

# **Cancer in Australia 2001**

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The Australasian Association of Cancer Registries (AACR) is a collaborative body representing state and territory cancer registries in Australia and New Zealand. Most are members of the International Association of Cancer Registries. The AACR was formed in November 1982 to provide a formal mechanism for promoting uniformity of collection, classification and collation of cancer data.

The objectives of the AACR are to:

- Achieve national agreement on cancer-specific data definitions and coding and to encourage compliance with such agreements. As far as possible, data definitions and coding should be consistent with existing International Association of Cancer Registries (IACR) protocols and conventions.
- Facilitate the production of Australian, state and territory and national statistical publications on cancer that are comparable with each other and with international statistical publications.
- Improve the operational efficiency, and data completeness and quality, of the state and territory and New Zealand cancer registries through collaborative sharing of information.
- Contribute to national cancer control development in Australia and New Zealand through the regular and timely publication of local and national cancer statistics and the provision of data for cancer control research and health promotion.
- Contribute national data to international publications of the IACR.
- Contribute to international cancer coding and statistical analysis developments via members' involvement with IACR.
- Facilitate national epidemiological research projects on cancer (given appropriate local and AIHW ethics committee approvals).

CANCER SERIES

Number 28

# **Cancer in Australia 2001**

**December 2004**

Australian Institute of Health and Welfare  
Australasian Association of Cancer Registries  
Canberra

AIHW cat. no. CAN 23

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This publication is part of the Australian Institute of Health and Welfare's Cancer Series. A complete list of the Institute's publications is available from the Media and Publishing Unit, Australian Institute of Health and Welfare, GPO Box 570, Canberra ACT 2601, or via the AIHW's web site <<http://www.aihw.gov.au>>.

ISSN 1039-3307  
ISBN 1 74024 434 6

### **Suggested citation**

Australian Institute of Health and Welfare (AIHW) & Australasian Association of Cancer Registries (AACR) 2004. Cancer in Australia 2001. AIHW cat. no. CAN 23. Canberra: AIHW (Cancer Series no. 28).

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Published by Australian Institute of Health and Welfare

Printed by Elect Printing

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## Preface

The Australian Institute of Health and Welfare (AIHW) and the Australasian Association of Cancer Registries (AACR) are pleased to present *Cancer in Australia 2001*, the most recent report generated from the National Cancer Statistics Clearing House.

This report contains updates of the national cancer incidence and mortality data found in previous editions, and presents summary cancer statistics for several other national data sources held by the AIHW. These include statistics on multiple cause of death, mortality by remoteness, cancer screening, expenditure on cancer, the cancer workforce and general practice management of cancer.

National monitoring of cancer is particularly important as it is a National Health Priority Area and one in three men and one in four women can expect to be diagnosed with a cancer before the age of 75 years. As cancer is a disease that largely emerges in later life, ageing of the population means that numbers of cancer patients and the demand for cancer services are increasing faster than population growth. This report shows that the number of new cases of cancers increased by 34% from 65,966 in 1991 to 88,398 in 2001, compared with population growth of 12.3%.

Reflecting this increase in demand, AIHW health expenditure analysis has found that expenditure on cancer now accounts for 5.7% of national health expenditure, and that there was a 31% increase in inflation-adjusted cancer expenditure from 1993–94 to 2000–01. There have also been substantial increases in the numbers of oncology medical specialists and nurses.

This report also provides some international data on cancer incidence and mortality. It is pleasing to note that, while Australia has relatively high age-standardised incidence, our mortality rates are relatively low when compared with similar countries. This suggests that the Australian health system is performing comparatively well in the areas of early detection and treatment of cancer.

The statistics in this report are supplemented by additional tables, a national cancer data cube and further reports on the AIHW web site at <[www.aihw.gov.au](http://www.aihw.gov.au)>. There is a wealth of state and territory cancer data and many cancer research reports found on the state and territory cancer registry web sites listed in Appendix E. 'Related publications' lists many of the published reports available from state and territory registries.

The AACR and the AIHW wish to acknowledge the efforts of all the cancer registries in compiling and providing data to the National Cancer Statistics Clearing House so that this report could be published.

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## Contributors

This report has been prepared mainly by Edith Christensen, Susan Colwell and Ian McDermid of the Health Registers and Cancer Monitoring Unit of the Australian Institute of Health and Welfare.

The section on management of cancer in general practice was authored by Jan Charles, Ying Pan and Stephanie Knox of the AIHW General Practice Statistics and Classification Unit while Serge Chrisopolous provided workforce data and Nick Mann expenditure data. Suraiya Nargis prepared sections on cancer expenditure and international comparisons. However, this joint report between the Institute and the Australasian Association of Cancer Registries would not have been possible without the cooperation and effort of those who direct the operation, promotion and development of the state and territory cancer registries. These people, identified below, have all worked to produce the national cancer incidence statistics in this publication.

Incidence information provided by state and territory cancer registries is sourced predominantly from hospitals, pathologists and departments of radiation oncology, with supplementary information provided by medical practitioners in private practice. The major contributors of information on cancer deaths are the state and territory Registrars of Births, Deaths and Marriages and the Australian Bureau of Statistics. We thank them for their contribution.

