



NATIONAL RURAL
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ALLIANCE INC.

ABN: 68 480 848 412

National Rural Health Conference
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PO Box 280 Deakin West ACT 2600

Phone: (02) 6285 4660 • Fax: (02) 6285 4670

Web: www.ruralhealth.org.au • Email: nrha@ruralhealth.org.au

**Submission to House of Representatives
Standing Committee on Health**

**Skin Cancer in Australia: awareness, early diagnosis
and management**

21 March 2014

This Submission is based on the views of the National Rural Health Alliance but may not reflect the full or particular views of all of its Member Bodies.

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Executive Summary

Cancer is responsible for Australia's largest disease burden and the further from a major city patients with cancer live, the more likely they are to die within five years of diagnosis. Cancer is more common in older Australians. The impact of cancers is worse for older people, people of low socio-economic status and those in rural and remote areas.

The incidence rate for cancers is higher for Aboriginal and Torres Strait Islander Australians, people living in lower socioeconomic status areas, and in Inner regional areas.

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.

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

Skin cancer knows no social or geographical barriers, but is a largely preventable disease. It is often referred to as 'Australia's national cancer', with Australian adolescents having 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 and because of the difficulties experienced by rural people in accessing skin cancer diagnosis, their presentations (especially among men) are likely to be later.

The incidence of melanoma is higher in regional Australia than in Major cities. Rates in remote Australia are indistinguishable from those in Major cities. Those rates are almost certainly moderated by the lower incidence overall amongst Aboriginal people who are especially prevalent in Remote and Very remote areas. 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.

Melanoma mortality is higher in Inner regional areas than in Major cities, but in Outer regional and remote areas is indistinguishable from Major cities. The mortality figures for remote areas are likely to be moderated by the fact that some of those diagnosed with melanoma re-locate to larger communities, particularly towards the end stages of the condition.

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

The incidence of skin cancer is increasing among people aged 65 years and over, and the ageing of Australia's population is more marked in regional and remote areas.

The incidence of melanoma is higher for country than city men, with farmers having a 60 per cent higher death rate due to melanoma and other malignant skin cancers than the general population. Skin cancer deaths in farmers 65 years of age and over are more than double the rate of other Australians.

Notwithstanding their serious mal-distribution, it remains the case that nurses, doctors and allied health professionals are at the heart of primary care, including for skin cancer. Given the constraints on their time and energies in the vast areas they serve, 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 in the country. Dermatology is one of the most poorly-supported medical services in rural areas, with very few residing outside metropolitan areas.

A high priority should therefore be given to maximising the expertise of existing health professionals in rural and remote areas, including in relation to the detection, early diagnosis, treatment and management of skin cancer. These local teams also have a key role to play in raising awareness about skin care.

Specific ways of providing better support would include the provision of additional education and professional development so that they can make better use of clinical decision-making support tools such as Tele-Derm* and other telehealth applications.

People with skin cancer in rural and remote areas very often have to travel long distances to regional or metropolitan centres for more specialised treatment. The challenge for governments and health service providers is to find 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.

Health promotion messages need to be effectively targeted to people in high-risk groups. Health promotion campaigns relating to skin cancer need to be sustained over the long term and research is needed to ensure that they are having equal effect in rural and remote areas as in the major cities.

Early diagnosis and prevention require all sectors of the community, health professions and other groups to be well-informed. Ideally, skin cancer prevention is everyone's business. The submission includes a set of recommendations for government action to support the desirable community activity on skin cancer issues.

Introduction

The National Rural Health Alliance (NRHA) is comprised of 37 member bodies, each a national body in its own right, representing rural and remote health professionals, service providers, consumers, Indigenous health interests, educators and researchers (see Attachment A). The vision of the National Rural Health Alliance is good health and wellbeing in rural and remote Australia. For further information see: www.nrha.org.au

The Alliance is pleased to provide a submission to the inquiry.

The prevalence of cancer

The Australian Institute of Health and Welfare (AIHW) has reported that cancer is responsible for Australia's largest disease burden.

About one-third of the people affected by cancer live in rural and regional areas and they have poorer survival rates than people living in major cities. The further from a major city patients with cancer live, the more likely they are to die within five years of diagnosis.

Significantly, as the National Health Performance Authority's *Healthy Communities: Avoidable deaths and life expectancies in 2009–2011*, reports, the rate of 'treatable deaths' (of which skin cancer is one cause), increases with remoteness, ranging from 41 deaths per 100,000 people in Inner East Melbourne to 110 per 100,000 in Central and North West Queensland.¹

Overall, the impact of cancers is worse for older people, for people of low socio-economic status and for people in rural and remote areas.

In the five years 2004-2008, the age-standardised **incidence rate** of all cancers combined was:

- significantly higher for Aboriginal and Torres Strait Islander Australians than their non-Indigenous counterparts (461 and 434 per 100,000 respectively) (New South Wales, Queensland, Western Australia and the Northern Territory);²
- higher for people living in lower socioeconomic status areas than for those in higher socioeconomic status areas;² and
- significantly higher in Inner regional (504 per 100,000) than other ASGC-Remoteness Areas.²

In the five years 2006-2010, the age-standardised **mortality rate** of all cancers combined was:

¹ Media Release: *Avoidable Deaths and Life Expectancies*, National Health Performance Authority <http://www.nhpa.gov.au/internet/nhpa/publishing.nsf/content/Media-Release-Report-Avoidable-deaths-and-life-expectancies>

² AIHW & Australasian Association of Cancer Registries 2012. Cancer in Australia: an overview, 2012. Cancer series no. 74. Cat. no. CAN 70. Canberra: AIHW

- significantly higher for Indigenous Australians than for their non-Indigenous counterparts (249 and 174 per 100,000 respectively) (New South Wales, Queensland, Western Australia, South Australia and the Northern Territory);²
- significantly higher for people living in lower socioeconomic status areas than for those in higher socioeconomic status areas;² and
- significantly higher in Remote and Very remote areas (196 per 100,000) than in Major cities (171 per 100,000).³

In the five years 2006-2010, the five-year relative **survival rate** from all cancers combined was:

- significantly higher for people living in the highest (71 per cent) compared with the lowest (63 per cent) socioeconomic status areas;¹ and
- higher in Major cities (67 per cent) and lowest in Remote and Very remote areas (63 per cent).¹

Cancer is more common in older Australians:

- in 2009, 73.5 per cent of new cancer cases were diagnosed in men aged 60 years and over; and 63.6 per cent in women aged 60 years and over.⁴

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

Skin cancer

Melanoma is often referred to as 'Australia's national cancer',⁵ with Australian adolescents having the highest incidence of malignant melanoma in the world.⁶

The ABS's 2011-2012 Australian Health Survey reported that the incidence of new cases of melanoma was significantly higher in regional areas than in major cities.⁷ Because of the difficulties experienced by rural people in accessing skin cancer diagnosis, their presentations (especially among men) are likely to be later, by which time their condition is likely to be exacerbated.⁸

Men in rural and remote areas in particular, also had [2001-2003] significantly higher rates of cancers diagnosed in advanced stages, which underscores the importance of

³ AIHW & Australasian Association of Cancer Registries 2012. Cancer in Australia: an overview, 2012. Cancer series no. 74. Cat. no. CAN 70. Canberra: AIHW.

