computing technology, more efficient methods of data collection (with attempts at electronic data transfer).

As with all data collections, speed of data turnaround is heavily dependent on resources, and many of the cancer registries do not have the resources and the Australian Institute of Health and Welfare have to operate within financial constraints which make it difficult to significantly speed cancer data collections.

The Commonwealth will continue to encourage the States to ensure their Cancer Registries are up to date, and to transfer data to the Australian Institute of Health and Welfare in a timely manner. It acknowledged that this is important to the capacity to understand and to monitor breast cancer in the population. In particular information on the incidence and size of breast cancers is critical to a scientific evaluation of the success of the National Program for the Early Detection of Breast Cancer. The National Program will conduct a national workshop in 1995 to explore further issues relating to this long term evaluation. State Cancer Registries will be actively involved in the workshop.

Recommendation 26

That recognising the fundamental importance of research into the diagnosis and treatment of breast cancer, that the Commonwealth provides a specific allocation for research into breast cancer in future Commonwealth budgets.

The Government supports this recommendation.

Specific funding was provided for breast cancer in this year's Budget to enable the establishment of the Kathleen Cuningham Research Foundation. Ongoing funding for breast cancer research will be provided through the National Health and Medical Research Council (NHMRC). While recognising that only good quality research should be supported, and that breast cancer will benefit from multidisciplinary research across many areas, the Government has indicated to the NHMRC that it wishes to see that breast cancer remains a priority for medical research. The mechanisms for the most effective direction of research funds towards breast cancer will be determined by the NHMRC.

Recommendation 27

That the Commonwealth Government provide additional funding for the conduct of clinical trials into breast cancer to assess existing management protocols and to develop new treatment schedules.

The Government supports this recommendation.

The Commonwealth has provided significant new funding for clinical trials of treatment and prevention in breast cancer to commence next year through the NHMRC. The Government is concerned to ensure that proposed clinical trials are of a high standard and will continue to assess proposals via peer review process through the NHMRC. Additional resources for clinical trials may be obtained from the Kathleen Cuningham Foundation.

The National Breast Cancer Centre will develop guidelines and information to translate research findings into improved treatment and care for people with breast cancer.

ATTACHMENT 1

NATIONAL PROGRAM FOR THE EARLY DETECTION OF BREAST CANCER

COMMUNICATION STRATEGY - 1993-94

In 1990, the Commonwealth Government committed $64m over 3 years towards the development of a National Program for the Early Detection of Breast Cancer. The Program is being cost-shared with the States and Territories.

The National Program is intended to be a clearly identifiable, integrated, systematic and co-ordinated program.

A State Co-ordination Unit (SCU) in each State/Territory has primary responsibility for the implementation of the National Program and advertising of services will be done at the local level by the SCUs or the service itself.

The National Co-ordination Unit (NCU) provides a central co-ordination function for the National Program. The role of the NCU is to develop and implement national education, information and public awareness campaigns in consultation with the appropriate professional and client bodies and SCUs.

RATIONALE

As the National Program for the Early Detection of Breast Cancer is a joint Commonwealth/State program, the communication strategy needs to be consistent with agreed State and Commonwealth responsibilities. Communication activities undertaken by the Commonwealth should avoid causing excessive demands on the State screening services. National activities should be planned in consultation with the State Co-ordination Units and national activities will be complementary to, and consistent with, the activities planned by the States and Territories.

Given that mammography screening services will progressively become accredited, a steady build-up of communication activities is proposed. These phases will need to be planned in detail to ensure each can be brought on as the need arises or in response to Ministerial directives.

In the initial phase, communication activities should promote the National Program and its co-ordinated, accredited nature. The target for this phase should be women and health professionals. Accurate coverage of breast cancer issues by the media should be encouraged and relevant information materials should be developed.

The next phase should focus on the primary target audience and should provide specific information about breast cancer and screening mammography.

The final phase, a consolidation phase, should reinforce the campaign messages of the earlier phases and would rely on media to keep breast cancer issues on the public agenda.

COMMUNICATION OBJECTIVES

The overall communication objectives for this Program are to:

- increase awareness of the National Program and its co-ordinated, accredited nature by focusing on:

    - the phased implementation of the Program;
    - the accredited screening and assessment centres; and
    - priority access for women aged 50-69 years.

- increase awareness that:
    - the risk of breast cancer increases with age;
    - mammography screening has been shown to reduce deaths from breast cancer among women over 50 years of age;
    - there is insufficient evidence of benefit from mammography screening for women aged 40-49 years, and that there is no evidence of benefit for women under 40 years; and

- increase accurate coverage of breast cancer screening by the media.

TARGET AUDIENCES

Primary audiences (in order of importance to communication):

Women
- over 50 years
- 40-49 years
- under 40 years,

with special consideration being given to the following sub-groups:

- women from non-English speaking backgrounds
- Aboriginal and Torres Strait Islander women
- women in rural and remote areas.

Health professionals, including:

- general practitioners
- radiologists
- radiographers
- surgeons
- pathologists
- nurses
- community and women's health workers.

Secondary audiences include:

- broader community
- Parliamentarians
- workers in the National Program
- other health professionals not working in the National Program.

MESSAGES

The **primary** messages for women and health professionals are:

- a national, co-ordinated network of accredited breast screening services is being established throughout Australia; and

- screening mammography can reduce deaths from breast cancer in women over 50 years of age, if done properly.

The **secondary** messages for the identified target audiences are:

- breast cancer is a major health issue for women - it kills more than any other cancer;

- the incidence of breast cancer increases with age;

- screening does not prevent breast cancer, but it can detect cancers at an early stage when treatment is most effective;

- screening mammography is not as effective in pre-menopausal women;

- women in the target age group should attend for screening; and

- GPs will be kept fully informed of their patient's results unless the woman chooses otherwise.

RESEARCH (TO DATE)

The National Program's policy is based on the recommendations of the Australian Health Ministers' Advisory Council (AHMAC) Breast Cancer Screening Evaluation report "Breast cancer screening in Australia: future directions". This report considered data from a number of pilot projects in Australia and overseas but does not provide much detail on the attitudes of women and the medical profession to a national screening program or their knowledge of breast cancer and screening benefits.

Australian research to date reveals that there is limited knowledge amongst Australian women about age groups most at risk of breast cancer, and about treatment alternatives. Only 50% of a recent sample had heard of screening mammography with 22% viewing themselves as personally susceptible to breast cancer.

There is some information available on factors which influence women's participation or intention to participate in a mammography screening program. However, studies show that knowledge of breast cancer, and contact with breast cancer are not strong predictors of intention to attend for screening.

Research done in relation to General Practitioners (Cockburn et al) shows that GPs need more information about mammography and screening. One study showed that:

- only 25% of GPs knew that the risk of breast cancer increased with age;
- 30% knew that the evidence for a reduction in mortality as a result of mammography screening is weakest for women less than 50 years of age; and
- 97% of GPs had a favourable or higher attitude to mammography.

The conclusion of the study is that GPs need correct information about the target group for screening so that women in the appropriate age groups are encouraged to attend screening programs.

