

Fact Sheet 8

Cancer in rural Australia

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Cancer is responsible for Australia's largest disease burden, and people with cancer in rural areas have poorer survival rates than those living in major metropolitan centres.

The burden of cancer in rural Australia

The Australian Institute of Health and Welfare (AIHW) reports that cancer is responsible for Australia's largest disease burden, with more than 108,000 new cases and more than 39,000 cancer deaths in 2007. About one-third of the people affected by cancer live in regional and rural areas. For them, the burden of cancer is disproportionately heavy.

People living with cancer in regional and rural areas have poorer survival rates than those living in major cities, and the further from a major city patients with cancer live, the more likely they are to die within five years of diagnosis. A study by Jong et al published in the Medical Journal of Australia (MJA) in 2004 found that people with cancer in remote areas of NSW were 35 per cent more likely to die within five years of diagnosis than patients in metropolitan areas. For prostate and cervical cancers, patients in remote NSW were up to three times more likely to die within five years of diagnosis than those living in more accessible areas.

There is limited data on cancer in Indigenous people living in regional and rural areas, but it is known that Indigenous Australians, two thirds of whom live outside capital cities, experience significantly poorer survival outcomes than non-Indigenous Australians.



Access to treatment and support

About one third of people diagnosed with cancer live outside the major population centres where the majority of tertiary cancer care is available. Cancer patients who live furthest from a large treatment centre are at the highest risk of a poor treatment outcome.

In 2006, a COSA study found there were marked deficiencies in cancer services in rural and regional areas of Australia and that the quality and availability of services directly influenced survival rates.

Previous studies (summarised by Jong, Vale and Armstrong in the MJA, 2005) have documented examples of poorer cancer care in rural and remote areas including less diagnosis, staging and treatment of prostate cancer; less breast-conserving surgery for women with breast cancer; and an apparently lower probability of completing radiotherapy treatment for rectal cancer.

Contributing factors

Factors which contribute to lower survival rates for people with cancer in rural areas include:

- less availability of diagnostic and treatment services;
- later diagnosis;
- lower socioeconomic status;
- reduced rates of physical activity;
- increased rates of high risk alcohol consumption;
- higher rates of smoking;
- the higher proportion of Aboriginal and Torres Strait Islander people; and
- increased sun exposure.

The incidence of all cancers is higher for people in regional areas, which may be partly due to lifestyle factors. There is a significantly higher incidence of bowel cancer, melanoma (associated with sun exposure) and prostate cancer. The incidence of cervical cancer, lung cancer (associated with smoking) and cancer of unknown primary site are significantly higher in those living in remote areas compared to those in major cities.

Rural men experience poorer survival rates from prostate cancer than their urban counterparts due to reduced use of diagnostic and treatment services.

Financial and personal burdens

For most people a cancer diagnosis causes significant physical and emotional distress, loss of income and substantial expense. Because of the complexity of cancer treatment and the absence of specialist services, most rural people with cancer need to travel to major centres for at least some of their care. This adds to the financial and personal burden for patients and their families.

A patient's preference to be treated close to their home and family should not compromise access to high-quality care. In addition to providing better services in larger regional centres there is a need to utilise new technologies such as tele-oncology to enable improved access without compromising quality of care.

The travel and accommodation schemes for cancer patients and their families in each State and Territory are complex and inadequate. Reform is needed to provide greater assistance to cancer patients.

Rural and regional oncology services

Australians in rural and remote areas have relatively poor access to cancer treatment and support:

- 38 per cent of rural hospitals administering chemotherapy had neither a resident nor visiting medical oncology service;
- only 58 per cent of rural hospitals surveyed reported that most chemotherapy orders were written by a medical oncologist;
- as the remoteness of hospitals increased, chemotherapy was increasingly administered by people other than a chemotherapy-trained nurse, such as other nurses and general practitioners;
- 7 per cent of non-metropolitan hospitals that reported administering chemotherapy had access to a radiation unit;
- many hospitals reported long waiting times for allied health and inpatient services; and
- 61 per cent of the hospitals requested urgent access to psychological services and support.

Clinical Oncological Society of Australia. Mapping rural and regional oncology services in Australia, 2006

Reducing the gap

The burden of cancer in Australia is increasing as our population ages and there is evidence that people in rural and remote areas will continue to bear a disproportionate part of this burden. Addressing current deficiencies in rural and regional cancer services is essential to improving survival and outcomes for country people. This requires governments to work closely with healthcare professionals to improve access to cancer services.

A key purpose of COSA's national mapping project in 2006 was to identify areas for reform. Following consultation with cancer care professionals working in rural and regional Australia, COSA recommended several measures to improve access to best-practice cancer services for rural patients:

- establishment of Regional Cancer Centres of Excellence – in regions with a suitable population – to provide multidisciplinary care and improve support and educational services;

- investment in clinical data systems to audit, monitor and plan oncology services;
- investment in psychosocial support services, as people in rural and remote areas have limited access to such services;
- support for distance education, mentoring and innovative models such as telemedicine in remote areas; and
- improved coordination of government-funded travel and accommodation schemes for cancer patients and their families in remote areas.

Regional Cancer Centres

COSA and other interest groups welcomed the announcement in the 2009-10 Federal Budget of \$560 million in capital grants for up to 10 regional cancer centres (RCCs).

Following a workshop convened by COSA and Cancer Council Australia in August 2009, the following recommendations were agreed:

- the location of RCCs should be based on population/ demographic profiling and planning, using tumour-specific cancer incidence data and projections;
- RCCs must be part of a wider workforce strategy demonstrating that recruitment, training, placement and ongoing professional development plans are in place to ensure staffing meets local needs and supports capital investment;
- RCCs must be able to provide genuine multidisciplinary care – ie coordinated, patient-centred care involving services from clinical specialists integrated with psychosocial support, allied health etc;
- RCCs must have capacity for patient accommodation;
- capacity must be increased in smaller, networked outreach services for remote populations;
- facilities such as telemedicine must be available to support outer remote services and to allow linkage to metropolitan centres;
- efficient data-sharing capacity must be built into the networking of RCCs, to improve referral pathways and ensure capacity to manage single electronic health identifier (as the Government's e-health agenda progresses);
- the capacity for workforce development and support, with formal links to educational resources in metropolitan teaching hospitals, should be a core requirement of a RCC;
- RCCs should be able to provide access to cancer clinical trials; and
- the needs of remote Indigenous communities should be built into centres as required.

The Clinical Oncological Society of Australia's Regional and Rural Oncology Group is a multidisciplinary group focused on the unique issues facing cancer service delivery outside the metropolitan areas. It is working to highlight deficiencies in service delivery, enhance equity of access to current best practice care and facilitate clinical research and access to clinical trials.



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For more information on rural cancer and on the Clinical Oncological Society of Australia, visit www.cosa.org.au