Cancer care for Indigenous Australians

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Low socioeconomic status and assumptions about Indigenous people may be jeopardising their access to care

In this issue of the Journal, the case–control study by Coory et al (*page 562*)[1] shows that Indigenous people in Queensland are less likely than non-Indigenous people to receive adequate management for lung cancer, even after controlling for geographic location and socioeconomic factors.

Other studies and reports have also shown that Indigenous people have a lower cancer survival rate and are much less likely to be offered diagnostic and therapeutic procedures,[2-6] but the study by Coory et al is the first to show a clear treatment bias for cancer.

Why are Aboriginal people less likely than other Australians to receive treatment for lung cancer? Drawing on my experience in Aboriginal health over the past 20 years, I think there are some likely explanations for this finding, most of which Coory et al have considered.

Late diagnosis is a key factor leading to poorer treatment outcomes and lower survival rates for Indigenous people.[1,5] As Indigenous people do not have the same level of access to primary medical care as non-Indigenous people, early detection of cancer by general practitioners is less likely. In spite of significant additional Australian Government funding provided through the Office for Aboriginal and Torres Strait Islander Health (OATSIH) (an additional $500 million recurrent since 1995), the gap in access to primary medical care resources appears to be still widening, primarily due to worsening access to the Medicare Benefits Schedule and the Pharmaceutical Benefits Scheme, which is not compensated for by the OATSIH funding.[2,7] The “Close the Gap” campaign recently announced by the federal government is indeed timely.[8]

Achieving better participation rates in cancer screening programs has also been recognised as an important issue, and systemic changes are needed.[2] In the Northern Territory, breast cancer rates are increasing significantly among Aboriginal women, with a 223% increase reported between 1991 and 2001.[3] However, for many Aboriginal women, access to mammography services remains poor. For example, the mammography screening service visits Alice Springs three to four times a year for 3 weeks at a time, but often with only a few weeks’ notice. Women who are more organised and literate can read the advertisements in the newspapers and make their own appointments at short notice, but many Aboriginal women do not do this. Health services can try to contact them to let them know, but this is not always effective. It would be possible to redesign the system to give much better access for Indigenous women, and this needs to occur. For example, the service could again be provided from the more culturally secure local Aboriginal women’s health service, Congress Alukura, on a regular planned basis. This would better utilise transport services, Aboriginal liaison officers and the Patient Assisted Travel Scheme (PATS) to improve attendance for Aboriginal women.

Coory et al consider the possibility that access to specialist care could be one of the issues involved. Schemes such as PATS[9] allow rural and remote residents to have access to specialists in major centres, but I think it is very likely that Indigenous people from rural and remote areas do not receive the same access to care through such schemes as other rural and remote residents. In addition, the gap fees charged by private specialists in all localities present a more significant economic barrier to many Indigenous people, who are therefore much more reliant on the public hospital outpatient system, with its substantial delays.

In Alice Springs, for example, men with raised prostate-specific antigen levels have been waiting 6–12 months or longer to see a urologist and have a prostate biopsy in order to be given a definitive diagnosis and treatment for prostate cancer. If patients can afford to pay about $300 to have the procedure done privately, they are sent by PATS to see a urologist in Adelaide, thus avoiding a long waiting period. However, public patients do not have this option. Although steps are now being taken to reduce the barriers that have led to these unfortunate delays, this is occurring as the result of a complaint from the Central Australian Aboriginal Congress in December 2007, rather than in response to an analysis of routine data, which could have revealed the problem much earlier. It is very unlikely that this type of problem is unique to Alice Springs. What we do not know is whether there is a differential waiting time for Indigenous men compared with non-Indigenous men, or whether the system equally disadvantages all men who do not have private health insurance. Is there a systemic bias against Indigenous men that needs to be better understood and addressed?

The results from the study by Coory et al add to other evidence suggesting that barriers to care for Indigenous people need to be systematically explored throughout the Australian health system. Whether it is cancer treatment, access to renal transplantation,[10] access to prostate biopsies for suspected cancer, or a range of other key endpoints, it seems that the system is not working well for Indigenous people.

A final question that was not considered by Coory et al is whether cancer specialists themselves make different decisions about the appropriateness of certain treatment options for Aboriginal people based on their own assumptions about the socioeconomic and cultural circumstances of Indigenous people. I learned this lesson many years ago when two of my Aboriginal patients with rheumatic heart disease and atrial fibrillation died suddenly and unexpectedly in their early forties, from intracardiac clots. These women had been seeing the visiting cardiologist every 6 months and seeing me as often as needed in between. The use of warfarin in such patients was not yet standard practice at the time, but the cardiologist had already been routinely prescribing warfarin for non-Aboriginal people in these situations for about 12 months. He had never suggested warfarin treatment for these women because he assumed that they would not be able to take it safely and that they would have nowhere to store the drug, thus putting children at risk because of the possibility of them accessing and accidentally taking warfarin tablets. This was the late 1980s, and as a GP who was unaware of recent evidence confirming the benefits of warfarin in such patients, I was assuming I would be getting the best practice advice from the visiting cardiologist. It was not until after the women had died that I spoke to him and discovered the assumptions he had made in deciding against warfarin treatment. These types of assumptions may also be being made by specialists about other routine treatments. In the NT, this situation has been improved over recent years through a range of initiatives, including the strengthening of links between key specialists and Aboriginal health services. Many specialists, including cardiologists, now routinely provide services through Aboriginal health services. However, this still needs to occur more widely and to include a broader range of specialists.

Given the evidence now available on the differential survival rates for Indigenous people with cancer, it is imperative that better data be routinely collected on the comparative rates of access to specialists and key diagnostic and therapeutic procedures in secondary and tertiary hospitals. State and territory governments could be induced, as part of the Australian Health Care Agreements, to collect more rigorous data in this area. The Australian Health Care Agreements are agreements reached between the Australian Government and the state and territory governments on the health system. They provide a mechanism through which the Australian Government can influence the states and territories, through financial levers, to improve key health system outputs such as equity of access to specialist services and procedures. Key data to be collected would include the comparative times on waiting lists for specialist appointments in public hospitals; the rate of access to key diagnostic procedures; the frequency of giving radiotherapy and chemotherapy for specific cancers (where these treatments are known to be effective); and the rate of surgery performed on patients with cancers amenable to treatment. These types of indicators have been suggested by Aboriginal health services for more than a decade.

It is too often assumed that Indigenous people do not wish to travel long distances to access care and be away from their families, or that they have different priorities in life and do not value treatment for illnesses that are likely to be terminal. While poorer compliance or higher refusal rates for treatment may be pertinent factors in some cases, it is important not to assume these types of explanations when there are obvious systemic barriers to accessing care in the current health system. Once these barriers have been addressed, any remaining barriers, if they actually exist, can be explored and dealt with separately.

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