Senate Community Affairs Reference Committee
Inquiry into services and treatment options for persons with cancer

Submission by:
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Relevant term of reference

(a) The delivery of services and options for treatment for persons diagnosed with cancer, with particular reference to:

> (iv): differing models and best practice in delivering services and treatment options to regional Australian and Indigenous Australians.

This submission briefly summarizes the impact of cancer on Indigenous and non-Indigenous people in the Northern Territory (NT), and in particular draws the Committee's attention to two innovative programs that have been proven to be effective in improving Pap test screening and follow-up for Indigenous women in NT remote communities, and to improvements in cancer survival that have occurred in the NT since the early 1990s.

These issues are discussed in greater detail in two attachments, a review of Cancer in Indigenous Australians published recently by myself and colleagues,[a] and a copy of a thesis chapter which summarizes recent research investigating cancer in Indigenous people in the Northern Territory.

Cancer and non-Indigenous people in the NT

Cancer has a similar impact on non-Indigenous people in the NT as on Australians generally, with two exceptions: higher incidence of tobacco-related cancers and lower cancer survival.

For the NT non-Indigenous population, incidence rates for most cancers are similar to total Australian rates. [1] The exceptions are lung and other smoking-related cancers, which are more common in NT non-Indigenous people because smoking prevalence is higher in non-Indigenous people in the NT than elsewhere in Australia. Tobacco control is a major issue for all people in the NT, Indigenous or otherwise.

Cancer survival is lower for non-Indigenous people than for Australians in other states. NT non-Indigenous cancer survival has improved since the early 1990s, probably because of improvements in health service capacity to diagnose and treat cancer, but survival rates remain lower than elsewhere in Australia. In the early 1990s, the risk of cancer death for NT non-Indigenous people with cancer (adjusted for age at diagnosis and type of cancer) was 22% higher than that for people with cancer in Western Australia and Tasmania combined (total Australia data was not

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available for this comparison). This differential was reduced during the 1990s, but risk of cancer death remained 12% higher for cancer patients in the NT than in WA/Tas in 1997-2001 (J. Condon, unpublished data).

Cancer services are relatively under-developed in the NT compared to elsewhere in Australia. A coordinated, multidisciplinary cancer diagnosis and treatment service has not yet developed in the NT. In Darwin there is only one specialist oncologist; in Alice Springs there is only a visiting oncologist from Adelaide. There is no radiotherapy service available in Darwin or Alice Springs; all patients requiring radiotherapy services are required to travel interstate.

Cancer and Indigenous people in the NT

Cancer has a very different, mostly greater, impact on Indigenous people in the NT than on other Australians. Some cancers occur much more commonly in Indigenous people than in other Australians, particularly lung and other smoking-related cancers, cervical, liver and thyroid cancers. Other cancers including melanoma and breast, bowel and prostate cancers occur much less frequently in Indigenous people.[1] However, for almost all cancers, survival rates are lower for NT Indigenous people than for other Australians.[2]

Recent research has demonstrated that lower survival rates for NT Indigenous people are partly because Indigenous people were more likely to be diagnosed late, with advanced disease which had spread from the original site of origin and was thus less amenable to curative treatment, and partly because of deficiencies in cancer treatment after cancer had been diagnosed.[3]

The major innovations in cancer services in the NT, and improvements in health outcome, have been for control of cervical cancer, particularly for Indigenous women. In the early 1990s the incidence of cervical cancer in NT Indigenous women was 3-4 times higher than the total Australian rate, and mortality was approximately eight times higher than the total Australian rate.[4;5] Recent research has demonstrated that cervical cancer incidence decreased by 25% between 1991 and 2001 for NT Indigenous women, and mortality decreased by over 50% over a similar period.[3]

There have been two innovative women's health programs in the NT which appear to have played a major role in these improvements in cervical cancer incidence and mortality for Indigenous women: the Well Women's Screening Program (WWSP) and the Gynaecology Outreach Service (GOS).

The WWSC is an amalgamation and modification of the National Breast Screening Program and the National Cervical Screening Program, with a more holistic approach to women's health that better suits the needs of Indigenous women living in remote communities in the Northern Territory. The WWSP has been evaluated and found to be successful and highly supported.[6] There is indirect evidence that Pap test coverage has increased in remote NT communities since the commencement of the WWSP, although Pap test coverage rates for Indigenous women specifically are not available.[7]

Similarly, evaluation of the Specialist Outreach Program has found that the GOS has considerably improved access to specialist services for Indigenous women with gynaecological conditions, including Pap test abnormalities. [8-10] The number of gynaecology consultations for women from remote communities in the Top End of the NT increased from less than 200 per year before the GOS commenced in 1997 to approximately 1,000 in 1999; over 90% of these consultations were provided by the GOS. The number of women from Top End remote communities with abnormal Pap tests fell from over 90 in the second half of 1997 to approximately 30 in the first half of 1999.[8]

These two services are successful models of holistic approaches to health care, implemented through primary health care services with specialist support and assistance. However, difficulties in maintaining the specialist support required presents a threat to the long-term sustainability of these programs, particularly the GOS. The GOS is dependent on one gynaecologist who has provided the service for the past eight years, traveling to remote communities for 2-3 days each week, while also assisting with the gynaecology service at Royal Darwin Hospital. Under current resourcing and management arrangements, the risk of staff burnout is high, almost inevitable.

Evaluation of these two programs focused on process and output measures, and on client and service provider satisfaction; data on health outcomes in regard to prevention and treatment of cervical cancer were not available at the time the evaluations were undertaken. It is likely that the WWSP and the GOS have been largely responsible for the large reductions in cervical cancer incidence and mortality rates for Indigenous women during the 1990s, but research to determine whether this is the case has only just commenced.

Unfortunately, other cancer services in the NT have not been as well resourced and imaginatively developed as have services for other health issues such as renal services, communicable disease control and the preventable chronic diseases strategy (which does not include cancer). The resourcing and organization of cancer services in the NT needs to be further developed so that the innovations and successful outcomes achieved in the area of cervical cancer can be achieved for other types of cancer, and the recent improvements in cancer survival can be continued until survival disparities between people with cancer in the NT, both Indigenous and non-Indigenous, can be further reduced and eventually eliminated.

I would be happy to provide further information that would be of assistance to the Committee in its deliberations.

Reference List

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