Lung Foundation Australia

Time to take the next step

Delivering equitable lung cancer reform in Australia

Lung Foundation Australia's
third national Blueprint for action on lung cancer

For more than 30 years, Lung Foundation Australia has walked alongside people living with lung disease and lung cancer, helping them navigate some of life's hardest moments with care, knowledge and hope.

We provide trusted support through our nurses, peer support programs and social workers. We fund research that leads to better treatments. We speak out for people who need lung health to be taken seriously.

Everything we do helps protect the gift of breath, so that more Australians can breathe easier, live well and feel less alone.

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Acknowledgement of Country

Lung Foundation Australia acknowledges the Traditional Custodians of the lands on which we work throughout Australia and their unceded sovereignty of and continuing connection to land and sea. We pay our respects to First Nations cultures and to Elders past and present. We acknowledge the overrepresentation of Aboriginal and Torres Strait Islander peoples in lung disease and lung cancer. We commit to working with communities to Close the Gap on lung health and build on the strengths of communities to lead the path to healthy lungs for all.

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Acknowledgements

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Executive Summary

Lung cancer is Australia's leading cause of cancer death. In 2025, around 15,100 Australians were expected to be diagnosed – 41 people every day – and 9,000 will die. It has the lowest 5-year survival rate of the 5 most commonly diagnosed cancers, with most cases diagnosed too late for curative treatment. The burden falls disproportionately on Aboriginal and Torres Strait Islander peoples, people living in rural and remote areas, those experiencing socioeconomic disadvantage and other priority populations.

Time to take the next step: Delivering equitable lung cancer reform in Australia (the Blueprint) sets out an evidence-informed roadmap for reform across 6 interconnected areas spanning the full continuum of lung cancer care. Now is the time to build on the promise of screening by addressing persistent inequities. The reforms are ambitious but achievable, and cannot wait.

Reform areas	Policy recommendations
1 Promote lung health for all Australians	1.1. Invest in a national lung health education and awareness campaign 1.2. Develop and implement a National Clean Air Strategy
2 Advance equitable lung cancer outcomes for Aboriginal and Torres Strait Islander peoples	2.1. Embed culturally safe, community-led lung cancer care 2.2. Strengthen early detection and diagnostic pathways 2.3. Improve access to curative and specialist lung cancer treatments 2.4. Remove structural barriers to care 2.5. Build and sustain a culturally safe workforce
3 End Australia's tobacco epidemic to improve lung health	3.1. Introduce a tobacco and vape-free generation policy 3.2. Explore the potential of denicotinisation of tobacco products 3.3. Reduce tobacco retail availability 3.4. Strengthen access to effective and culturally safe quit supports 3.5. Protect policy from tobacco and vaping industry interference
4 Expand and optimise the National Lung Cancer Screening Program	4.1. Address barriers to screening participation 4.2. Invest in targeted promotion and awareness to drive screening participation 4.3. Review and expand eligibility criteria 4.4. Embed smoking cessation as a core Program component 4.5. Progress towards an integrated, multi-disease screening approach 4.6. Embed a nurse-led navigation model of care within the Program 4.7. Fund translational research to support Program evaluation and continuous improvement
5 Strengthen support for people living with lung cancer and their carers	5.1. Invest in more Lung Foundation Australia Specialist Lung Cancer Nurses 5.2. Sustain and strengthen the Lung Foundation Australia Lung Cancer Specialist Nurse telehealth service 5.3. Build dedicated survivorship support and lung cancer specific resources
6 Increase investment in lung cancer research and innovation	6.1. Strengthen Australia's lung cancer research workforce and capability 6.2. Establish a national lung cancer clinical quality data platform 6.3. Expand lung cancer biobanking and precision medicine infrastructure 6.4. Prioritise optimal diagnostic pathways and access to precision diagnostics

Foreword

Lung cancer touches the lives of thousands of Australians every year. It affects not only those diagnosed, but also the families, carers, communities and health professionals who support them. Behind every diagnosis is a person, a story and a future that matters.

For too long, lung cancer has carried an undeserved stigma, received disproportionately low investment, and delivered outcomes that fall far short of what Australians deserve. That is beginning to change. We now stand at a moment of real opportunity – and real responsibility – to make good on our vision of **Lung Health for All**.

Time to take the next step is Lung Foundation Australia's third national Blueprint for action on lung cancer, and it arrives at a genuinely historic moment. In July 2025, Australia became the 13th country in the world to launch a National Lung Cancer Screening Program. This milestone was decades in the making and has the potential to fundamentally change the story of lung cancer in this country. Through earlier detection, improved survival rates and greater opportunities for curative treatment, this screening program is a landmark achievement and a cause for genuine hope.