RESEARCH REQUIRED:

Up-to-date information on women's and health professionals' knowledge and attitudes to screening and the factors that influence attendance (collected as part of the current interim evaluation of the Program), will assist in the fine tuning of communication messages.

Once the messages and the mediums through which those messages will most effectively be conveyed to the target audiences are known, there will need to be focus testing of any advertising/print materials that are developed.

COMMUNICATION ACTIVITIES

As this campaign involves a number of target audiences requiring different and complex messages, a phased public-relations-based approach is recommended for the communication strategy.

Phase 1, commencing immediately and to be co-ordinated within the Department, should comprise the following co-ordinated public-relations activities:

- development of a general information brochure about the national program;
- media monitoring and issues management, including the provision of background information to selected women's magazines;

- encouragement of informed print and electronic media coverage of the National Program and breast cancer screening issues;
- encouragement of breast cancer themes in television drama programs;
- production of an information kit for Parliamentarians;
- opportunities for the Minister to endorse the National Program (eg. opening screening services, awarding accreditation certificates, etc); and
- focus on the medical media, possibly through the publication of journal articles by professionals within the Program.

Phase 2 of the campaign would focus on the development, by a creative agency, of a message suitable to be conveyed to the target audiences via a number of media. Television advertising, while costly, is probably the best way of raising awareness of an issue quickly. It would need to be supported by print (women's magazines and the medical press) and radio advertising; interviews on electronic media; perhaps a more detailed brochure/fact sheets, as well as a continuation of the public relations activities already outlined in Phase 1.

Women from non-English speaking backgrounds and Aboriginal and Torres Strait Islander women are seen as having special needs and will most likely need to be targeted with specific radio and print/poster advertisements. The attached budget includes the envisaged costs of producing materials of direct relevance to these groups.

The media should also be encouraged to provide extensive coverage of a National Breast Cancer Day, the National Screening Conference and the Breast Cancer Research Conference in 1994.

Nationally co-ordinated, community-based public relations activities, such as breast cancer information displays at shopping centres and community centres could also be considered in this phase of the campaign.

In this Phase, direct marketing should be considered as an effective way of communicating with workers in the National Program, GPs and other health professionals, Family Planning Clinics, Out-patient areas in public hospitals, Migrant Health Centres and women's groups. Information kits specific to these individual groups could be developed and forwarded under cover of a letter signed by the Minister.

Phase 3 of the communication strategy, the consolidation phase, should build on the campaign messages of the earlier phases and rely on the media contacts made earlier to keep breast cancer issues firmly and accurately on the public agenda.

ATTACHMENT 2

NHMRC - NATIONAL BREAST CANCER CENTRE

TERMS OF REFERENCE

The Centre is to support and progress current NHMRC initiatives and to work towards improving breast cancer outcomes in Australia.

The Centre should:

- Act as a clearing house for information on breast cancer.
- Undertake evidence-based analyses (including meta-analysis) of national and international scientific and other literature on breast cancer, and inform researchers, service providers and the public on these matters.
- In conjunction with the relevant NHMRC committees, cancer societies and professional bodies, progress the work on development and implementation of guidelines and frameworks for best practice in breast cancer treatment.
- In conjunction with the existing National Program for the Early Detection of Breast Cancer, develop best practice guidelines for diagnosis of breast cancer.
- Establish a program to develop a broad consensus approach to the implementation of best practice guidelines among professionals.
- Develop and implement educational packages for service providers across the health spectrum, women and the public on breast cancer and the best practice for screening and treatment.
- Undertake such evaluation of education strategies and programs as required to underpin the roles of the Centre.
- Liaise with the NHMRC and the Australian Breast Cancer foundation in relation to perceived research priorities.
- Develop and implement a strategy to ensure independence from Commonwealth funding by 30 June 1998.

The Centre must, through consultation, develop a program which complements and supports the work of other NHMRC bodies, the National Program for the Early Detection of Breast Cancer, the relevant professional bodies, non-government organisations and other groups dealing with breast cancer.

ATTACHMENT 3

POLICY AND PRACTICE IN RELATION TO SYMPTOMATIC WOMEN IN THE PROGRAM

Summary

- **The National Program selects women on the basis of age alone.**
- **Decisions on eligibility based on the presence or absence of symptoms would be impractical.**
- **It is Program policy that women with symptoms are actively discouraged from attending the Program.**
- **The Program has a responsibility to those women who attend for screening and who have symptoms and requires protocols to be in place for this situation.**
- **It screens such women, and recommends further investigation (either within the Program or through the women's GP) regardless of the outcome of the mammogram.**

Rationale and Practice

The primary purpose of the National Program is to detect cancer sufficiently early so that prognosis is enhanced for those women found to have the disease. It aims to screen a large proportion of women in the age group for which mammography has been proven to be effective in reducing mortality - those 50-69 years.

In the scientific trials on which the Program was based, no distinction was made between women who had symptoms and those without symptoms. Mammography was offered to all women in the appropriate age group. It can be expected then, that the mortality benefits may be anticipated where screening is offered to the whole eligible population.

The basis on which women are eligible for screening must be clear and unequivocal. The recommendation of the Breast Cancer Screening Evaluation Committee that "a national mammography screening program should select women on the basis of age alone" provides such a basis. Generally there is no dispute about a women's age, regardless of any lack of consensus about what the age of eligibility should be.

There is no such clarity about the meaning of "symptom". The Program defines a symptom of breast malignancy as a lump or serous or bloody nipple discharge, although it does collect information on other "symptoms" nominated by the woman or health professional or observed during screening. Women themselves may define breast pain or other signs as "symptoms". There are obvious difficulties associated with any attempt to use the presence or absence of symptoms as a primary criteria for eligibility.

Any policy is only effective if it is able to be implemented.

In a system where women are recruited through the use of a population register and through generalised recruitment strategies, age is the only practical basis on which letters of invitation can be issued and eligibility promoted in general.

Population based mammographic screening is directed primarily at women without symptoms, and this is the practice throughout the National Program. Publicity and educational material stress that women who have symptoms should consult their general practitioner. If the practitioner considers it necessary they will be referred to the usual diagnostic services.

A letter mailed to all general practitioners in September 1992, from the Commonwealth spokesperson on Women's Health, Dr Margaret Dean, stated clearly that "women who have symptoms or indications of breast malignancy should not be referred to the National Program".

In all States women with symptoms are actively discouraged from attending for screening in all information available to women, - in publicity material and/or in letters. In some States women are discouraged when they attempt to make an appointment. This latter practice has ethical and resource implications in that appropriate clinical staff must be available to assess whether the woman does have symptoms, and to recommend appropriate action.

Another aspect of direct discouragement of this nature may be that women will disguise the presence of symptoms. Where the mammograph is then negative, the woman will not automatically receive the additional investigation (either at a Program Assessment Service, or by specific referral back to her general practitioner) she would be offered had the symptom been declared.