⁴ AIHW 2012. Cancer incidence projections: Australia, 2011 to 2020. Cancer Series no. 66. Cat. No. CAN 62. Canberra: AIHW.

⁵ Melanoma Institute Australia (2012), *Surf Life Saving's new partnership takes on fight against melanoma*. Media Release, 17 February 2012.

⁶ Page, Fleta (2014), "GG's husband reminds us to be sun smart", *The Canberra Times*, 7 February 2014, p6.

⁷ NRHA (2012), *Cancer in rural Australia*. Fact Sheet 8.

⁸ House of Representatives Standing Committee on Health and Ageing (2013), Roundtable on Skin Cancer (21 June 2013), Hansard, p13, Dr Tony Hobbs, former rural general practitioner.

*getting regular health checks from their doctors to increase the likelihood of early detection of cancer.*⁹

Table 1: Melanoma: annual incidence of new cases, annual mortality, and 5 year survival, by remoteness category

	MC	IR	OR	R/VR
	Rate per 100,000 population per year			
Incidence of new cases 2004-08	45.6	*57.1	*52.8	42.8
Mortality 2006-2010	5.7	*6.6	6.0	4.9
	Percent			
5 year survival	90	91	92	93

Notes: rates are age standardised. MC, IR, OR and R/VR relate to Major cities, Inner regional, Outer regional and Remote/Very remote areas under the ASGC Remoteness Areas classification. Numbers in bold and asterisked are statistically significantly higher than Major cities rates. Un-bolded numbers are not significantly different from those in major cities.

Source: “additional material” at <http://www.aihw.gov.au/publication-detail/?id=60129542359&tab=3>

The Table shows that:

- the incidence of melanoma is higher in regional Australia than in Major cities. Rates in remote Australia are indistinguishable from those in Major cities. Those rates are almost certainly moderated by the lower incidence overall amongst Aboriginal people who are especially prevalent in Remote and Very remote areas.
- Melanoma mortality is higher in Inner regional areas than in Major cities, but in Outer regional and remote areas is indistinguishable from Major cities. The mortality figures for remote areas are likely to be moderated by the fact that some of those diagnosed with melanoma re-locate to larger communities (regional centres or cities) - particularly towards the end stages of the condition.
- 5-year survival appears similar across remoteness categories which, again, is moderated by the re-location of patients.

Incidence of melanoma amongst Aboriginal people is one quarter of that in non-Aboriginal people, and mortality is a third of that in non-Aboriginal people. This is one of the very few conditions for which Aboriginal people fare better than non-Aboriginal people, although tragically the incidence:mortality ratio for Aboriginal and Torres Strait Islander people - as for so many conditions – is worse.

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

Consequently, the incidence of melanoma and mortality caused by it in regional (especially in Outer regional), and particularly in remote areas, is moderated by the lower rates of this cancer in the Aboriginal population and the higher proportions of Aboriginal people in those areas.

⁹ Dr Mark Short of the AIHW's Health Registers and Cancer Monitoring Unit, <http://www.aihw.gov.au/media-release-detail/?id=6442464703>

Also, there is a tendency for older people who have health problems, particularly the non-Indigenous, to migrate from more remote to less remote areas to access health and other services. It is probable that the 5-year survival rates shown in Table 1 are influenced by this migration, particularly those for Outer regional and remote areas.

The incidence of skin cancer is increasing quite dramatically among people aged 65 years and over. This cohort may well have missed the benefits of skin cancer messages in their earlier years. This is likely to have implications for Australia's rural areas, given that the ageing of Australia's population is more marked there.¹⁰

Cancer Council Victoria figures on melanoma incidence for 2008, as compiled by the Victorian Cancer Registry, show that:

- rural men were most at risk of developing the most lethal of skin cancers; their melanoma incidence was a third higher than men in the city;
- there were 39.4 cases of melanoma for every 100,000 men living in regional Victoria, compared to 29.6 for men in metropolitan and suburban areas; and
- the regional rate for women was 33.5 per 100,000 compared to 23.3 cases for city-living women.¹¹

A study from the University of Melbourne's Department of Medicine showed that Medicare claims were made in 1997 for 412,493 and in 2010 for 767,347 non-melanoma skin cancer (NMSC) treatments - an increase of 86 per cent. The study forecast that by 2015 the annual number of NMSC treatments will be 938,991. This would represent a doubling in the number of NMSC treatments between 1997 and 2015. The study also reported the total treatment cost, adjusting for health inflation, was \$511.0 million in 2010 with an estimate of \$703.0 million in 2015.¹²

Farmers have a 60 per cent higher death rate due to melanoma and other malignant skin cancers than the general population. Skin cancer deaths in older farmers (65 years and over) are more than double the rate of other Australians.¹³

As mentioned, Australian adolescents have the highest rates of skin cancer world-wide. Significantly, too, people who have had a non-melanoma skin cancer before the age of 25 years, have their lifetime risk of developing melanoma increased by 99.

"To put that in perspective, if you smoke a packet of cigarettes a day for 50 years your relative risk of getting a lung cancer is 40. If you have a BCC [basal cell carcinoma] at the age of 25, your risk of getting a melanoma is 99."¹⁴

¹⁰ NRHA (2013), *A Rural Perspective on Living Longer, Living Better*. Fact Sheet, October 2013.

¹¹ <http://news.smh.com.au/breaking-news-national/rural-men-at-highest-risk-for-melanoma-20110309-1bn3g.html>

¹² *Non-melanoma skin cancer in Australia* (2012), Medical Journal of Australia, https://www.mja.com.au/journal/2012/197/10/non-melanoma-skin-cancer-australia?0=ip_login_no_cache%3D9c1788a13d88944f328c07c058716b82#0_i1149983

¹³ Farm Health and Safety Tool Kit for Rural General Practices, AgHealth, http://www.aghealth.org.au/tinymce_fm/uploaded/Health%20Workers/_gp_toolkit_booklet_lores.pdf

¹⁴ House of Representatives Standing Committee on Health and Ageing (2013), Roundtable on Skin Cancer (21 June 2013), Hansard, p11, Professor Rodney Sinclair, dermatologist and academic [in a private capacity].