While lung cancer screening is transformative, screening by itself will not close the gap. Its benefits will only be fully realised if we also address the systemic barriers, inequities and service gaps that leave too many Australians behind. This is particularly true for Aboriginal and Torres Strait Islander peoples, people living in rural and remote communities and other priority populations. A program that reaches only some of those who need it most has not yet fulfilled its promise.

The Blueprint sets out what needs to happen over the next 3 years to turn this moment of possibility into lasting change. It aligns with a growing global movement to prioritise integrated approaches to lung health and is grounded in *Lung Foundation Australia's corporate strategy, lung health for all.* This work reflects deep collaboration and shared purpose, and has been developed by leading clinicians, researchers and advocates from across the country. Critically, it was also shaped by people at risk of or living with lung cancer and their carers - their experiences and perspectives are central to this work and remain our strongest call for action.

The Blueprint calls on governments, health systems and partners to act across 6 interconnected reform areas. These span the full continuum of lung cancer care, experiences and outcomes.

While this agenda is ambitious, it is also achievable and the evidence is clear. The infrastructure is being built. The global momentum is real. Most importantly, the people who need change most cannot afford to wait. What is needed now is sustained leadership, investment and the political will to deliver.

We are deeply grateful to everyone who contributed their expertise, time and lived experience to this work. This Blueprint sets out a clear roadmap for the sector and a mandate for improving outcomes for people affected by lung cancer. It reflects Lung Foundation Australia's commitment to lung health for all.

Professor Lucy Morgan

Lung Foundation Australia Board Chair and Respiratory Physician

Introduction

This is Lung Foundation Australia's third national Blueprint for action on lung cancer: a national policy and advocacy framework guiding coordinated action over the next 3 years to improve outcomes for people affected by lung cancer in Australia.

Time to take the next step furthers the work of our 2 previous national blueprints:

- *Making lung cancer a fair fight: a blueprint for reform* (2018) established the case for reform and laid the foundation for national advocacy[1]
- *The next breath: accelerating lung cancer reform in Australia* (2022) advanced the agenda during a period of significant policy progress. It included investments in lung cancer nursing, improved treatment access and a recommendation for a National Lung Cancer Screening Program.[2]

The landmark recommendation *of the next breath* was realised on 1 July 2025, when Australia's National Lung Cancer Screening Program commenced.

Our third Blueprint reflects a new era in lung cancer reform, one shaped by both the launch of the National Lung Cancer Screening Program and growing global momentum. That momentum includes the World Health Organization's 2025 resolution calling for integrated approaches to lung health.[3]

This Blueprint was developed through evidence review, expert consultation and meaningful community engagement. A guiding principle of equity sits at the heart of all 6 reform areas. Six chapter leads –leading Australian lung cancer clinicians, researchers and advocates – led the development of each reform area. Importantly, the perspectives of people living with lung cancer and their carers are embedded throughout, drawing on Lung Foundation Australia's Lived Experience Working Group and years of structured consumer insight work. The reforms are grounded in what people living with lung cancer and their carers consistently tell us they need.

This Blueprint is also aligned with key national and international policies and strategies, including:

- Lung Foundation Australia corporate plan 2026-2030: lung health for all[4]
- Lung Foundation Australia research strategy[5]
- Australian Cancer Plan[6]
- Aboriginal and Torres Strait Islander Cancer Plan[7]
- National Preventive Health Strategy 2021–2030[8]
- National Tobacco Strategy 2023–2030[9]
- National Aboriginal and Torres Strait Islander Health Plan 2021-2031[10]
- National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021–2031[11]
- National Agreement on Closing the Gap[12]
- National Health and Medical Research Strategy 2026-2036[13]
- NHMRC Research Translation Strategy 2026–2030[14]
- Statement on Consumer and Community Involvement in Health and Medical Research[15]
- National Strategic Framework for Chronic Conditions 2026–2035[16]
- Future focused primary health care: Australia's Primary Health Care 10 Year Plan 2022-2032[17]
- Health Technology Assessment Policy and Methods Review Final report[18]
- Enhance HTA: An Enhanced Consumer Engagement Process in Australian Health Technology Assessment – A report of recommendations[19]
- World Health Organization resolution: Promoting and prioritizing an integrated lung health approach[20]
- World Health Organization Cancer strategy[21]
- World Cancer Declaration 2025-2035[22]

The burden of lung cancer in Australia

4th most commonly diagnosed cancer in Australia[23]

15,108 new cases of lung cancer diagnosed in 2025[23] – **around 41 Australians diagnosed every day**