The Program recognises that, whatever the discouragement, some women with symptoms will present for screening. It accepts a responsibility to those women who indicate at presentation that they have a symptom, or who insist that they will not attend elsewhere for investigation or who are unable to attend elsewhere. In these cases the women are screened.

Each Service is required to have a protocol governing procedures for the screening of women with symptoms. The existence of such protocols does NOT indicate that the Program encourages woman with symptoms to be screened, but is a reflection of the responsibility indicated above.

The existing National Accreditation Guidelines require that all women in whom symptoms are identified be recommended for further assessment, regardless of the result of the mammogram. In some situations a clinical examination is performed at the time of screening. IN others women are referred to their general practitioner or recalled to an assessment clinic for further investigation.

In all cases the Program policy is that the women will be advised to have significant symptoms further investigated. Where a woman has nominated a general practitioner she/he will also be provided with that advice.

The Program closely monitors its performance and data will be collected and reported on the screening of women who have identified symptoms.

National Co-ordination Unit
March 1994

To be reviewed in March 1996.

(Developed in consultation with the National Advisory Committee for the Early Detection of Breast Cancer)

ATTACHMENT 4

BREAST CANCER

Morbidity and Mortality

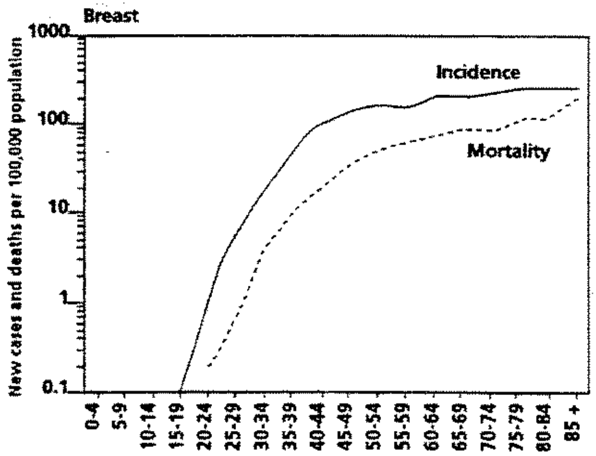
Breast cancer is the most common cause of cancer deaths in Australian women.[1] In Australia in 1990, almost 7,000 cases of breast cancer were diagnosed and in 1992 there were 2,438 deaths from breast cancer in women.[2] There has been an increase in the incidence of breast cancer in the five year period from 1983 to 1988. One woman in 15 in Australia will develop breast cancer by age 74.[1] This risk varies with age as shown in Table 1.

TABLE 1: Risk of developing breast cancer in Australia in 1983 and 1988

Age group (years)	1983	1988
20 - 39	1 in 250	1 in 250
40 - 49	1 in 84	1 in 77
50 - 59	1 in 66	1 in 60
60 - 69	1 in 54	1 in 45
70 - 79	1 in 42	1 in 39
Lifetime	**1 in 17**	**1 in 15**
50 - 69	**1 in 30**	**1 in 26**

Source: Australian Institute of Health and Welfare, unpublished, 1994

FIGURE 1: Age specific incidence and mortality rates for breast cancer, Australia 1988



Source: Cancer in Australia 1986-1988, Australian Institute of Health & Welfare.[1]

Primary Prevention

Currently, there is little that can e done to prevent breast cancer. Major risk factors for breast ancer are non-modifiable. Known risk factors explain only bout 30% of breast cancers.[3]

Major Risk Factors

ge: Over 70% of breast cancer ccurs in women who are aged 0 years or over.[1] The incidence f breast cancer and mortality om breast cancer rises with ge as shown in Figure 1.

amily history: Women who ave a first degree relative nother, sister or daughter) who eveloped breast cancer before e age of 50 years have an creased risk of breast cancer d this risk increases with the umber of first degree relatives fected. Breast cancer in one first degree relative is associated with a two-fold increase in risk, increasing if more first degree relatives are affected.[3,4] However, only about 4-5% of breast cancers are linked to family history.

Genetics: In cases of inherited breast cancer, there may be more than five genes involved with studies indicating that at least half of these involve errors in a single gene, called BRCA1.[5,6]

Previous history of breast cancer: Women who have previously been treated for cancer in one breast have an increased risk of developing cancer in the other breast.

Benign breast disease: Women with some forms of benign breast disease have an increased risk of developing breast cancer, particularly where biopsy indicates atypical hyperplasia.

AUSTRALIAN CANCER SOCIETY

Other Risk Factors

Hormonal factors: Hormonal factors linked to breast cancer include early menarche, late menopause and older age at time of first full term pregnancy. A woman who does not have children has a greater risk of developing breast cancer than one who has had children.

To date, oral contraceptives have not been shown to affect risk, however the effects with long term use from an early age are unknown.[7] Research into the role of post-menopausal oestrogen therapy has yielded contradictory findings. For each individual woman, the potential to increase the risk of breast cancer needs to be balanced against the documented beneficial effects of hormone replacement therapies in relation to osteoporosis and heart disease.

Diet: The role of diet in breast cancer is still being evaluated. There is some evidence to show there is an association between dietary fat consumption, low fibre diets and breast cancer.[8] Alcohol consumption may be associated with breast cancer.[9]

Exposure to toxic chemicals: Exposure to chemicals, especially pesticide residues, may be a causal factor in breast cancer development.[10]

Early Detection

The best hope of reducing mortality from breast cancer currently lies in early detection. It has been demonstrated that the five-year survival rate for women with non-localised breast cancer is less than 60%, with survival increasing to 91% if the cancer is detected and treated at a localised stage. The survival rate approaches 100% if the cancer is detected in situ.[11]

There are four methods of early detection:

1. Breast self examination (BSE)

Meta-analysis of studies investigating BSE have shown that the tumours detected by women practising BSE tend to be smaller and have less axillary node involvement than those in women not practising BSE. However, improvements in survival rates in women practising BSE have yet to be demonstrated.[12]

Recommendation: The Australian Cancer Society (ACS) recommends that women over 35 years of age practise BSE monthly.

2. Physical examination by a doctor

Currently, there do not appear to have been any trials examining the impact of physical breast examination by a doctor on survival from breast cancer. However, it seems likely that such examinations would improve the rate of early detection.

It is important that women who are having screening mammograms continue to receive an examination from their doctor and to practise BSE, as up to 30% of breast cancers will develop as a palpable lump between screening mammograms, even when the previous mammogram is normal.[13]

Recommendation: The ACS recommends that every woman from age 40 has a clinical breast examination as a part of a routine annual examination. The policy of the Royal Australian College of General Practitioners (RACGP) is that regular clinical examination should be offered because not all breast cancers can be detected by mammography.[14]

3. Prompt reporting of breast changes

A number of changes to the breasts may be indicative of breast cancer including:

- a lump in the breast not related to menstruation,
- bleeding or discharge from the nipple,
- an alteration in the shape of the breast,
- puckering or dimpling of the skin of the breast,
- soreness or retraction of the nipple.

The shorter the delay between the detection of a breast change and its treatment, the greater the survival rate.