“But 900 deaths a year in Australia are totally preventable...if you have the right person looking at the skins of Australians you could save 900 lives straight away. Improving access to care is important.”¹⁵

The Alliance notes that various Australian regional and rural areas including Broome in Western Australia, Queensland’s Cairns, Mackay and Nambour and possibly high-altitude locations such as Armidale and the Snowy Mountains in NSW, may have relatively high rates of melanoma. These (and other) places may warrant an additional focus in terms of screening, detection, early-intervention and awareness-raising initiatives.

Workforce issues

As is well known, the availability of health professionals is reduced as one moves from Major cities to remote areas (Table 2).

Table 2 The geographic distribution of doctors and nurses in Australia

	MC	IR	OR	R	VR
	Number per 100,000 population				
Medical clinicians 2012	371	249	226	210	
Primary care doctors 2010	118	104	99	126	
GPs 2012	114	116	114	118	
Specialists 2012	139	70	50	27	
Enrolled nurses 2012	187	282	292	267	177
Registered nurses 2012	1040	941	872	1006	994

Note: until 2010, AIHW reported primary care practitioners but not general practitioners. After 2010 AIHW reported general practitioners but not primary care practitioners.

Sources: Australian Institute of Health and Welfare 2014. Medical Workforce 2012. National health workforce series no. 8. Cat. no. HWL 54. Canberra: AIHW.

<http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129546076>

and

Australian Institute of Health and Welfare 2013. Nursing and midwifery workforce 2012. National Health Workforce Series no. 6. Cat. no. HWL 52. Canberra: AIHW. <http://www.aihw.gov.au/publication-detail/?id=60129545333&tab=3>

As Table 2 shows, the rural and remote nursing and midwifery workforce is much larger and more evenly geographically distributed than doctors, although still insufficient in number to meet health needs in these areas. In fact, the more rural and remote one travels, the more likely one will find that the last woman standing with healthcare capacity is a registered nurse or midwife.

¹⁵ House of Representatives Standing Committee on Health and Ageing (2013), Roundtable on Skin Cancer, 21 June 2013, Hansard, pp10-11, Professor Sinclair.

Notwithstanding their serious mal-distribution, it remains the case that nurses, doctors and allied health professionals are at the heart of primary care, including for skin cancer. Because nurses are the largest and best-distributed health professionals in rural and remote areas, the best way to provide a workforce for skin cancer care in those areas is through continuing support for their recruitment, retention and professional support.

Given the constraints on their time and energies in the vast areas they serve, GPs cannot provide cancer care alone. Nor does the solution lie in the recruitment of more specialists, such as (in this case) dermatologists. There are simply not enough specialists available in rural and remote areas or to rural and remote people.

Rural medical generalists, GPs, registered nurses and midwives, and remote area nurses are pivotal in cancer care in the bush. In many instances it would be appropriate for processes necessary for the detection, diagnosis, treatment and management of skin cancer conditions to be undertaken in a rural general practice or rural hospital environment where care would be provided by the local healthcare team. In many cases no dermatologist would be required.

For this reason, a high priority should be given to maximising the expertise of the existing health professionals in rural and remote areas, including in the detection, early diagnosis, treatment and management of skin cancer. These local teams also have a key role to play in raising awareness about skin care.

Providing more support for these health professionals is imperative to enable them to more effectively undertake the jobs for which they are qualified. Tangible ways of providing better support would include the provision of additional education and professional development so that they can make better use of clinical decision-making support tools such as Tele-Derm and other telehealth applications. Support for professional development helps practitioners to build upon their existing professional knowledge and practical clinical skills, and increases their capacity in awareness-raising and educating the community and other practitioners about the many preventive aspects of skin cancer.

Significantly, the Practice Nurse Incentive Program (PNIP) includes a rural loading in recognition of the fact that nurses are educated and trained to ably deliver health care to their communities based on the identified health need and risks. Nurses are well equipped to play a strong community role including in addressing the attitudinal and behavioural patterns of some people, which might help to reduce skin cancer.

The specialised workforce: the distribution of dermatologists

AIHW survey data show that in 1997 (the most recent year for which data are available), 92.6 per cent of dermatologists were located in capital cities and other major urban centres, 4 per cent were in large rural centres, and 3.3 per cent were in other rural areas (1997). Medicare data provided a similar distribution pattern, showing 8.7 per cent of dermatologists are located in a rural area. The Australasian College of Dermatologists/Australian Medical Workforce Advisory Council 1997 survey of dermatologists found that only 7.8 per cent of respondents lived and worked outside a major urban centre.¹⁶

¹⁶ *The Specialist Dermatology Workforce in Australia – Supply Requirements and Projections 1997-2007* (1998), Australian Medical Workforce Advisory Committee,

Dermatology is one of the most poorly-supported specialist medical services in rural areas, with very few residing outside metropolitan areas. For example there is no dermatologist available for private consultations in Darwin (2011).¹⁷ Medicare data indicate that in 1995-96 there were 6,877 patients per dermatologist in rural areas compared with 2,700 per dermatologist in capital city and other metropolitan areas.¹⁸

What's different about rural and remote areas?

Australia is a recognised world leader when it comes to skin cancer prevention, achieved “on the smell of an oily rag”,¹⁹ and has one of the highest five-year relative survival rates for melanoma of the skin.

However, the Alliance is concerned that the more than 6.7 million people living in Australia's rural and remote areas have a lower rate of survival after diagnosis.

Factors which contribute to lower survival rates for people in rural areas include less availability of diagnostic and treatment services, lower socioeconomic status, and higher proportions of Aboriginal and Torres Strait Islander people.²⁰ Although the prevalence among Aboriginal and Torres Strait Islander people is lower, it is wrong to assume that they are immune from melanoma - as noted at the 2013 Parliamentary roundtable on skin cancer.²¹ Significantly too, the “important expertise” related to skin cancer is clustered around the city centres despite the fact that doctors “see many more big lesions in the country”.²²

Even an issue such as lack of shade can have significance. For example, research suggests that access to shade is an important factor in rural and remote areas, and is aligned to a socioeconomic differential. Public open spaces in lower socioeconomic status (SES) areas are less likely to have shade than those in higher SES areas and, significantly, adults and adolescents living in higher SES areas are less likely to report sunburn than those living in lower SES areas.