Funding and support of cancer registries in Australia is undertaken by state and territory governments and non-government bodies. We recognise the support of the state and territory governments, the New South Wales Cancer Council, the Cancer Council of Victoria, the Queensland Cancer Fund, the Cancer Foundation of Western Australia, the Northern Territory Anti-Cancer Foundation and the Australian Cancer Society. Finally, the contributions of the staff and volunteers who work with the state and territory cancer registries are acknowledged.

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Contact details for the state and territory cancer registries are provided in Appendix E.

## Executive summary

This report presents national cancer incidence and mortality statistics for 2001 and information on multiple causes of death, mortality by remoteness, cancer screening, expenditure on cancer, the cancer workforce and general practice cancer management. It also provides international comparative data on incidence and mortality. It is part of a series of publications concerning cancer patterns in Australia. The state and territory cancer registries provide the incidence data for this report whereas the mortality data are provided by the state and territory Registrars of Births, Deaths and Marriages and coded by the Australian Bureau of Statistics. Other data sources include the AIHW National Hospital Morbidity Database and the 2001 National Health Survey conducted by the Australian Bureau of Statistics.

Mesothelioma, currently a subject of national interest as an asbestos-related disease, features in this report.

The main findings are as follows.

### *New cases of cancer and mortality*

- Excluding non-melanoma skin cancers, there were 88,398 new cancer cases and 36,319 deaths due to cancer in Australia in 2001. At the incidence rates prevailing in 2001 (541.4 per 100,000 males and 393.3 per 100,000 females), it would be expected that 1 in 3 men and 1 in 4 women would be diagnosed with a cancer in the first 75 years of life. Further, an estimated 257,458 potential years of life would be lost to the community as a result of people dying of cancer in 2001 before the age of 75. Cancer currently accounts for 31% of male deaths and 26% of female deaths (29% of all deaths, compared with 26% in 1991).

### *New cases of cancer in males and females*

- In males, prostate cancer (11,191 new cases diagnosed in 2001) is the most common registrable cancer, followed by colorectal cancer (6,961), lung cancer (5,384) and melanoma (5,024). These four cancers account for 60% of all registrable cancers in males.
- In females, breast cancer (11,791) is the most common registrable cancer, followed by colorectal cancer (5,883), melanoma (3,861) and lung cancer (2,891). These four cancers account for 60% of all registrable cancers in females.

### *Cancer deaths*

- The most common cancers causing death are lung (4,657 deaths in 2001), prostate (2,718) and colorectal (2,601) cancers in males, and breast (2,594), lung (2,382) and colorectal (2,153) cancers in females.
- In Australia there were 36,750 deaths registered in 2001 where the underlying cause was cancer and 4,519 additional deaths where cancer was an associated cause reported on the death certificate.
- Among the 4,519 cases where cancer was an additional cause of death, the most common underlying cause of death were ischaemic heart disease, chronic obstructive pulmonary disease and stroke.

### *Remoteness*

- Lung cancer, cervical cancer and cancer of the uterus as a proportion of the cancer deaths in the population all increase with remoteness from the major cities in Australia.
- Breast cancer, leukaemias, ovarian cancer and stomach cancer as a proportion of the cancer deaths in the population all decrease with remoteness.
- The age-standardised average annual cancer death rate for all cancers from 1998–2002 was lowest for Major Cities at 187.0 per 100,000 population. This was significantly below the national average.
- The median age of death from cancer in 1998–2002 was 73 years for Major Cities and Inner Regional areas and 72 for Outer Regional Areas. This fell to 69 for Remote Areas and 65 for Very Remote Areas.

### *Age distribution*

- The risk of cancer increases with age, with four times as many cancers diagnosed in those over the age of 60 years as in those under 60 years.
- The median age of first diagnosis for males was 69 years and for females was 65 years in 2001.

### *Mesothelioma*

Because of a high fatality rate and relatively short survival after diagnosis, incidence and mortality numbers of cases and rates are similar. Trends are as follows:

- The age-standardised incidence per 100,000 population increased from 1.2 in 1982 to 2.9 in 2001.
- The numbers of new cases per year has increased from around 150 in the early 1980s to 567 in 2001, while the peak number of recorded deaths to date was 519 in 2001.
- Although female incidence is substantially lower than male incidence, the age-standardised rate for females has greatly increased since the early 1980s to 1.0 per 100,000 women, while the male rate has more than doubled during the same period to 5.3 per 100,000 males.

Other features of mesothelioma are:

- The median age at diagnosis for men is 70.0 years and the median age at death is also 70.0 years.
- For women, the median age at diagnosis is 71.0 years and median age at death 72.0 years.

### *Screening*

- The proportion of women in the target age group (50 to 69 years) who were screened under the BreastScreen Australia program in a 2-year period rose from 52% in 1996–1997 to 57% in 2001–2002.
- The proportion of women in the target age group who were screened under the National Cervical Cancer Screening Program in a 2-year period rose from 61% in 1996–1997 to 63% in 1998–1999 and then declined to 61% in 2000–2001. The decline is unexplained but may be due to improvements in the linking of records to identify women previously screened and to lack of media campaigning in most states.