Recommendation: The ACS recommends that women with breast symptoms report them promptly to their general practitioner and that the general practitioner refers women with suspicious findings.

4. Mammography

Screening mammography can detect cancers which are too small to be found through physical examination. It is the most effective method available to detect breast cancer at an early stage when conservative treatment and a successful recovery are more likely.[13 14] A mammogram can identify a very small tumour well before the lump can be palpated or before there are any symptoms or signs of breast cancer.

Overseas research into screening mammography programs has demonstrated significant reductions in breast cancer mortality. The National Cancer Institute held an International Workshop on Screening for Breast Cancer in 1993 to conduct a review of the most recent clinical trial data on breast cancer screening, ncluding eight major randomized controlled trials from around the world.[17] Every study found a protective effect due to screening for women in the 50-69 year age group of around 30-35%.

For women in the 40-49 year age group, there was no reduction in mortality from breast cancer attributable to screening in the first 5-7 years after entry and an uncertain marginal reduction in mortality at about 10-12 years.[17] The breast tissue of younger women is more fibrous and dense than that of older women, making mammography less accurate. This may result in a higher recall rate, higher benign to malignancy biopsy rate and a lower cancer detection rate.[18,19] The National Health and Medical Research Council state that there is insufficient evidence to recommend screening women under 50 years.[20]

The general practitioner has a vital role to play in encouraging eligible women to attend for mammographic screening. Australian research has shown that up to 90% of women will attend for screening following a recommendation from their general practitioner.[21]

Recommendation: The ACS recommends screening mammography for women over 50 years. RACGP policy is that mammography is the most useful tool currently available to detect asymptomatic breast cancers.

AUSTRALIAN
CANCER SOCIETY

REFERENCES

1. Jelfs, P., Giles, G., Shugg, D., Taylor, R., Roder, D., Fitzgerald, P., Ring, I., Condon, J. *Cancer In Australia 1986-1988.* Australian Institute of Health and Welfare, Canberra, 1994.

2. Senate Standing Committee on Community Affairs. *Breast Cancer Screening and Treatment in Australia, Report of the Senate Standing Committee on Community Affairs.* Commonwealth of Australia, Canberra, 1994.

3. Seidman, H., Stellman, S.D., Mushinski, M.H. A different perspective on breast cancer risk factors: some implications of the non attributable risk. CA-A Cancer *Journal for Clinicians*, 1982, 32:301-313.

4. Colditz, G.A., Willett, W.G., Hunter, DJ, Stampfer, M.J., Manson, J.E.,Hennekens., C.H.,Rosner.,Speizer.,F.E. Family History, age and risk of breast cancer - prospective data from the Nurses' Health Study. Journal of the American Medical Association, 1993, 270:338-343.

5. Cowley, G., Family matters, *Newsweek*, 6 December 1993, 46.

6. Brown, P., Breast Cancer. A lethal inheritance. *New Scientist*, 18 September 1993, 34-35.

7. Anti-Cancer Council of Victoria, Canstat, Cancer Epidemiology Centre, Anti-Cancer Council of Victoria, Victoria, 1993, 17:1-16.

8. Baghurst, P. Rohan, T. High-fibre diets and reduced risk of breast cancer. *International Journal of Cancer*, 1994, 56:173-176.

9. Marshall, E. Search for a Killer: Focus shifts from fat to hormones. Science, 1993, 259:618-621.

10. Wolff, M.S.,Toniolo, P.G., Lee, E.W.,Rivera, M., Dubin, N. Blood levels of organochlorine residues and risk of breast cancer. *Journal of the National Cancer Institute*, 1993, 85:648-652.

11. American Cancer Society, *Cancer Facts and Figures*, American Cancer Society, New York, 1987.

12. Hill, D., White, V., Jolley, D., Mapperson, K. Self-examination of the breast:is it beneficial? Meta-analysis of studies investigating breast self-examination and extent of disease in patients with breast cancer. *British Medical Journal*, 1988, 297:271-275.

13. Australian Cancer Society, *National Cancer Prevention Policy 1993*, The Australian Cancer Society, Sydney, 1993.

14. Royal Australian College of General Practitioners. *Royal Australian College of General Practitioners, Policy 77, Policy on Screening for Early Breast Cancer*,February 1993.

15. Bonett, A., Roder, D., McCaul, K., Milliken, L., *Epidemiology of Cancer in South Australia*, South Australian Cancer Registry, 1992.

16. Hurley, S.F., Kaldor, J.M. The benefits and risks of mammographic screening for breast cancer . *Epidemiological Reviews*, 1992, 14:101-130.

17. Fletcher, S; Black, W; Harris, R; Rimer, B; Shapiro, S;. Report of the International Workshop on Screening for Breast Cancer. *Journal of the National Cancer Institute. 1993*, 85:1644-1656.

18. Transcript of Evidence by RACS to the Senate Standing Committee on Community Affairs on Breast Cancer Screening and Treatment in Australia, 1994:1348.

19. Transcript of Evidence by the AMA to the Senate Standing Committee on Community Affairs on Breast Cancer Screening and Treatment in Australia, 1994: 1389.

20. National Health and Medical Research Council, *Mammography Guidelines for Women Under 50 years of Age*, October 1992,

21. Clover,K.A.; Redman,S.;Forbes,J.F.;Sanson-Fisher,R.W.;Dickinson,J.A. Promotion of attendance for mammographic screening through general practice; a randomised trial of two strategies. *Medical Journal of Australia*, 1992, 156:91-94.

This Fact Sheet was developed on behalf of the ABCD Taskforce by the NSW Cancer Council with the assistance of the Australian Cancer Society, the Royal Australian College of General Practitioners and the National Program for the Early Detection of Breast Cancer in August 1994.

SCREENING MAMMOGRAPHY

What is Screening Mammography?

Screening mammography is performed in an organised and systematic manner in women without any symptoms or signs of breast cancer, so that early treatment may improve the outcome.

Unlike screening mammography, diagnostic mammography is for women who have breast symptoms or signs which require investigation. Diagnostic mammography is normally performed in conjunction with clinical assessment and other investigations, particularly breast ultrasound, fine needle aspiration and biopsy.

Women with breast symptoms should be referred to an appropriate service for diagnostic mammography by their general practitioner. They should not be referred to a screening mammography service.

What are the Benefits of Screening Mammography?

There is evidence to show that screening mammography is the most effective method available to detect breast cancer at an early stage when conservative treatment and a successful recovery are more likely.[1,2] A mammogram may identify a very small tumour well before the lump can be palpated and before there are any symptoms of breast cancer.

Overseas research has demonstrated that screening mammography programs can result in significant reductions in breast cancer mortality.[3,4,5] However, a review of major randomized controlled trials on screening mammography from around the world found that no significant reduction in mortality has been demonstrated in women aged under 50 years.[5]

What Is the National Program for the Early Detection of Breast Cancer?

The National Program for the Early Detection of Breast Cancer (NPEDBC) is jointly funded by the Commonwealth and State Governments. A network of dedicated, accredited Screening and Assessment Services is being established throughout Australia.