<http://www.ahwo.gov.au/documents/Publications/1998/The%20specialist%20dermatology%20workforce%20in%20Australia.pdf>

¹⁷The Implementation of Teledermatology in Australia (2011), DoHA,

[http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/256BA3C38B7EEA22CA2577EA006F7C42/\\$File/CHSWTFsub-TeleDerm.pdf](http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/256BA3C38B7EEA22CA2577EA006F7C42/$File/CHSWTFsub-TeleDerm.pdf)

¹⁸ *The Specialist Dermatology Workforce in Australia – Supply Requirements and Projections 1997-2007* (1998), Australian Medical Workforce Advisory Committee,

<http://www.ahwo.gov.au/documents/Publications/1998/The%20specialist%20dermatology%20workforce%20in%20Australia.pdf>

¹⁹ House of Representatives Standing Committee on Health and Ageing (2013), Roundtable on Skin Cancer, 21 June 2013, Hansard, p6, Mr Terry Slevin, Chair, Cancer Council Australia's National Skin Cancer Committee.

²⁰ NRHA (2012), *Cancer in Rural Australia*. Fact Sheet 8, January 2012.

²¹ House of Representatives Standing Committee on Health and Ageing (2013), Roundtable on Skin Cancer, 21 June 2013, Hansard, p6. Professor John Thompson, Cancer Council Australia and Melanoma Institute Australia Executive Director, noted that the Celtic genes of a 35-year-old Aboriginal person with advanced skin cancer may have increased her predisposition towards contracting skin cancer.

²² House of Representatives Standing Committee on Health and Ageing (2013), Roundtable on Skin Cancer, 21 June 2013, Hansard, p10, Professor Sinclair.

In 2007, 45 per cent of Victorian adults believed that adequate shade was hard to find at their local park or playgroup and even more difficult to find at sports grounds, with rural and regional residents finding it harder than those in metropolitan areas (SunSmart 2008). When considering improving shade provision, priority should be given to socio-economic status and the particular characteristics of rural and regional areas.²³

As for so many other conditions, people with skin cancer in rural and remote areas very often have to travel long distances to regional or metropolitan centres for more specialised treatment. Consider the following outline of the experiences of ‘Tania’ and her husband, ‘Peter’, residents of the NSW remote area of Tibooburra.

- After the removal of a small benign lesion (identified by a visiting skin specialist at a Royal Flying Doctor Service clinic in Tibooburra—population of 151 and located some 850 kms from Adelaide), Tania had the lesion removed. A doctor in Broken Hill (330 kms from Tibooburra) performed further surgery on the lesion and a nurse in White Cliffs (249 kms from Tibooburra) later removed the stitches. Tania’s husband Peter had melanoma. After travelling to a Broken Hill surgeon for removal of the lesion, the procedure could not proceed because Peter had not been advised prior to surgery to cease taking his blood-thinning medication. On a second trip to Broken Hill, the lesion was removed. Later, when Peter flew to Adelaide for follow-up specialist treatment, he was advised that there had not been enough surrounding tissue removed. He underwent further surgery in Broken Hill where more of the surrounding tissue was removed. On a subsequent visit to Adelaide, the specialist concluded that the procedure had been satisfactory. A communication mix up was particularly disappointing and frustrating for Peter on a later day when he had travelled the long distance from Tibooburra to Adelaide only to find that he did not have an appointment, and the surgeon did not need to see him.

When such communication mix-ups occur in urban and regional areas, rescheduling will be much easier than for people such as Peter, who travelled from Tibooburra to Adelaide to see his specialist. His experience exemplifies where teledermatology (discussed below) could have helped to reduce the dislocation, disruption, travel and costs. He might also have availed himself of a video-conference consultation with his specialist via telehealth²⁴ perhaps through MBS²⁵ from his local GP’s office where the two health practitioners could have engaged and reviewed the histology report.

The Alliance acknowledges the Australian Department of Health’s programs to assist in the prevention, detection and treatment of skin cancers, including via assistance for people to access medical and diagnostic services, medicines and therapeutics, and research initiatives

²³ Skin cancer prevention framework 2013-2017, DoH VIC, [http://docs.health.vic.gov.au/docs/doc/6E83ACF33C737A85CA257AD0000F3753/\\$FILE/Skin%20Cancer%20Prevention%20Framework.pdf](http://docs.health.vic.gov.au/docs/doc/6E83ACF33C737A85CA257AD0000F3753/$FILE/Skin%20Cancer%20Prevention%20Framework.pdf)

²⁴ The International Organisation for Standardisation defines Telehealth as the “use of telecommunication techniques for the purpose of providing telemedicine, medical education, and health education over a long distance”.

²⁵ MBSOnline. Medicare rebates are available for video consultations between specialists and patients in telehealth eligible areas, and in eligible aged care facilities and Aboriginal Medical Services throughout Australia. Rebates are also available for clinical services provided by a health professional located with the patient during the video consultation. <http://www.mbsonline.gov.au/telehealth>

through the National Medical and Health Research Council and Cancer Australia. However issues such as access to treatments, medications and technologies – and their costs – still present challenges for rural and remote area people, their health professionals, and governments.

The central challenges include 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. Health promotion messages need to be effectively targeted to people in high-risk groups. Access to timely intervention, emerging treatments, drugs and technologies, and clinical practices needs to be available in settings with sparse populations.

On top of the pain, emotional distress, inability to work, loss of productivity and grief for families, many people with cancer in rural and remote areas currently face difficulties in accessing treatment and professional support that city residents might take for granted.

Responding to the Terms of Reference

Increasing awareness in the community and among healthcare professionals

Over the last 20-30 years, various public health campaigns in Australia have successfully convinced many Australians (especially the under 50s) about the possible dangers of too much sun, and the importance of reducing their exposure.²⁶ But there is a need for more education and awareness-raising, particularly among men and older people in rural areas, and adolescents everywhere.²⁷ General practitioners, registered nurses and allied health professionals are ideally placed to provide community education to raise awareness about the risks of developing skin cancer and the precautions to be taken.

A significant proportion of adolescents seem oblivious to the potential danger of sun exposure, verified by various Monday Night surveys conducted by Cancer Council Australia about being sunburnt on the previous weekend. “Yes” responses of 25 per cent, 24 per cent and 21 per cent respectively in 2003-2004, 2006-2007 and 2010-2011 demonstrate that still more work needs to be done.²⁸ While teenagers tend to be educated about the risks of too much sun, the messages about the importance of prevention do not seem to be registering²⁹ but many people are not necessarily making the link between having non-melanomas and the possibility of subsequent, more serious cancers.³⁰

Country Women’s Association of Australia (CWAA)³¹ members are highly supportive of continuing with awareness-raising programs about skin cancer. Based in country Queensland,

²⁶ House of Representatives Standing Committee on Health and Ageing (2013), Roundtable on Skin Cancer, 21 June 2013, Hansard, p3, Professor Sinclair.

²⁷ Page, Fleta (2014), “GG’s husband reminds us to be sun smart”, *The Canberra Times*, 7 February 2014, p6.

