D R P A U L W . H O W A T

M B B S F R A N Z C O G
D i r e c t o r o f O b s t e t r i c s a n d G y n a e c o l o g y
D i r e c t o r o f O u t r e a c h S e r v i c e s
C a i r n s B a s e H o s p i t a l

Tuesday 16th May 2006

Senate Committee
Gynaecological Cancer

To whom it may concern,

RE: GYNAECOLOGICAL CANCER

I would like to raise some issues relating to this committee, particularly relating to access to services and outcomes for women in remote Queensland, especially including indigenous women.

I am the Director of Obstetrics and Gynaecology at Cairns Base Hospital in Queensland. Our hospital services a population of approximately 250,000 people over an area larger than the state of Victoria. Half live in Cairns and surrounding towns, half live in regional and remote communities. Thirty percent of my practice population is indigenous. Indigenous women in particular have some of the worst gynaecological cancer incidence rates and survival rates in the world, whereas Australia has amongst the best treatment successes and survival rates overall. There is a huge discrepancy of access and outcome for these women, and it is a great shame which must be corrected.

Cervical screening rates for North Queensland are below that of the national average, and even lower for indigenous women. This is despite a number of well trained health professionals who are readily available to provide these services. These include RFDS doctors, visiting women's health primary care doctors, and mobile women's health nurses, remote area midwives health workers, visiting specialists, general practitioners and hospital doctors. Indigenous women in particular do not avail themselves of these services. Research is desperately needed into why this is so, and programs developed whereby these women can be encouraged to have Pap smears. The health professionals are there in large numbers – yet many women remained unscreened. It is also a particular concern that many women remain unscreened despite attendances over the duration of several pregnancies – everyone involved in pregnancy care needs to make more of an effort in this regard.

Treatment services for precancerous conditions are provided, in the public sector, by the Cairns Base Hospital Gynaecologists. This occurs both within CBH and during outreach visits to regional and remote centres. Colposcopy is performed at these visits, and surgery performed either locally or at CBH. However, with only 4 staff specialists and 15 centres to visit, we cannot access all women who need colposcopy at each visit. The 'failure to attend' rate, even within CBH, is extraordinarily high. For example, 30% of new patients fail to attend their first colposcopy clinic appointment at CBH. The failure to attend rate is much higher in indigenous communities, where women really need to have a colposcopy performed opportunistically. Specialists are not always present to do this. Accordingly, I have trained 2 of my previous GP trainees to develop colposcopy skills as a special interest area within their advanced Diploma of the College of Obstetricians and Gynaecologists. GPs with special skills could provide these services in remote areas, rather than specialists, especially if they are resident in the community. I cannot express this highly enough, but if not for Dr Peter Holt, Dr Deena Case and Dr Amanda Blinco, the incidence of cervical cancer in the Torres Strait would be appalling. I visit Thursday Island for a week four times a year – to expect women from all the outer islands to turn up reliably for colposcopy during my visits is unrealistic. These three doctors have ensured that all cases of cervical dysplasia in the Torres Strait have received colposcopy and treatment locally, without the need for a specialist, and this could be a model for other areas. Unfortunately this concept is often met with incredulity from my city colleagues.

On the topic of outreach, the Department of O&G at Cairns Base Hospital has provided outreach services to Far North Queensland women for over 15 years. This is funded entirely through Queensland Health. We are not allowed to bulk bill patients, and we have been refused MSOAP funding for enhancing outreach services because we had an existing service. Hence, some of the poorest and most remote, and underprivileged women in Australia, have virtually no federal input into the treatment and care of premalignant conditions – it is all state based. This is inequitable, and I assume, not what these funding models intended to happen. Nevertheless, the most deserving get only what the state system can provide.

Cairns Base Hospital currently has no staff radiologists. A tele-radiology service is provided from Mt Isa. The senior medical staff are concerned about the standards of medical imaging in our hospital. Cairns Base Hospital should have an MRI scan to attract and retain staff radiologists. The current service is inadequate. This directly affects gynaecological cancer patients because their imaging is done in Cairns, and it is often unsatisfactory.

North Queensland has a population of 500,000. It does not have the services of a full time gynaecology oncology service. There is a visiting service 3 days per month in Townsville from Brisbane. This is not 'convenient' for more than half of the women who live in the north, as more than half live in the Cairns drainage population. Travel and accommodation are an issue. Access to radiotherapy services at Townsville Hospital is poor and often delayed. The visiting gynaecological oncologists are all in private practice and some display little interest in public patients or their treatments. Gynaecological oncology is very much a private practice subspecialty. This means that rich white women, not surprisingly, have the best outcomes in the world for treatment of their malignancies. Not so uninsured and indigenous women. Sometimes, requests for assistance and transfer are met with refusal, which means that generalists are sometimes forced to perform complex surgery in regional

areas without appropriate back-up. It is then not uncommon to be criticised by the same oncologists if there is a poor outcome. North Queensland has a larger population than Tasmania, has probably the worst outcomes for gynaecological malignancies – yet it lacks a full time service. A full time service based in Townsville, with visits to Cairns and Mackay, should be considered.

In summary, although we try very hard to provide quality care to women in the far north, we are limited almost entirely to state funding. Access to federal monies is blocked for the women who need it most. Access to screening is good, but take-up rates poor. Access to treatment for malignancies is poor, and outcomes much worse. Indigenous women are dying from cervical cancer at third world rates, while the rest of Australia basks in the lowest incidence and survival rates in the world. Gynaecological cancer services are inadequate – North Queensland needs its own service. Gynaecological oncologists are mostly private practitioners, but the worst outcomes are in public patients. A rethink is needed on how we provide this type of care to those who need it most.

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