Each Screening and Assessment Service consists of a number of screening units (fixed site and mobile), affiliated with an assessment centre. By July 1994, 87 screening locations had been established throughout Australia. These are located in both the private and public sector. Assessment centres provide further investigation of women with screen detected abnormalities in order to provide a definitive diagnosis.

Who is Eligible for Screening within the National Program for the Early Detection of Breast Cancer?

Eligibility for screening by the NPEDBC is based on age. The NPEDBC targets women aged 50-69 years.

Women aged 40-49 years and 70-79 years may also attend for screening, if they wish but they are not targeted for recruitment by the NPEDBC. The increased radio-density of the breast tissue of younger women limits the accuracy of screening mammography. It is recommended that women from age 35 years be encouraged to practise breast self examination and report any changes in their breasts to their general practitioner.

Women who present with a lump or symptoms of breast disease should not be referred to the Program. A Medicare rebate is available for diagnostic mammography for these women. If it is subsequently found that there is no evidence of malignancy, then these women can be screened within the Program if they are over 40 years and at the appropriate interval.

Women who have a family history of breast cancer may be referred to the screening program if aged over 40 years, or alternatively to a private radiologist. In this situation, the mammogram attracts a Medicare rebate.

AUSTRALIAN
CANCER SOCIETY

What are the Main Features of the National Program for the Early Detection of Breast Cancer ?

- The NPEDBC includes recruitment, screening and when required, assessment up to and including histological or cytological diagnosis of breast cancer. Some States do not currently provide open biopsy as part of the Program.
- Services are provided by staff with appropriate expertise, experience and training. Assessment is undertaken by multidisciplinary teams with expertise in radiology, pathology and breast surgery.
- The service is FREE.
- Women aged 50-69 years are systematically recruited to the NPEDBC by letter, through media campaigns and through other strategies.
- Women are routinely recalled for a mammogram every two years.
- Women are screened with two view mammography (cranio-caudal and medio-lateral oblique).
- All mammograms are taken by a radiographer specially trained in screening mammography.
- All films are read and reported independently by two or more doctors, at least one of whom must be a radiologist.
- Screening and assessment is carried out at services accredited in accordance with the National Program Standards and Requirements for Accreditation.
- The results of the screening and assessment are provided directly to the woman and to her nominated general practitioner.

What happens to women when they are screened in the National Program for the Early Detection of Breast Cancer ?

Recruitment

Personalised invitations based on the electoral roll are sent to women aged 50-69 years. Other promotional strategies are also used. Women who attend for screening are sent a letter reminding them to have a repeat mammogram every two years. They will be re invited at that time.

Appointment

Women are required to telephone to make an appointment for a mammogram. A woman may telephone 13 2050 from anywhere in Australia and she will be connected automatically to the Screening and Assessment Service closest to where she is telephoning. Special arrangements may be made for non-English speaking women. Ethnic health and bi-lingual health workers can organise appointments and transport for non-English speaking women.

Screening

All staff are trained to deal sensitively with women who attend the Program. When women attend for screening, they will be provided with information about what to expect and asked to complete a few personal details, including a consent form for screening. Women will be asked to undress from the waist up.

Results

The woman and her nominated general practitioner are notified in writing within 14 days of the mammogram if the result is normal. If the woman needs further investigation she and her nominated general practitioner are notified.

Follow-up and assessment of screen detected abnormalities

Out of every 100 women screened, less than 10 women will be recalled for assessment. Women with screen detected abnormalities are followed up within 14 days of the initial screening.

Most of the women recalled will not have breast cancer. Some recalls will be due to technical

COMMON QUESTIONS FROM PATIENTS ABOUT BREAST CANCER

Are all women at risk of developing breast cancer ?

Yes, all women are at risk. Known risk factors for breast cancer are:

- advancing age
- a family history of breast cancer involving a first degree relative (mother, daughter or sister)
- previous history of breast cancer
- the presence of particular genes which are currently the focus of much research.

However, known risk factors explain only about 30% of breast cancers.[1]

Can physical breast examination detect all breast cancers?

Breast examination cannot detect all reast cancers. Breast self xamination can find a lump pproximately the size of a grape. Breast examination by a doctor can ind a lump approximately the size of pea and a screening mammogram an find a tumour approximately the ize of a grain of rice.

What is a mammogram?

mammogram is an X-ray of the reast.

What is a screening mammogram?

screening mammogram is for omen who do not have breast umps, nipple discharge or other reast changes. The purpose a screening mammogram is to etect unsuspected breast cancer an early stage so that early eatment occurs. If treatment is mmenced early then it is less kely to involve the removal of the east and early treatment is more kely to result in a successful covery.[2,3]

I am 35 years old, can I have a screening mammogram through the National Program for the Early Detection of Breast Cancer (NPEDBC)?

Women under 40 years of age are not eligible to have a screening mammogram within the NPEDBC.

Results from overseas studies have not suggested that women aged under 50 years will benefit from mammographic screening.[3] In addition, the breast tissue of younger women is more fibrous and dense than that of older women, making mammography less accurate.

Are screening mammograms accurate? Do they find all breast cancers?

No test is 100% accurate, including screening mammograms. Screening mammograms may not find all breast cancers. However, having a screening mammogram is at present the most effective method available to find breast cancer early.

Do women with small breasts need screening mammography to detect breast cancer?

Women with small breasts have the same risk of developing breast cancer as women with larger breasts. At present mammography is the most effective technique for detecting small breast cancers in all women, including those with small breasts.

Will having a screening mammogram hurt?

During the mammogram discomfort may be felt for a few seconds whilst the breast is being compressed. Compression of the breast is necessary so that more of the breast tissue can be seen. If the breast is not compressed properly, the mammogram will not be as clear.

Most women report that a mammogram is not uncomfortable and not painful.[4] Women whose breasts are tender before their period, may find it more comfortable to have a mammogram during or just after a period.

Can a screening mammogram be harmful?

Women are exposed to only a small amount of radiation from a screening mammogram. The compression used during a mammogram decreases the amount of radiation the woman is exposed to. There is no evidence that mammograms cause breast cancer.[5] There is no evidence that the pressure placed on the breasts during a mammogram damages the breast tissue or causes a cancer to spread.

How often should screening mammograms be performed?

All women between 50-69 years should have a screening mammogram every two years. Overseas research has shown that two yearly screening mammograms among women aged over 50 will significantly reduce death from breast cancer.[3] The NPEDBC will send women a reminder letter when their next visit is due.

How long will it take to have a mammogram?

Two X-rays are taken of each breast. Having a mammogram only takes a few minutes. However, about 30 minutes may be required for the whole procedure, including the completion of forms.

What clothes should a woman wear when she has a screening mammogram?

It is easier for the woman if she wears a two-piece outfit, such as a skirt and blouse or trousers and blouse. It is recommended that she does not use

AUSTRALIAN CANCER SOCIETY

talcum powder or deodorant before she attends for her mammogram, as it may interfere with the clarity of the mammogram.

Should a woman take anything along with her when she has a screening mammogram?