²⁸ House of Representatives Standing Committee on Health and Ageing (2013), Roundtable on Skin Cancer, 21 June 2013, Hansard, p30, Mr Terry Slevin, National Skin Cancer Committee, Cancer Council Australia.

²⁹ Page, Fleta (2014), “GG’s husband reminds us to be sun smart”, *The Canberra Times*, 7 February 2014, p6.

³⁰ House of Representatives Standing Committee on Health and Ageing (2013), Roundtable on Skin Cancer, 21 June 2013, Hansard, p11, Ms Minna Knight, Member/Adviser, Melanoma Patients Australia.

³¹ CWAA representatives serve as members on the National Rural Health Alliance’s Council.

‘Eileen’ reported to the Alliance that her experiences in having skin cancer and treatments have reinforced for her the importance of a continuing focus on skin cancer prevention.

Given that the benefits of sun cancer prevention campaigns may not be discernible for five, 10, 15, 20, 30 or 40 years,³² campaigns need to be long term. And the relative lack of success of anti-smoking and quit campaigns in rural and remote areas, compared with major cities, suggests that a quite different approach may be needed for health promotion and messaging to achieve attitudinal change for people in those areas. Research is needed to determine whether safe-sun messages are as readily accessible and having equal effect in rural and remote areas as in other parts of Australia.

Such research would need to address issues such as:

- identifying primary target groups to which skin cancer prevention messages should be directed;
- identifying secondary target groups such as health professionals, groups and organisations best placed to persuade and impart prevention messages to individuals and groups;
- avenues for dissemination of messages according to, for example, age, gender, socio-economic status and location;
- writing message content to suit particular segments of the market;
- addressing communication barriers identified among some target groups such as teenagers - who tend to ignore messages from anyone older than themselves - and men, who may be in the habit of deferring visits to their health service until a condition becomes serious;
- ascertaining what (if any) health information and messages about skin cancer prevention primary healthcare professionals are presently imparting to people about skin cancer;
- determining if health professionals’ representative organisations are reminding their members about ‘opportunistic skin cancer’ checks of patients;
- ascertaining where rural and remote people are most likely to access their health information: electronic, print (including newspapers, pamphlets in community health centres, doctors’ waiting rooms, Medicare Locals, etc), or social media; mobile phone apps; radio; or personal communication;
- the role that high-profile people including sportsmen and women might play in reminding the community about having regular skin checks and taking preventive measures such as using sunscreens;
- maximising promotion opportunities via events such as National Skin Awareness Week and National Shade Day;
- investigating possibilities for free community service advertisements on regional radio and television; and
- ascertaining if school nurses, community health nurses and allied health professionals are being provided with sufficient and effective information and continuing professional development on skin cancer prevention.

³² House of Representatives Standing Committee on Health and Ageing (2013), Roundtable on Skin Cancer, 21 June 2013, Hansard, p7, Professor Thompson.

Public health education campaigns including those on skin cancer messages obviously would need to be informed and ‘road tested’ by the expertise of relevant stakeholders such as melanoma support and counselling services, health consumer groups, sports clubs, Cancer Australia, Cancer Council Australia, GPs and experts in public health education campaigns. It may well be that safe-sun health messages in rural and remote areas will need to be differently tailored and distributed than they would be in the major cities and even regional centres. Therefore, processes to test messages should include remote area people with specific expertise on rural communication matters.

The Alliance has received anecdotal evidence about the high rate of usage of mobile phones and phone apps in some surprisingly remote communities. This phenomenon might provide opportunities for targeted health messaging in those communities.

However it is generally true that telecommunications and broadband are much less reliable in rural and remote areas. The CWAA’s ‘Vivian’, reminded the Alliance that not everyone has computer access or even access to electronic media:

“...believe it or not we don’t have a television or radio to receive media coverage.”

Another member, ‘Paul’, has found the “information and pictures of all types of skin cancers” on the Sydney Melanoma Diagnostic Centre website to be useful.

Early diagnosis and prevention strategies

For improving early diagnosis and skin cancer prevention it is important that all sectors of the community, health professions and other groups are well-informed. Ideally, skin cancer prevention is everyone’s business and annual skin check-ups are vital, particularly for those in high-risk groups. While Australians are generally aware of the risks from too much sun exposure, it has to be acknowledged that people’s predisposition towards the disease can vary. As mentioned, a public education campaign has a role to play in this regard.

Various non-melanomas such as basal cell carcinomas and solar keratosis may be considered to be low risk when they are diagnosed early, that is before they become invasive and aggressive with perineural invasion. As with many other health matters, primary care practitioners already play, and must continue to play, a critical role in health promotion relating to skin cancers. It is important to identify pre-malignant lesions; they can be predictors of serious melanomas later which have perhaps a 10 per cent mortality rate.³³

The Alliance is aware of the integral role of rural GPs in regularly checking conducting patients’ skins, including assessing types and colour and health profiles, and advising about check-ups and safe sun messages. Given the social and cultural awareness of the dangers of sun exposure, it can be reasonably assumed that Australian-trained GPs are aware of the importance of regular skin cancer checks. Overseas-trained doctors play a key role in rural and remote Australia and effective skin cancer care can be picked up quickly in areas where doctors are exposed to it.

³³ House of Representatives Standing Committee on Health and Ageing (2013), Roundtable on Skin Cancer, 21 June 2013, Hansard, p4, Professor Sinclair.

However, other health practitioners including registered nurses and allied health professionals can also be further trained and supported in the early diagnosis of skin cancers via 'opportunistic skin checks' when undertaking a range of health and/or physical assessments and services.

The Alliance is aware that, especially in rural areas, optometrists regularly see and refer numerous patients with eyelid and periocular basal cell carcinomas and haemangiomas (benign tumours) and are in constant liaison with their patients' GPs about such health issues. Early detection by optometrists is often through high magnification slit lamp observation.

Nurses, pharmacists and allied health professionals also play an important role in early identification of skin conditions that warrant referral to someone with greater expertise in the area. On a broader level, just as family members and acquaintances are encouraged to check on their friends' mental health, many people could help with direct observation of family members' or friends' skins and take opportunities to remind others about regularly checking their own skin.

Teledermatology for early diagnosis, prevention and later management

When used appropriately, teledermatology can be useful in diagnosing and helping to prevent and manage skin cancers. It entails capturing an image digitally and transmitting the image to one or a number of dermatologists for opinion and assessment. Such 'at-a-distance' treatment has been happening for a decade or more.

The Australian College of Rural and Remote Medicine (ACRRM) is a proponent of teledermatology, focusing on professional development for rural general practitioners seeking to obtain practical advice on the diagnosis and management of skin disease.