9% of new cancer cases[24]

Lung cancer causes more deaths than any other cancer in Australia

#1 **Lung cancer** is Australia's leading cause of cancer death[23]

8,994 Australians lost their lives to lung cancer in 2025[23]

By age 85, an estimated

1 in 21 Australians will be diagnosed with lung cancer[23]

1 in 36 Australians will die from lung cancer[23]

Aboriginal and Torres Strait Islander peoples are disproportionately affected[23]

- **higher** incidence, at younger ages
- **higher** mortality
- **lower** survival

Female lung cancer rates are rising as male rates fall

Women

7,414

diagnosed in 2025, with incidence and mortality rates rising[23]

Men

7,694

diagnosed in 2025, with incidence and mortality rates declining[23]

Anyone with lungs can get lung cancer

Tobacco smoke is the leading risk factor for lung cancer[25-27]

but **1 in 4** people living with lung cancer have never smoked[28]

Risk factors include[25]

- Tobacco smoke (first or second-hand exposure)
- Environmental exposures (e.g. air pollution, radon)
- Occupational exposures (e.g. asbestos, silica)
- Increasing age
- Genetics
- Family history of lung cancer or personal history of cancer
- History of chronic lung disease
- HIV infection
- Past chest radiation

Burden of lung cancer is higher among certain population groups[23,25,28]

- People who currently smoke and people with a smoking history
- Aboriginal and Torres Strait Islander peoples
- People with significant environmental or occupational exposures
- People living in rural and remote areas
- People in lower socioeconomic groups
- Older people
- Females

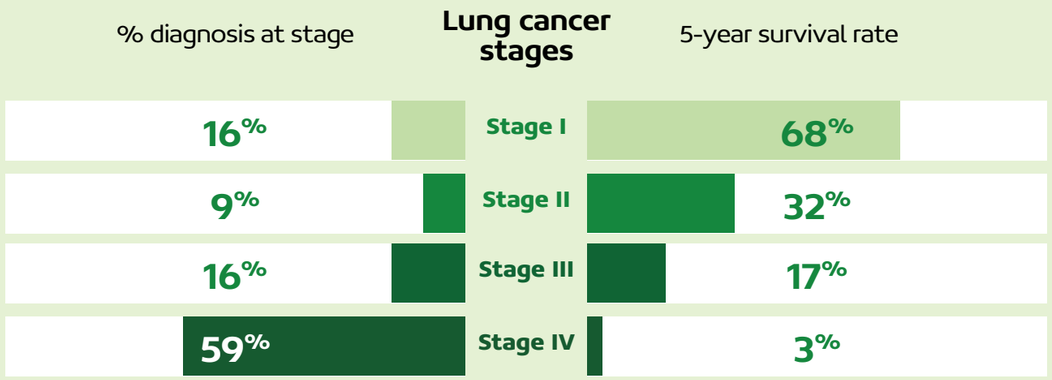
Early detection improves survival

Most lung cancers are diagnosed at an advanced stage, when curative treatment is less likely to be possible. Earlier diagnosis provides more treatment options, improves survival and reduces healthcare costs.

5-year survival for lung cancer is **27%**

- the lowest of the 5 most commonly diagnosed cancers[23,24]

Survival improves the earlier lung cancer is found[23]



More Australians are surviving lung cancer

More people are living with and beyond lung cancer than ever before, and this number will continue to grow as survival improves - placing increasing demand on the health system.[29]

45,500

Australians living in 2025 with a lung cancer diagnosis made in the past decade[23]

Lung cancer is costly

Lung cancer imposes significant costs on individuals, families, the health system and society.[27,30]

$1.9b

Total health system expenditure in Australia in 2023-24:[31]

$988.7m
Pharmaceutical Benefits Scheme

$541.7m
Public hospital admitted patients

$174.2m
Public hospital outpatients

$14.9m Indirect costs (e.g. lost productivity)[2]

In 2023-24, for the first time, lung cancer accounted for more health spending than any other individual cancer — nearly 10% of all cancer spending in Australia[31]

The human impact of lung cancer

A lung cancer diagnosis changes everything. It impacts the person diagnosed and everyone who loves and cares for them.

Physical burden

Severe, ongoing symptoms from the disease and treatment steadily reduce independence and make daily life harder for people living with lung cancer.

84% of people report moderate to significant impact on physical movement[32]

Higher symptom burden than most other cancers[33,34]

Mental and emotional burden

Ongoing fear, uncertainty and treatment stress create lasting psychological strain from diagnosis through survivorship, while access to psychosocial support remains inconsistent.