If the woman has had previous mammograms, she should take them with her to her screening visit and she should take reading glasses if she needs them to complete forms.

She should also take her general practitioner's name and address to the screening unit. This enables the unit to send her general practitioner a copy of the results, if she agrees to this.

Who will get the results of the mammogram?

The results of the mammogram will be given to the woman by mail or telephone, within 14 days of having had the mammogram. At the time of screening, the woman will be asked to nominate a general practitioner to receive a copy of the results. The National Program encourages women to nominate a general practitioner to whom their results will be sent.

A woman reports that she was called by the screening centre and was told that her mammogram had an abnormality that needed further assessment. What does this mean?

If something is found on the mammogram or if there was a technical problem with the mammogram, the woman will be recalled for further investigation. Further investigation may include a repeat mammogram, ultrasound, fine needle aspiration or a needle biopsy. She will be invited to attend for assessment within 14 days of the initial mammogram. Most abnormalities detected by a screening mammogram are not breast cancer. Of 10 women recalled for further assessment, less than 1 will have breast cancer.

The woman will be asked to nominate a general practitioner to be notified of her need for assessment and the results of assessment. The general practitioner will be notified by mail or telephone.

What is the cost to women of having a screening mammogram?

All services provided by the National Program for the Early Detection of Breast Cancer are free.

How can women be sure that the National Program for the Early Detection of Breast Cancer is as good as possible?

All of the Screening and Assessment units within the National Program are required to meet national accreditation standards. Accreditation aims to ensure successsful performance in a quality assurance program and covers such aspects as the minimum number of women each radiographer in the Program must screen each year, the requirement for two independent film readers (one of whom must be a radiologist) and the timeframe within which women are notified of the results of their mammogram.

If breast cancer is found, does it mean that the breast needs to be removed?

The treatment for breast cancer depends on the size of the cancer, whether it has spread or not and the woman's general health. All the possible treatment options will be discussed with the woman so that she may make an informed choice which is right for her. The main types of treatment are surgery, radiotherapy, hormone therapy and chemotherapy. Treatment may involve a combination of these types of treatment. Surgery may involve:

- **lumpectomy** (removing the lump and a small part of the breast around it and perhaps the lymph nodes),
- **partial mastectomy** (removing the lump and more of the tissue around it, but not the whole breast),
- **simple mastectomy** (removing the whole breast including the nipple) or
- **modified radical mastectomy** (removing the breast and nipple, the lymph nodes under the arm and some muscle from the chest).[6]

When breast cancer is detected early, its treatment is less likely to involve removal of the breast. Reconstructive breast surgery is available to women who undergo mastectomy.

Who will be in charge of looking after a woman's treatment for breast cancer?

The Program seeks to maintain an active role for the general practitioner in the ongoing management of women with screen-detected abnormalities. The nominated general practitioner will be kept informed every step of the way along the screening pathway.

Although treatment of breast cancer is outside the NPEDBC, all cases of breast cancer are followed up to determine the outcome. Women with histologically or cytologically confirmed breast cancer will be given the option of referral to a treatment clinic specialising in the treatment of screen-detected breast cancer or returning to their nominated general practitioner for referral to an appropriate surgeon.

REFERENCES

1. Seidman, H., Stellman, S.D., Mushinski, M.H. A different perspective on brea cancer risk factors:some implications of the non attributable risk. CA-A Cancer Journal for Clinician 1982, 32:301-313.

2. Bonett, A., Roder, D., McCaul, K., Milliken, L., Epidemiology of Cancer in South Australia, South Australian Cancer Registry, 1992.

3. Hurley, S.F. , Kaldor, J.M The benefits and risks of mammographic screening fo breast cancer . Epidemiological Reviews, 1992, 14:101-130.

4. Bennett, I.C., Robert, D.A., Osborne, J.M., Baker, C.A. Discomfort during mammography:, a survey of women attending a breast screening center. Breast Disease, 1994, 7:35–41.

5. Feig, S.A., Ehrlich, S.M. Estimation of radiation risk from screening mammography: recent tren and comparison with expect benefits. Radiology, 1990, 174:638-647.

6. NSW Cancer Council. Understanding Breast Can NSW Cancer Council, Sydn 1991.

This Fact Sheet was develo on behalf of the ABCD Taskforce by the NSW Canc Council with the assistance the Australian Cancer Soci the Royal Australian Colleg of General Practitioners an the National Program for t Early Detection of Breast Cancer in August 1994.

problems with the first mammogram. Less than 1% of women screened will be diagnosed with breast cancer. Further assessment may include physical examination of the breasts, repeat specialised mammography, ultrasound, fine needle aspiration and biopsy.

Open surgical biopsy is offered free within the NPEDBC in the ACT, NSW, Victoria and Western Australia. If a surgical biopsy is required, the woman can choose to have it performed by a surgeon associated with the Program or e referred to a surgeon by her eneral practitioner.

The screening service aims to notify the woman's nominated eneral practitioner on the ay with regard to a ecommendation for open biopsy r where a cancer is diagnosed.

Counselling is available to all women attending for assessment.

Treatment

he Program does not provide reatment for women with reast cancer. However, it refers omen for treatment and ollects data on treatment utcomes.

Women diagnosed with breast ancer can choose to select their wn surgeon after discussion ith their general practitioner can choose to be treated by urgeons associated with the rogram.

What is the Role of the General Practitioner in Relation to the National Program for the Early Detection of Breast Cancer?

Research suggests that general practitioners in Australia play a vital role in encouraging women to participate in screening mammography.[7-9] As a general practitioner, you can assist women to participate in the Program by:

- encouraging asymptomatic women aged 50-69 years to attend for screening.
- explaining the importance of screening and its advantages and limitations.
- answering any questions about screening.
- assisting women to make informed decisions about participating in the National Program.
- displaying screening mammography brochures and posters in your surgery.
- providing breast checks between screening rounds.

General Practitioners have the opportunity to play a central role in the early detection and management of breast cancer. The Program aims to involve the general practitioner throughout the screening pathway. The Standards and Requirements for Accreditation require that the woman's nominated general practitioner be kept informed of the results of screening and any subsequent assessment, unless the woman requests otherwise.

REFERENCES

1. Bonett, A., Roder, D., McCaul, K., Milliken, L., *Epidemiology of Cancer in South Australia*, South Australian Cancer Registry, 1992.

2. Hurley, S.F. , Kaldor, J.M. The benefits and risks of mammographic screening for breast cancer . *Epidemiological Reviews*, 1992, 14:101-130.

3. Shapiro, S., Venet, W. Strax, P., Venet, L., Roeser, R. Ten-to-fourteen year effect of screening of breast cancer mortality. *Journal of the National Cancer Institute,* 1982, 69:349-355.

4. Shapiro, S. Current results of the breast cancer screening randomised trial: The Health Insurance Plan (HIP) of Greater New York in : *Screening for breast cancer*. 1988, Day, N.E., Miller, A.B., Huber, Hans, 3-16.