Tele-Derm* is an online resource designed primarily for rural doctors interested in obtaining practical advice on the diagnosis and management of skin disease in general practice. It is administered by ACRRM.³⁴

The doctor submits a digital photo of affected skin and a history (and diagnosis, if he or she has made one). An experienced dermatologist examines the evidence, and reports back to the doctor - usually within two days - with diagnosis and/or treatment options.

GPs are also able to access online dermatological case studies, education opportunities, recommended links, and discussion forums moderated by an experienced dermatologist. Tele-Derm also allows rural doctors anywhere in Australia to electronically submit specific de-identified cases for assessment.

There is no funding for the referring doctor to use the Tele-Derm 'store and forward' model where the patient is not necessarily present when the information is sent to the specialist and the advice is received back within a couple of days.

³⁴ Skin cancer prevention framework 2013-2017, DoH VIC,
[http://docs.health.vic.gov.au/docs/doc/6E83ACF33C737A85CA257AD0000F3753/\\$FILE/Skin%20Cancer%20Prevention%20Framework.pdf](http://docs.health.vic.gov.au/docs/doc/6E83ACF33C737A85CA257AD0000F3753/$FILE/Skin%20Cancer%20Prevention%20Framework.pdf)

Video consultations with specialists are used more frequently as the patient in a rural and remote area will be reimbursed under Medicare for the appointment with both the local doctor and the specialist dermatologist who are involved in the consultation.³⁵

Some experts believe that because of the highly-visual nature of the specialty, most skin conditions can be diagnosed from an image, especially if there is some history available. Such opinions suggest that dermatological treatments can be instituted and monitored by practitioners without any specialist training, making telemedicine an ideal solution.³⁶

Contrary views are held by some medical practitioners, particularly specialists, who believe that the best medical assistance for diagnosing skin cancers entails face-to-face consultations between doctors/specialists and patients, where clinicians can study lesions and surrounding skin and access a patient's history.

However, it is acknowledged that there is an important role for teledermatology in assisting immobile nursing home patients who have "fairly extensive disease" and are encountering difficulties in accessing specialists. "Teledermatology can be quite beneficial when you can send a photo around to 100 dermatologists around the country and have some interaction, and get a recommendation".³⁷

Improving evidence-based best practice treatment and management

The Alliance receives regular updates from health consumers and professionals about the lack of doctors and specialists (including dermatologists) in rural, remote and even regional Australia. Medical students report their difficulties in obtaining consistent exposure to clinical dermatology especially that which would equip them for rural and remote practice.

Various postgraduate education programs are available which are designed to fill this gap including short courses and diplomas in dermatology or skin cancer medicine. Many educational opportunities are available for GPs to upskill and/or maintain skills. The use of dermatoscopy has increased and offers another diagnostic tool for GPs. There is a Masters of Medicine course at University of Queensland and the Cardiff dermatology diploma. Enhancing telehealth with dermatologists and dermatoscopy would also help.

Given that skin cancer training of a four-year post-graduate medical course at Melbourne University is only a two-hour roundtable (one hour on non-melanoma and one hour on melanoma)³⁸, it is apparent that increased training for doctors would be beneficial, especially since skin cancer has been shown to be on the increase in Australia. As a very experienced rural GP noted, more undergraduate training in dermatology is important and such training

³⁵ Australian College of Rural and Remote Medicine website accessed March 2014.

³⁶ Muir J and Lucas L, 'Tele-dermatology in Australia', *Stud Health Technol Inform*, (131):pp245-253, 2008. Abstract.

³⁷ House of Representatives Standing Committee on Health and Ageing (2013), Roundtable on Skin Cancer (21 June 2013), Hansard, p9, Dr Robert Rosen, dermatologist.

³⁸ House of Representatives Standing Committee on Health and Ageing (2013), Roundtable on Skin Cancer (21 June 2013), Hansard, pp9-10, Professor Sinclair.

should not end with graduation. There needs to be a commitment to ongoing, continuing professional development.³⁹

Many people are caring for themselves where skin cancer is concerned. Now in his early 70s, Michael Bryce, Patron of Cancer Council ACT, recently described himself as “a walking example of skin cancer” after having “grown up in Queensland as a fair-skinned boy with no awareness of the danger of UV exposure”. Skin checks and procedures are now part of his life as his “formative years take their toll”.⁴⁰ His story is a familiar one among older people, including the following CWAA members who provided their stories to the Alliance:

- Sixty-eight-year old ‘Linda’ spent a lot of her childhood in the sun on a Clarence Valley (northern NSW) dairy farm. Nowadays, regular check-ups are part of her life after having spots removed by a local GP from when her first skin cancer was detected 15 years ago. Since then, a local GP and “a skin cancer doctor”, along with a visiting plastic surgeon from Coffs Harbour, have assisted with her skin cancer management.
- ‘Paul’ a 55-year-old Blue Mountains resident, recognises the importance of early diagnosis and ongoing management, especially since effective treatment 25 years ago for a malignant melanoma. Now feeling “lucky” that his melanoma was removed early and has not spread, Paul has progressed through three-monthly, six-monthly and yearly check-ups to being “discharged” to check himself for any new lesions.
- ‘Patricia’ lives outside Jindabyne, NSW, with her 70-year-old husband, ‘Jim’, a former Snowy Mountains worker. He attends a Sydney skin specialist every three months, travelling via bus and train, and staying overnight. Over the last 10-15 years, he has had many deep skin cancers removed and also had plastic surgery. He regularly uses sunscreen and wears a hat and a long-sleeve shirt (though new lesions keep appearing). Two of Jim’s relatives died of malignant melanoma. Originally from the Northern Hemisphere, Patricia, who has had a basal cell carcinoma and sunspots removed, has lived in high-altitude areas in Australia and attributes her skin problems to constant exposure to the sun when driving as a community nurse (without using sunscreen). The couple have now installed tinted windows in their car.
- After initial procedures from her local rural GP and further treatment, Toowoomba resident, ‘Eileen’, spent a month in Brisbane for daily radiation, followed by care through her GP. Eileen described supportive and caring staff and considerable expenses covered by the Patient Assisted Travel Scheme.
- ‘Vera’ from Port Macquarie, NSW, described her 86-year-old husband’s skin cancer treatments. Having spent many days in the sun in his early life, it was not until he reached 32 years of age that he regularly wore a hat. The sun has taken its toll. A melanoma on his back was removed many years ago (with no further problems for 20 years). Ten years later, a basal cell carcinoma (BCC) on his nose was removed (twice) followed five years later by the removal of a BCC from his temple. His GP undertook most of these procedures, but a later large cancer on his forehead required specialist surgery. In the last two years he has another BCC excised from his cheek and nose; he regularly uses prescription creams. He has also had many treatments for spots on his forehead and nose with liquid nitrogen.

