

**SUBMISSION TO SENATE COMMUNITY AFFAIRS REFERENCES COMMITTEE
INQUIRY INTO GYNAECOLOGICAL CANCER IN AUSTRALIA****(a) Level of Commonwealth and other funding for research addressing gynaecological cancers**

There is evidence from the Northern Territory (NT) cancer registry that there is a high and increasing incidence of vulvar pre-cancer and cancer in some groups of Aboriginal women in the NT. There is an urgent need for funding for research into the causes of this high incidence and to establish effective interventions for both prevention and early detection. The NT Government is providing resources for an initial investigation, which is partially completed. A grant application to the National Health and Medical Research Council has been submitted for further investigation, however a guaranteed funding source is required.

There is also a need for additional research into vulvar and anal cancers, with respect to the role of human papilloma virus (HPV) types and potential for protection from these using the new HPV vaccines.

(b) Extent, adequacy and funding for screening programs, treatment services, and for wider health support programs for women with gynaecological cancer**Cervical cancer screening**

Access to cervical cancer screening in the Northern Territory (NT) is limited by availability of appropriate health care services. Currently, across both the Government and non-Government sectors, there are 22 vacant medical officer positions in remote areas of the NT. Current incentives to work in remote areas are insufficient to attract doctors, who find more lucrative employment in urban areas. Even in the Darwin and surrounding area, there is a shortage of General Practitioners (GPs). Many women prefer to have their cervical smear taken by a female practitioner, compounding problems of access to appropriate services.

In remote Aboriginal communities, most cervical smears are taken by nurse practitioners. While cervical smears performed by nurse practitioners now attract a modest Medicare rebate there are administrative barriers and serious opportunity costs associated with health services making claims on occasions of service basis. Most of the cost of providing the service is met by the health service, which for many communities in the NT is the NT Government. Health service funding and program delivery in NT remote communities are faced with a significant challenge in deciding on service priorities due to the very high burden of disease in remote Aboriginal populations.

Pap smear coverage varies across the NT, with rates of 25% to 75%. With adequate access to appropriate health services, high cervical cancer screening rates can be obtained in remote Aboriginal women. Cervical cancer incidence and mortality in Indigenous women has been falling as a result of improved screening, but remains four times higher in NT Aboriginal women than in Australian women overall.

Recent analysis of the NT Pap Smear register has shown adequate follow-up of women with abnormal cervical smears has been consistently achieved in remote areas of the Top End of the NT, but not in Central Australia. Colposcopy follow-up in the Top End has been via an outreach program, where a single female gynaecologist visits remote health centres and undertakes colposcopies with a mobile colposcopy unit. She has been able to gain the trust of Aboriginal Health Workers and women in the community as well as provide colposcopy without the need for women to travel to an urban centre. This successful model should be recommended for remote Aboriginal communities across Australia.

Treatment services

The population of the NT is too small to provide enough work for a full time gynaecology oncologist. Currently the NT is served by a visiting gynaecology oncologist from Adelaide who visits four times a year. Women diagnosed with cancer in between her visits have to go to Adelaide for treatment.

Approximately 50% of gynaecological cancers at some stage require radiotherapy treatment, which is presently not available in the NT. Current proposals to establish a radiology oncology unit in Darwin will improve gynaecological cancer treatment for NT women.

Wider health support

Wider health support services for women with gynaecological cancer are lacking both in the NT and across Australia. The Breastcare model of social and psychosocial support for women with breast cancer could be used to provide an equivalent level of support to women with gynaecological cancers.

(c) Capability of existing health and medical services to meet the needs of Aboriginal populations and other cultural backgrounds, and those living in remote regions;

This is discussed in (b). Competing health priorities, lack of available trained health service workers, inaccessibility to Medical Benefits Scheme funding sources, and the higher costs of service delivery in remote areas all contribute to lack of service access for NT Aboriginal women.

Analysis of health records for all selected cancers, including cervical, during a 10 year period in the NT showed that Aboriginal patients were less likely than non-Aboriginal patients to choose and complete treatment and to travel interstate when referred. This association was strongest for Aboriginal patients with an Aboriginal first language. Cancer death was highest in Aboriginal people with an Aboriginal first language. When first language was taken into account, there was no difference in the cancer death rate between those living in a remote area and those in an urban centre. Similarly, remote residence was not associated with increased risk of

death for non-Aboriginal people. For Aboriginal people with English as their first language, the risk of cancer death after adjustment for age, cancer type and stage was no higher than that for non-Aboriginal people. The authors concluded that issues of “social and cultural” proximity should be addressed to reduce the gap in cancer outcomes between Aboriginal and non-Aboriginal people. That is, there is a need to increase the number of Aboriginal doctors, nurses and Aboriginal health workers to provide health services that meet the needs of those whose first language is an Aboriginal language.

The analysis provides evidence that NT services are enabling people living in remote areas to receive the same level of treatment as those in urban areas in the NT (after controlling for Aboriginal first language).

(d) Extent to which the medical community needs to be educated on the risk factors, symptoms and treatment of gynaecological cancers

In the NT, women’s health educators are employed to educate both remote health centre nursing and Aboriginal Health Worker staff about women’s health issues, including cervical cancer screening.

(e) Extent to which women and the broader community require education of the risk factors, symptoms and treatment of gynaecological cancers

The women’s health educators also undertake community education delivered to groups of women on women’s health issues. Face to face interactive sessions are important methods of education for remote Aboriginal women, in whom written materials are of limited use. The development of appropriate multimedia resources, such as videos would greatly assist education of these women.

Education of women about symptoms of vulvar pre-cancer and cancer lesions is urgently required. Plans for this are underway, but this is a significant challenge.

(f) Extent to which experience and expertise in gynaecological cancer is appropriately represented on national health agencies, especially the recently established Cancer Australia

No comment.