5. Tabar, L., Faberberg, CJS; Gad, A., Holmberg, L.H; Ljungquist, U; Fagerberg, C.J.G;Baldetorp, L; Grontoft, O;Lundstrom, B., Manson, J.C. Reduction in mortality from breast cancer after mass screening with mammography. *Lancet*, 1985, 325:829-832.

6. Fletcher, S; Black, W; Harris, R; Rimer, B; Shapiro, S; Report of the International Workshop on Screening for Breast Cancer. *Journal of the National Cancer Institute*. 1993, 85: 1644-1656.

7. Clover K., Redman S. General practice based recruitment. Paper presented at Mammographic Screening Recruitment Strategies Workshop. Anti-Cancer Council of Victoria, May 1990.

8. Irwig L, Turnbull, D, McMurchie M. A randomised trial of general practitioner written invitations to encourage attendance at screening mammography. *Community Health Studies*, 1990, 14:357-364.

9. Clover K, Redman S, Forbes JF, Sanson-Fisher RW, Dickinson J. Promotion of attendance for mammographic screening through general practice : a randomised trial of two strategies. *The Medical Journal of Australia*, 1992, 156:91-94

This Fact Sheet was developed on behalf of the ABCD Taskforce by the NSW Cancer Council with the assistance of the the Australian Cancer Society, the Royal Australian College of General Practitioners, and the National Program for the Early Detection of Breast Cancer in August 1994.

[redacted]

RESOURCES AVAILABLE TO PATIENTS AND HEALTH PROFESSIONALS RELATED TO BREAST CANCER

Australian Cancer Society Members

The Australian Cancer Society (ACS) member organisations provide the following resources:

- Brochures, booklets, posters and videos on breast cancer, mammographic screening, breast self examination (BSE) and breast cancer treatment and management and living with breast cancer. These resources are frequently updated.

- Directory of Cancer Services (professional services, voluntary support services, government and commercial support services).

- Information Officers
  Each of the ACS member organisations have Information Officers available by telephone to answer questions on breast cancer risk factors and epidemiology, mammographic screening, BSE, breast cancer treatment and management, services available for cancer patients and printed and audio-visual resources for patients and health professionals.

or more information contact the CS member organisation in our State or Territory. Please efer to the listing overleaf.

Breast Cancer Support Service(BCSS)

This is a free service which offers practical and emotional support to women diagnosed with breast cancer. Women receive contact with specially selected and trained volunteers by telephone and in person. Volunteers are women who have been treated for breast cancer. The volunteers do not give medical advice. When they are asked for advice they refer the woman to her general practitioner or breast specialist. The volunteers are provided with supervision and continuing education.

The volunteer can phone or visit a woman prior to her treatment, during hospitalisation or at home following hospitalisation and maintain contact during treatment and recovery time, or at the time of breast reconstruction. The woman is provided with the volunteers telephone number.

For more information on the BCSS contact the State Co-ordinators in your State or Territory. Please refer to the listing overleaf.

The National Program for the Early Detection of Breast Cancer

The State and Territory screening mammography programs provide the following resources:

- Brochures, booklets, posters and videos on mammographic screening.

- Promotion Officers who can provide information to the general public and health professionals in the form of printed materials and verbal presentations.

For more information on the screening mammography programs in your State or Territory, please refer to the listing overleaf for the National Program for the Early Detection of Breast Cancer.

AUSTRALIAN
CANCER SOCIETY

	State ACS Member Organisations	BCSS Co-ordinators	National Program for the Early Detection of Breast Cancer
ACT	ACT Cancer Society Inc 15 Theodore Street Curtin ACT 2605 Phone(06) 285 3070 Fax (06) 285 3221	Ms Karen Sorenson ACT Cancer Society Inc 15 Theodore Street Curtin ACT 2605 Phone(06) 285 3070 Fax (06) 285 3221	Ms Jenny Brogan Women's Health Program ACT Health Building Corner Moore & Alinga Sts Canberra ACT 2601 Phone (06) 205 1085 Fax (06) 205 1394
NSW	NSW State Cancer Council 153 Dowling Street, Woolloomooloo NSW 2011 Phone (02) 334 1900 Fax (02) 357 2676	BCSS Co-ordinator NSW State Cancer Council 153 Dowling Street Woolloomooloo NSW 2011 Phone (02) 334 1900 Fax (02) 357 2676	Ms Ellen Ryan NSW Program for Mammographic Screening NSW Cancer Council 153 Dowling Street Woolloomooloo NSW 2011 Phone (02) 334 1938 Fax (02) 358 1452
NT	NT Anti-Cancer Foundation Shop 24 Casuarina Plaza Casuarina NT 0810 Phone (089) 274 888 Fax (089) 274 990	Ms Sue Hearn NT Anti-Cancer Foundation Shop 24 Casuarina Plaza Casuarina NT 0810 Phone (089) 27 4888 Fax (089) 274990	Ms Cynthia Croft Women's Cancer Prevention Unit Health House 87 Mitchell Street Darwin NT 0811 Phone (089) 892 922 Fax (089) 892 955
QLD	Qld Cancer Fund 553 Gregory Terrace Fortitude Valley QLD 4006 Phone (07) 257 1155 Fax (07) 257 1306	Ms Susan Steginga Qld Cancer Fund 553 Gregory Terrace Fortitude Valley QLD 4006 Phone (07) 257 1155 Fax (07) 257 1306	Ms Jennifer Muller Womens Cancer Prevention Program State Health Building 147-163 Charlotte Street Brisbane QLD 4000 Phone (07) 234 0907 Fax (07) 234 1577
SA	Anti-Cancer Foundation of the Universities of SA 202 Greenhill Road Eastwood SA 5063 Phone (08) 291 4111 Fax (08) 291 4122	Ms Margaret Tobin Anti-Cancer Foundation of the Universities of SA 202 Greenhill Road Eastwood SA 5063 Phone (08) 291 4111 Fax (08) 291 4122	Mr Walter Spehr SA Breast X-ray Service 1 Goodwood Road Wayville SA 5034 Phone (08) 373 4381 Fax (08) 373 4395
TAS	Tasmanian Cancer Committee 13 Liverpool Street Hobart TAS 7000 Phone (002) 312 990 Fax (002) 313 186	Ms Maureen Ramsden Tasmanian Cancer Committee Cnr Howick and Mulgrave Sts Launceston TAS 7250 Phone (003) 340 311 Fax (003) 316 433	Ms Valerie Gardner Tasman Breast Screening Service AMP Building 86 Collins Street Hobart TAS 7001 Phone (002) 336 356 Fax (002) 333 453
VIC	Anti-Cancer Council of Victoria 1 Rathdowne Street Carlton South VIC 3053 Phone (03) 279 1111 Fax (03) 279 1270	Ms Sue Bottomley Anti-Cancer Council of Victoria 1 Rathdowne Street Carlton South VIC 3053 Phone (03) 279 1111 Fax (03) 279 1270	Ms Onella Stagoll Breast Screen 31 Pelham Street Carlton South VIC 3053 Phone(03) 660 6889 Fax: (03) 662 3881
WA	Cancer Foundation of WA 334 Rokeby Road Subiaco WA 6008 Phone (09) 381 4515 Fax (09) 381 4523	Ms Carol Bishop Cancer Foundation of WA 334 Rokeby Road Subiaco WA 6008 Phone (09) 381 4515 Fax (09) 381 4523	Ms Barbara Edwards Women's Cancer Prevention Unit 9th Floor, Eastpoint Plaza 233 Adelaide Terrace Perth WA 6000 Phone (09) 323 6900 Fax (09) 325 1033

This fact sheet was developed on behalf of the ABCD Taskforce by the NSW Cancer Council with the assistance of the Australian Cancer Society, the Royal Australian College of General Practitioners and the National Program for the Early Detection of Breast Cancer in August 1994.