³⁹ House of Representatives Standing Committee on Health and Ageing (2013), Roundtable on Skin Cancer (21 June 2013), Hansard, p13, Dr Tony Hobbs, former rural general practitioner.

⁴⁰ Page, Fleta (2014), “GG’s husband reminds us to be sun smart”, *The Canberra Times*, 7 February 2014, p6.

Various people have responded to the Alliance for this submission by outlining some of the difficulties and benefits they have experienced.

- ‘Vivian’ cited her husband’s experience that the “burning system” [of cryotherapy to remove skin cancers] seemed to be rather “hit and miss” and called for more effective clinical methods.
- New South Wales coastal resident, ‘Penny’, described problems encountered by herself and others in trying to organise appointments for treatments with a Canberra dermatologist’s clinic: long waiting times for appointments and “numerous administrative barriers...to put you off continuing to try and make an appointment”. Communication to the office was a problem: the phone was rarely answered and patients could not leave phone messages. New patients (or those who had not seen the doctor in the previous 12 months) were only given appointments through the mail (when the clinic received the GP’s referral). She noted: the “challenges” of changing appointments; a surgery where two-hour waits (for roughly 10 minutes with the specialist); and waiting room processes which often left elderly patients very confused—as being the norm.

Other CWAA members raised a variety of issues confronting rural and remote people with skin cancer such as the high costs incurred for accommodation and travel to access treatment; lack of knowledge about how to obtain treatment; concern about “now paying the price” for earlier-life sun exposure; extra susceptibility of transplant recipients (who take immunosuppression medication) to skin cancers; possible role of massage therapists in reminding people to seek medical advice; dismay at “the full surgeries” when attending a skin specialist; and suggestions for taxation concessions on sunscreens for people whose occupations involve significant time outdoors.

‘Kate’s Story’ (below), outlines the difficulties for a very young woman from Uralla (near Armidale, NSW) and her family and friends. Kate lost her life to melanoma at the age of 22. Her last few years encompassed many experiences involving medical consultations, diagnostic tests and procedures, surgery and trials of cancer drugs and medications, and of course, considerable financial costs, long-distance travel and disruption to many aspects of her life.

Clearly many factors need to be addressed to help reduce skin cancer in Australia including finding ways to ensure various groups, including men and older people in rural and remote areas, seek medical advice at earlier stages. Flexible clinic hours help people whose employment makes it difficult to make appointments in standard business hours. Information gleaned in formulating a communication and education campaign about skin cancer may be useful in identifying more effective ways to encourage men to have their skin regularly checked.

Access to more specialised cancer care has been significantly improved for people in more remote areas through the establishment of regional cancer centres. Tertiary hospitals in the capital cities also provide specialist cancer care. Experience from one of the Melbourne outreach clinics showed the burden of disease in the first year to be “enormous” but by three

to four years, and with trained GPs, they become more like city clinics where clinicians see the walking well more than people with a high burden of disease

Conclusion

Skin cancer knows no social or geographical barriers - but is a largely preventable disease. As noted, there is a significantly higher incidence of melanoma (associated with sun exposure) among people in Australia's rural and remote areas than in the capital cities. The incidence of skin cancer is increasing among Australians aged 65 and over.

Many skin cancer prevention campaigns in Australia have been successful in alerting people in Australia to the potential dangers of sun exposure but a clear need exists to continue to raise awareness about skin cancer prevention, particularly among adolescents, and men and older people in rural and remote areas.

Various organisations including the Australian Government through its Health portfolio could have a role in formulating and managing a campaign to achieve positive outcomes for all Australians, including people in rural and remote areas. Much of the responsibility in helping to prevent, diagnose and provide quality treatment lies with health professionals but individuals themselves need to also have ownership. Underpinning everyone's efforts is the need to continue public education and awareness campaigns about skin cancer, which have been largely successful.

People in rural and remote areas affected by skin cancer and their families and friends experience a range of hardships and challenges, a perennial issue being the lack of specialists.

A multi-faceted approach to raising awareness and assisting with early diagnosis and management of skin cancer is required, based on the skills of the health professionals already working in and committed to their rural and remote patients.

Recommendations

To improve the situation for rural and remote people in terms of skin cancer awareness and evidence-based treatment and management, the Alliance proposes the following recommendations.

1. All governments (Federal, State/Territory and local) should develop and maintain an awareness of how policies and programs for which they have responsibility support 'sun-smart' or 'skin-safe' attitudes and behaviours, particularly for those who live in rural and remote areas where health-promoting infrastructure is relatively poorly developed.
2. Public awareness campaigns to address skin cancer need to be scrutinised to determine if they are equally available and effective in rural and remote areas and, if they are not, what changes are needed to increase their effectiveness so that people not only hear the messages, but heed and act upon them.
3. People in Australia's rural and remote areas should be recognised as a priority target group regarding all matters aimed at addressing the detrimental effects of sun exposure.

4. The Australian Department of Health should use its professional communication expertise and knowledge to formulate and roll out an effective communication and education program to educate the community and health professionals about all facets of skin cancer, with a particular focus on rural and remote areas, and emphasising the importance of simple preventive measures (ie, sunscreens, hats and shade) and regular screening by health professionals and people themselves.
5. The special needs of Aboriginal and Torres Strait Islander people must be considered, and included in all policy deliberations and public education campaigns to alert individuals, health professionals, organisations and other groups about the potential dangers of sun exposure.
6. All governments (Federal, State/Territory and local) must consider information about the lack of shade in many rural and remote areas and ensure that the provision of shade becomes a high priority for all local government planners with responsibility for parks and public spaces in rural and remote areas.
7. All governments (Federal, State/Territory and local) should collaborate and share evidence about the extent to which people in remote areas are missing out compared to their counterparts in the major cities in accessing effective drugs and advanced treatments for skin cancer.
8. Professional development and further education on skin cancer detection should be made available to all health professionals working in rural and remote areas, so that they are able more effectively to assist and advise people on skin cancer issues, including when to suggest that people seek GP and/or specialist advice.
9. Professional development on the use of technology such as teledermatology, to assist in diagnosing sun cancers, should be available to rural and remote health professionals.
10. The 'best practice' ideas relating to diagnosis, treatment and management of skin cancer raised at the 2013 Parliamentary Roundtable should be considered by the Australian Government in terms of how they could be adapted so that people in rural and remote areas are able to access more timely and efficient medical treatment for skin cancer than is presently the case.
11. The Australian Government should provide resources to melanoma patient support groups so that people receive specific advice, support and counselling and opportunities to network with relevant individuals and agencies, including in Australia's rural and remote areas.
12. Best practice clinical guidelines for general practitioners on skin cancer need to take account of the particular challenges and circumstances of people in rural and remote areas who are affected by skin cancer.

