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House of Representatives
Standing Committee on Health

Skin Cancer in Australia: awareness, early diagnosis and management

Public Hearing, Canberra
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Opening statement

On behalf of the 37 national organisations in the National Rural Health Alliance, we welcome this opportunity to make our views known about the rural and remote aspects of skin cancer awareness, diagnosis and management.

The Alliance's purpose is to ensure that in all processes relating to policies and programs which impact on health and wellbeing, the particular circumstances and needs of rural and remote communities are not only understood but are taken account of in action that ensues.

The Alliance uses the much maligned (and soon-to-be improved?) classification system known as ASGC-RA. Its five areas are Major cities, Inner regional, Outer regional, Remote and Very remote areas. More than 6.7 million people live in rural and remote Australia including all the people who live in the many smaller places in the Inner regional classification, right through Outer regional and Remote to those in Very remote communities.

First, let us summarise some issues for cancer in general. It is responsible for Australia's largest burden of disease. The impact of cancers is worse for older people, people of low socio-economic status and those in rural and remote areas.

Of particular importance for the Alliance is the fact that the further from a major city patients with cancer live, the more likely they are to die within five years of diagnosis. The mortality rate from all cancers combined is higher for Indigenous Australians, people living in lower socioeconomic status areas, and in Remote and Very remote areas. (There is a complex set of relationships here and great complexity when it comes to cause and effect. Remote areas have a much higher proportion of Aboriginal and Torres Strait Islander people and of people of lower socioeconomic status. But these two factors do not explain all of the impact of

remoteness on health. Remoteness is itself a risk factor, helping to determine such other factors as years of completed education and income.)

The five-year survival rate from all cancers combined is lowest in Remote and Very remote areas.

Often referred to as 'Australia's national cancer', skin cancer is a largely preventable disease. Australian adolescents have the highest incidence of malignant melanoma in the world.

The ***incidence*** of new cases of melanoma is significantly higher in regional areas than in Major cities. Because of the difficulties experienced by rural people in accessing skin cancer diagnosis, their presentations are likely to be later, especially among men.

However, published data do not show the usual gradient of incidence as one moves from regional to remote areas. The published rates in remote Australia are indistinguishable from those in Major cities. We suspect that this may be a statistical artefact due to the higher proportion of Aboriginal and Torres Strait Islander people in more remote populations[1], among whom the incidence of melanoma is one quarter what it is for non-Indigenous people, and the greater likelihood of late or no diagnosis for all who live in more remote areas.

Certainly the incidence is higher for country than city men. Another issue for rural areas is that the incidence of skin cancer is increasing among people aged 65 years and over, and the ageing of the population is more marked in regional and remote areas.

Melanoma ***mortality*** is higher in Inner regional areas than in Major cities but, as is the case for incidence, in Outer regional and remote areas it is indistinguishable from Major cities. We believe that these figures are moderated by the fact that some of those diagnosed with melanoma re-locate to larger communities, particularly towards the end stages of the condition. Farmers have a 60 per cent higher death rate due to melanoma and other malignant skin cancers than the general population, and skin cancer deaths in farmers 65 years of age and over are more than double the rate of other Australians in that age group.

Five-year survival rates for patients with melanoma appear to be similar across remoteness categories. Again, this is likely to be moderated by the re-location of patients.

In our submission there is a specially-prepared Table showing the latest data for the availability of medical practitioners, primary care doctors, general practitioners, medical specialists, enrolled nurses and registered nurses by rurality.

Notwithstanding their serious mal-distribution between capital city and country areas, it remains the case that nurses, doctors and allied health professionals are at the heart of primary care, including for skin cancer.

GPs cannot provide cancer care alone. Nor does the solution lie in the recruitment of more specialists, such as dermatologists. Much of the specialised expertise relating to skin cancer is clustered around the city centres despite the fact that doctors are likely to see more big lesions

[1] Aboriginal people make up 1 per cent of the population of Major cities, and 2, 5, 13 and 44 per cent of the Inner regional, Outer regional, Remote and Very Remote populations respectively.

in the country. Dermatology is one of the most poorly-supported medical services in rural areas, with very few residing outside metropolitan areas.

Skin cancer awareness, early diagnosis and management should therefore be given a high priority in work to support and extend the expertise of existing health professionals in rural and remote areas. Professional development and further education on skin cancer detection should be made available to all health professionals working in those areas.

Better support could be provided through more training in skin cancer for health students, continuing professional development for health professionals in rural and remote areas, and enhanced access to and support for clinical decision-making support tools such as for teledermatology and other telehealth programs.

The Alliance welcomes the rural, remote and aged care focus on access to telehealth consultations with specialists (through MBS) where country patients and their local doctor, nurse or Aboriginal health workers are involved in the appointment. There is potential for further development of this approach to better target specialties such as skin cancer and to better involve the full range of local health professionals whether through the MBS or in community or hospital settings.

Finding the means by which best practice in prevention, early diagnosis and ongoing management of skin cancers can be made available away from the major cities and regional cancer centres is a critical challenge for governments and health service providers. Last year's Parliamentary Roundtable had some good ideas on this. Patient assisted travel and accommodation schemes are important, as are outreach programs that are well-integrated with local services and local clinicians. And all levels of government have a role to play in promoting sun-smart messages and the development of health-promoting infrastructure such as shade trees and shaded areas for recreation. Melanoma patient support groups should be resourced and promoted.

With regard to awareness and prevention, health promotion messages need to be sustained over a long period and effectively targeted to people living in rural and remote areas. Evidence from quit-smoking campaigns suggests that the messages are not being received and acted upon in rural and remote areas to the extent they are in the major cities. The same could be true for skin care messages.

Prevention and early diagnosis require all sectors of the community, health professions and other groups to be well-informed. Ideally, to some extent the prevention of skin cancer and its early diagnosis should be everyone’s business.