Breast Cancer Screening and Treatment in Australia Report of the Senate Standing Committee on Community Affairs

The Committee RECOMMENDS:

1. That representations be made to the Victorian Electoral Commissioner to obtain access to the Victorian Electoral Roll for the purposes of the screening Program in Victoria.

2. That the Commonwealth Government, in co-operation with the States and Territories, undertake a national education campaign promoting the National Program for the Early Detection of Breast Cancer and that the educational campaign:

   . emphasise the importance for women of the early detection of breast cancer and the services currently available;

   . clarify the limitations of the screening program, emphasising that mammographic screening is an aid to the diagnosis of breast cancer but will not prevent the disease;

   . provide information to women and the community generally as to why the Program specifically targets women aged 50-69 years;

   . provide information to women, the medical profession and the community generally on the difference between diagnostic and screening mammography;

   . disseminate culturally relevant information about the Program to Aboriginal and Torres Strait Islander women; and ensure that this information is widely disseminated through Aboriginal and Torres Strait Islander organisations, especially through the network of Aboriginal Health Services; and

   . disseminate information to women of non-English speaking backgrounds and women in rural and remote areas.

3. That the State and Territory Co-ordination Units provide data collected relating to the screening Program to the National Breast Cancer Centre for further analysis and research.

4. That the supply of radiographers be regularly monitored by Commonwealth and State and Territory Governments.

5. That the supply of radiologists be regularly monitored by Commonwealth and State and Territory Governments.

6. That breast cancer support and counselling services be encouraged and expanded.

7. That strategies be implemented to improve access to the Program in rural and remote areas and that these strategies involve, where appropriate, the provision of financial assistance to encourage women to participate in the Program.

8. That strategies, sensitive to Aboriginal and Torres Strait Islander cultural values, be implemented to increase the access of these women to the Program, and that these strategies involve:

   . close liaison with Aboriginal and Torres Strait Islander community based health organisations, especially the Aboriginal Health Services; and
   . the dissemination of culturally appropriate information about the Program throughout the Aboriginal and Torres Strait Islander community.

9. That strategies, sensitive to the cultural backgrounds and values of women of non-English speaking backgrounds be implemented to increase the access of women from these groups to the Program.

10. That the focus of the Program remain women aged 50-69 years, but that mammographic screening continue to be available to women aged 40-49 years and 70 years and over.

11. That recognising that the Program is for well women, that symptomatic women inquiring or phoning for appointments be advised why the Program is not appropriate for them; and be provided with specific advice and information regarding the availability of other medical services.

12. That should symptomatic women present for mammographic screening they be screened under the Program; and be provided with advice and information regarding the availability of further medical services.

13. That information about the screening Program be more widely disseminated to the medical profession, and in particular to GPs; and that the further education of GPs in relation to all aspects of the Program be given priority.

14. That the role of GPs in their recruitment and support roles be recognised and encouraged under the Program.

15. That the Fellows of the Australian Society of Breast Physicians may be employed as second film readers under the Program, on condition that indemnity is provided by the employing authority.

16. That the Program avoid any duplication in the provision of screening services, but that it utilise both the private and public sectors in the provision of screening services subject to all services meeting the guidelines for accreditation established by the National Program.

17. That the funding of screening mammography under the Program continue to be independent of Medicare fee-for-service schedules.

18. That open biopsy not be included as part of the screening Program.

19. That action to implement the above recommendation await any recommendations that the House of Representatives Standing Committee on Community Affairs, which is currently inquiring into the management and treatment of breast cancer in Australia, may propose in this area.

20. That more information be provided to women diagnosed with breast cancer on the various treatment options available to them; and that women be encouraged to participate in decisions regarding appropriate courses of treatment.

21. That the supply of radiotherapy services be regularly monitored by the National Breast Cancer Centre.

22. That the geographical distribution of radiotherapy services be improved so that women living in areas outside the major metropolitan centres can obtain equitable access to these services.

23. That the Commonwealth Government, in co-operation with the State/Territory Governments, improve the level of travel and accommodation assistance available to women living in areas outside the major metropolitan centres requiring radiotherapy treatment.

24. That hospital-based cancer registries be established as a matter of priority.

25. That statistics collected by State and Territory cancer registries be collected on a more uniform and consistent basis and that data on cancers generally be provided to the Commonwealth Government on a timely and regular basis to ensure that current national statistics on the incidence of cancers are readily available.

26. That recognising the fundamental importance of research into the diagnosis and treatment of breast cancer, that the Commonwealth Government provide a specific allocation for research into breast cancer in future Commonwealth Budgets.

27. That the Commonwealth Government provide additional funding for the conduct of clinical trials into breast cancer to assess existing management protocols and to develop new treatment schedules.

JUNE 1994

SUMMARY OF RESPONSES TO EACH RECOMMENDATION

Recommendation	
1 - Access to Electoral Roll	Accepted -Victoria now has access
2 - Educational Campaign	Accepted - National strategy being developed
*3 - Data to NBCC	Accepted - Propose supply through the NCU
4 - Supply of Radiographers	Supported - essentially a State issue
5 - Supply of Radiologists	Supported - essentially a State issue
6 - Support and Counselling	Supported - Funded through community groups
7 - Improve rural/remote access	Supported - Financial assistance a State issue
8 - Access for ATSI women	Accepted
9 - Access for NESB women	Accepted
10 - Target women aged 50-69	Accepted - in line with Program policy
11 - Symptomatic women	Accepted - in line with Program policy
12 - Symtomatic women	Accepted - in line with Program policy
13 - Info to medical profession	Accepted - Strategy being developed
14 - Role of GPs	Accepted - Strategy being developed
15 - Breast Physicians	Consistent with current Program policy
16 - Private & public sector	Accepted
17 - Independent funding	Accepted
*18 - OB not included	Concerns expressed
19 - Await next report	Supported
20 - Info to women re: TRT	Accepted - to be a function of the NBCC
*21 - Supply of radiotherapy	Concern - not within the NBCC terms of reference
22 - Access to radiotherapy	State issue - will refer to AHMC
23 - Assistance for radiotherapy	State issue - will refer to AHMC
24 - Hosp. based ca. registries	Supported - normally a State issue
25 - Uniform cancer statistics	Supported - limited influence in State registries
26 - Importance of research	Supported
27 - Funding for clinical trials	Supported