Kate's Story

A young woman from country NSW who lost her life to melanoma

Originally from Uralla (near Armidale, NSW), Kate Philp was only weeks from celebrating her 19th birthday when she had a mole removed from the top of her left big toe by a local general surgeon. A biopsy revealed a melanoma. Further surgery and a skin graft were undertaken by the local general surgeon, with results indicating no further sign of melanoma. But Kate was advised to have regular (three-monthly) check-ups.

Kate passed away on 13 March 2010 aged 22. Kate's story in her last few years depicts a busy life of travelling, working and being involved in university studies and the social activities of a typical young person, interspersed with travelling from Albury or Armidale to Sydney (552 kms and 475 kms respectively) for medical procedures and treatments.

Commenting about the dangers of too much sun exposure and skin cancer risks, her mother, Joanna Dolan, says: "Kate was not an outdoors type, but we now know she was genetically predisposed to the disease. You never know how much sun exposure is too much. And melanoma is such a fast-acting cancer."

When diagnosed with melanoma, Kate had just returned from the UK following a GAP year where she worked as a carer in Jubilee Lodge respite centre for people with disabilities. She enjoyed the experience so much that she had applied for a permanent position and intended to return to the UK to start work in late February 2007. With the surgery, her departure was delayed by a few weeks (much to her annoyance!). Kate organised her three-monthly check-ups with a London-based skin specialist and worked happily at Jubilee Lodge for almost 18 months when a lump appeared in her groin. She was given the bad news that the melanoma had spread to her lymph nodes and returned home to Australia (on her UK specialist's advice) for treatment including removal of lymph nodes in her left groin in August 2008.

This operation appeared to be successful and Kate started the process of enrolling at Charles Sturt University to commence a speech pathology degree. She was accepted for entry to commence in February 2009. However, melanoma was not finished with her: a lump appeared in her left armpit and surgery to remove the lymph nodes in that area was conducted in early December. Again, all was well and Kate prepared to move to Albury (after her sister's wedding in January 2009).

Just before beginning her first semester, a biopsy of a small lump on Kate's right cheek revealed melanoma; the day before her 21st birthday, Kate had surgery to remove it. Tests showed that the melanoma had metastasised and further surgery was not an option. The situation became more dire as no viable treatment was available and Kate was ineligible for any of the known trials being conducted at the time.

The one possibility was a drug being clinically trialled in the UK, USA and Australia: Oblimersen. However, Kate was not eligible for the trial so her family and friends

raised over \$50,000, to import the drug from the USA under Australian Government licence. This paid for the first two treatments and then Kate received more treatments at no cost on “compassionate grounds” through the Australian Government. As seems to be the case with most melanoma drugs, Oblimersen was effective for some time but is not a cure. Treatment with Oblimersen was discontinued in August and Kate was fortunate to be accepted on a clinical trial for a new drug – BRAF Inhibitor.

Back in Albury, she commenced her studies in late February and as Joanna recalls: “She was achieving and doing really well.” Jo and Kate travelled from Albury and/or Armidale to Sydney for treatments and check-ups, the extra costs, re-arrangements and logistics that country people face, adding to their difficulties. “There are no dermatologists in Armidale”, reminds Joanna: “But the reality is that beyond surgery, melanoma treatment is still so new and is predominantly clinical trials, so it’s based in the major cities.”

“Throughout that time, all the doctors who helped Kate were wonderful, they were magnificent!”

Not surprisingly the financial costs of accommodation, airline travel and car hire were “extremely expensive” and Kate’s family bore most of that cost.

Since Kate’s death, Joanna Dolan has set up the Kate Philp Melanoma Research Fund and raises funds for melanoma research through various activities and projects. Joanna reminds people about the importance of prevention and early diagnosis and lends support to those living with various stages of melanoma. Joanna considers that education and awareness-raising campaigns are vital, particularly those featuring “high-profile people who’ve had melanoma—that would grab people’s interest and remind them and doctors of the need for precautionary measures.”

Specialised counselling and support are also high priorities for Joanna: “As a parent, I know it’s important to recognise that when teenagers have melanoma, it comes at a time when they’re trying to strike out on their own. We need to let them have their sense of autonomy about their cancer. It’s important to let them be themselves, but of course be there for them.”

Member Bodies of the National Rural Health Alliance

ACEM (RRRC)	Australasian College of Emergency Medicine (Rural, Regional and Remote Committee)
ACHSM	Australasian College of Health Service Management
ACM (RRAC)	Australian College of Midwives (Rural and Remote Advisory Committee)
ACN (RNMCI)	Australian College of Nursing (Rural Nursing and Midwifery Community of Interest)
ACRRM	Australian College of Rural and Remote Medicine
AGPN	Australian General Practice Network
AHHA	Australian Healthcare and Hospitals Association
AHPARR	Allied Health Professions Australia Rural and Remote
AIDA	Australian Indigenous Doctors' Association
ANMF	Australian Nursing and Midwifery Federation (rural members)
APA (RMN)	Australian Physiotherapy Association Rural Member Network
APS	Australian Paediatric Society
APS (RRPIG)	Australian Psychological Society (Rural and Remote Psychology Interest Group)
ARHEN	Australian Rural Health Education Network Limited
CAA (RRG)	Council of Ambulance Authorities (Rural and Remote Group)
CRANApplus	CRANApplus – the professional body for all remote health
CWAA	Country Women's Association of Australia
ESSA (NRRC)	Exercise and Sports Science Australia (National Rural and Remote Committee)
FRAME	Federation of Rural Australian Medical Educators
FS	Frontier Services of the Uniting Church in Australia
HCRRRA	Health Consumers of Rural and Remote Australia
IAHA	Indigenous Allied Health Australia
ICPA	Isolated Children's Parents' Association
NACCHO	National Aboriginal Community Controlled Health Organisation
NRF of RACGP	National Rural Faculty of the Royal Australian College of General Practitioners
NRHSN	National Rural Health Students' Network
PA (RRSIG)	Paramedics Australasia (Rural and Remote Special Interest Group)
PSA (RSIG)	Rural Special Interest Group of the Pharmaceutical Society of Australia
RDAA	Rural Doctors Association of Australia
RDN of ADA	Rural Dentists' Network of the Australian Dental Association
RFDS	Royal Flying Doctor Service
RHWA	Rural Health Workforce Australia
RIHG of CAA	Rural Indigenous and Health-interest Group of the Chiropractors' Association of Australia
ROG of OAA	Rural Optometry Group of the Australian Optometrists Association
RPA	Rural Pharmacists Australia
SARRAH	Services for Australian Rural and Remote Allied Health
SPA (RRMC)	Speech Pathology Australia (Rural and Remote Member Community)