81% of people report moderate to significant impact on their mental health and wellbeing[32]

Higher distress, anxiety and depression than most other cancers[35]

Financial burden

A lung cancer diagnosis frequently leads to significant and unexpected financial hardship. The burden falls most on disadvantaged groups, worsening existing inequities.

56% of people report moderate to significant impacts on their financial wellbeing[32]

70% of people report moderate to significant impact on their ability to work or study[32]

One in 10 cancer patients face catastrophic out-of-pocket costs; more than half spend over $1,000 within 2 years of diagnosis[37]

Social toll

Social isolation is common, particularly for people living in rural and remote areas. For Aboriginal and Torres Strait Islander peoples, separation from Country, family and community during treatment adds a profound additional burden.

73% of people report moderate to significant impact on their relationships[32]

Caregivers often face substantial burden and distress, affecting their health, work and wellbeing[36]

Kerryn, 50, Queensland

The moment my life split into a *before* and an *after*, I was in the middle of an ordinary workday. There was no warning, just an oncologist's clinical voice over the phone telling me I had incurable Stage 4 non-small cell lung cancer and a timeline: 3 years at best, one year at worst. I was only 49. In an instant, my entire world stopped.

How do you begin to process being told you are unlikely to live long enough to see your son finish school? To see who he becomes? The future I had always assumed I would be part of was suddenly something I was being written out of. My little boy was going to lose his mum.

I was a non-smoker, physically fit, and a single mum to an 11-year-old boy. I did not fit the stereotype people often associate with lung cancer, yet the reality is that lung cancer can affect anyone.

One of the most important things I've done since my diagnosis is build "My Team": trusted specialists who listen, explain, and treat me as a person, supportive family and friends, a psychologist, and services like Lung Foundation Australia's Lung Cancer Telehealth Nurse. As a single parent, support has been essential. My son, despite an incredibly disruptive year, has become my greatest source of strength - reminding me to keep finding happiness, humour and normality wherever I can, even on the hardest days. He truly is my motivation to be here.

Living with lung cancer has meant learning to sit with uncertainty. Much of cancer is waiting. Waiting for scans, results, and treatment. There are still days when the emotional weight feels unbearable; days when I want to curl up and cry, when I don't want to be strong or be a "cancer warrior." But somehow, I keep going. Even on the hard days.

Advances in research, genomic profiling, and new treatments give me hope. Despite what I was told at diagnosis, I am still here, living well. My life is different, but I am focused on creating a new version of normal, and I still have a lot of living left to do.

I am grateful for the doctors who have supported me, and for the many people dedicated to improving outcomes for lung cancer patients. Knowing this gives me hope and strength to keep moving forward.

Stigma

55% **of people living with lung cancer** have experienced stigma[32]

37% **of Australians** have less sympathy for people living with lung cancer compared with other cancers[38]

Stigma is a barrier to care

More than a quarter of people living with lung cancer felt stigma was a direct barrier to managing their disease.[32]

It can erode trust in health professionals and deter people from seeking medical help - which delays diagnosis and treatment and worsens health and wellbeing outcomes.[41-43]

For priority populations, stigma can compound existing barriers, discrimination and mistrust of health services, further entrenching health inequities.[46]

Stigma and psychological harm

Stigma is associated with significant distress, self-blame, guilt, shame and elevated suicide risk among people living with lung cancer.[39,40]

Misconceptions about lung disease

Community assumptions remain deeply tied to smoking and narratives around personal responsibility.

For people who currently smoke and people with a history of smoking, this judgement can lead to profound self-blame and guilt that can harm their wellbeing and deter engagement with medical care.

For people with no history of smoking, this misconception can lead to misdiagnosis or delayed diagnosis.[44,45]

One of the first things people said when they heard my diagnosis was, “But you’re so fit and healthy.” Then, after learning that I used to smoke, there was often an unspoken sense of, “Oh, now I understand.” The stigma associated with lung cancer is very real and can leave you blaming yourself for your diagnosis.

- Antoniette, 57, ACT

The reality is simple: if you have lungs, you can get lung cancer. Smoking is a major risk factor, but it is not the only cause. Yet public perception often reduces it to a “smoker’s disease,” creating shame, blame and silence. No one should have to justify why they got cancer. Compassion should never depend on how someone became sick. Every person deserves dignity, care and support without judgment.