### *Cancer expenditure*

- Allocatable expenditure on cancer in 2000–01, excluding public health expenditure, was \$2.7 billion, representing 5.7% of total allocatable health expenditure.
- 71% of cancer expenditure was in hospital care (\$1,988m) and 9% of all expenditure in hospitals was on cancer.
- Out-of-hospital medical services accounted for 12% of cancer expenditure (\$343m) and pharmaceuticals 6.6% (\$183m).
- \$215m was spent on cancer research in 2000–01, 18% of all health research expenditure in Australia.
- There was a 31% increase in inflation-adjusted cancer expenditure from 1993–94 to 2000–01.
- Average cancer expenditure per person was \$146 for males and \$135 for females in 2000–01. This was much higher in the older age groups. In the 65–74 year age group, average expenditure per person in 2000–01 was \$641 for males and \$389 for females, while in the 75 years and over age groups, the averages were \$984 for males and \$480 for females.

### *Cancer workforce*

- Although to 2001 there were increases in the numbers of most of the medical disciplines providing cancer services, medical oncologist numbers fell from 187 in 1999 to 171 in that year. The numbers of radiation oncologists increased from 117 in 1995 to 182 in 2001.
- 87% of registered nurses and 78% of enrolled nurses working in oncology as their main work setting were employed in hospitals.
- There were 1,062 nurses working in hospices in 2001, almost the same as the number in 1995.
- At the 2001 population census, there were 808 radiation therapists, a 15% increase on the 700 in 1996.

### *Management of cancer in general practice*

- Skin cancers, including basal and squamous cell carcinomas and melanomas, are by far the most common cancers managed by general practitioners. The next most common are prostate cancer, female breast cancer and lung cancer.
- There was a significant decrease in prescribing of medications between 1998–2000 and 2002–2004, from 31 to 25 per 100 patient contacts.
- Opioids (synthetic narcotics that have opiate-like activities but are not derived from opium) were the most commonly prescribed medications for cancer, accounting for approximately one quarter of all prescriptions. They were prescribed by GPs at a rate of 7 per 100 cancer contacts in 2002–2004.
- There was a significant increase in the overall rate of other treatments provided between 1998–2000 and 2002–2004. GPs provided these treatments at a rate of 39 per 100 cancer contacts in 1998–2000 and at a rate of 46 per 100 in 2002–2004.
- A significant increase was found in the rate at which GPs undertook administrative procedures between 1998–2000 (0.8 per 100 cancer contacts) and the two later periods when the rates were 1.5 and 1.9 per 100 respectively.

- There were 20 referrals per 100 cancer patient contacts in 2002–2004. Of the ten most common individual referrals, only referrals to hospitals showed a significant change over time, decreasing from 1.4 per 100 cancer contacts in 1998–2000 to 0.6 per 100 in 2000–2002 and 0.6 per 100 in 2002–2004. As a percentage of all referrals, hospital referrals halved between the first and third time periods, from 6.8% to 2.9%.

### *International comparisons*

- In comparison to other developed countries, Australia has relatively high incidence rates but comparatively low mortality rates, indicating that cancer survival in Australia is relatively very good. This suggests that the health system in Australia is performing well in lengthening survival through early detection and in treatment of cancer.
- Australia's incidence rates for males and females are much higher than for the United Kingdom and Canada, but are slightly lower than for the United States, and are around 20 persons per 100,000 population lower than for New Zealand. Australia's mortality rates are lower than for all four of these countries.
- Colorectal cancer is a disease besetting affluent countries. The age-standardised incidence per 100,000 population is an average of 37 for more developed countries and 10 for less developed countries for males, with Australia having a very high rate by world standards of 50.
- Breast cancer is another disease particularly high in affluent countries. Australian age-standardised incidence per 100,000 population is much higher than the average for the more developed countries of the world, but is almost the same as for Canada and New Zealand and below that of the United States.
- The age-standardised incidence of prostate cancer in Australia is much higher than in the United Kingdom and other European countries, but is well below the very high rates found in the United States and New Zealand.
- Because of excessive sun exposure, Australia and New Zealand have by far the highest rates of both incidence and mortality of melanoma in the world. However, mortality rates for melanoma in Australia are quite low compared with others cancers.
- Australia's male lung cancer incidence and mortality rates are both well below the averages for the more developed countries of the world, especially compared with very high incidence rates in Canada, the United States and most European countries.
- Australian age-standardised incidence and mortality rates for non-Hodgkin's lymphoma are the same as those for New Zealand and Canada, but above the rates for the United Kingdom and below those for the United States.
- Because of the success of the national cervical cancer screening program in detecting and following up pre-cancerous abnormalities, Australia's cervical cancer incidence and mortality rates have been declining steadily for many years. They are both well below the averages for the more developed countries of the world, and also below those of the United Kingdom, Canada, the United States and New Zealand.