- Charmaine, 57, Victoria

Recommendations for lung cancer reform in Australia

1. Promote lung health for all Australians
2. Advance equitable lung cancer outcomes for Aboriginal and Torres Strait Islander peoples
3. End Australia’s tobacco epidemic to improve lung health
4. Expand and optimise the National Lung Cancer Screening Program
5. Strengthen support for people living with lung cancer and their carers
6. Increase investment in lung cancer research and innovation

1

Promote lung health for all Australians

Christopher, 62, New South Wales

I had never smoked, and as a result, I was blissfully naive to any thought that I would ever get lung cancer. In fact, like many people, I assumed lung cancer was a condition that mainly affected people who smoked. I was very surprised to learn that around a quarter of people diagnosed with lung cancer have never smoked.

After years of scans for bronchiectasis and mild asthma, a small spot on my lung that had been monitored for more than a decade finally changed. A biopsy confirmed it was lung cancer. I can still put myself back in that room where I was told the news - like in the movies, time stood still. The hardest part was sharing the diagnosis with my children.

After further scans, I underwent surgery to remove the lower lobe of my right lung, followed by weeks of recovery. One of the most wonderful moments of my life was receiving a phone call from my surgeon to say that he had removed all the cancer and that I would not need chemotherapy or radiotherapy.

The shock of the diagnosis remains a profoundly emotional memory, but so does my gratitude for the exceptional care I received from the professors, surgeon and nurses who looked after me. Lung cancer has changed how I think about living well: slowing down, appreciating the moment and making the most of time with my family.

Even now, whenever I tell someone I have had lung cancer, one of the first questions is often, “Were you a smoker?” Even after I explain that I never smoked, some people seem a little suspicious or disbelieving. In many ways, I understand that reaction because I once held the same misconception myself.

My experience showed me that lung cancer is not just a “smoker’s illness”, it can happen to anyone. Because many people believe lung cancer equals smoking, some never consider themselves at risk and may delay seeking medical advice when symptoms arise. **We need greater awareness of all lung cancer risk factors and better public understanding of lung health so more people recognise symptoms early, seek medical advice sooner and have the best chance of a positive outcome.**

1 Promote lung health for all Australians

Lung health outcomes in Australia are undermined by persistent stigma and a limited awareness and action around risk factors beyond smoking. Addressing this requires coordinated national action, including a lung health education and awareness campaign and a comprehensive national clean air strategy.

Lung cancer remains one of Australia's most serious health challenges, yet many of its drivers are preventable. Exposure to tobacco smoke, poor air quality and harmful workplace environments all contribute significantly to risk. The lack of awareness of different risk factors and the stigma associated with lung cancer contribute to delays in seeking help, diagnoses and treatment. Addressing these factors requires a coordinated, national approach. This strategy must move beyond individual blame and focus instead on prevention, early action and equitable care.

Anyone with lungs can get lung cancer

Tobacco is the leading risk factor for lung cancer[25–27]

1 in 4 **people** living with lung cancer have never smoked[28]

Other risk factors include:[25]

- Environmental exposures (e.g. air pollution, radon)
- Occupational exposures (e.g. asbestos, silica)
- Increasing age
- Genetics
- Family history of lung cancer or personal history of cancer
- HIV infection
- History of chronic lung disease
- Past chest radiation

As a woman and a mother, I have sometimes felt invisible within female-focused cancer campaigns. While many initiatives rightly support women with breast and reproductive cancers, women living with lung cancer can feel overlooked. This is despite facing the same fears around family, identity, motherhood and survival. I would love to see a broader and more inclusive representation of women's cancer experiences, so that no woman feels unseen because of the type of cancer she has. Inclusion does not take anything away from existing campaigns, it simply widens the circle of support.

- Kerryn, 50, Queensland

Policy recommendations

1.1 Invest in a national lung health education and awareness campaign

We recommend launching a properly funded, multi-year national campaign to promote general lung health, reduce stigma and encourage early symptom recognition.

Public understanding of lung cancer remains narrow and is often shaped by a strong association with smoking, which can be harmful. While tobacco use is a major risk factor, this narrow framing can contribute to stigma, reduce empathy and delay people from seeking help.

It may also foster a false sense of security among people who have never smoked. This leads some to incorrectly assume they are not at risk of lung cancer, which delays symptom recognition and seeking medical advice, potentially resulting in poorer outcomes.

This campaign must operate at sufficient scale and be co-designed with communities to reach diverse populations, cut across media channels and ultimately shift entrenched beliefs. Evidence from public health demonstrates that high-reach, sustained mass media campaigns with repeated exposure are among the most effective approaches in shifting knowledge, attitudes, and behaviours.[48] Short-term or low-intensity campaigns are unlikely to change deeply embedded social norms or achieve sustained change at population scale.[49,50]

Shifting public understanding requires a properly funded, multi-year national campaign that promotes lung health for all stages of life. A national lung health campaign should aim to:

- normalise lung health as an important part of living well and that it should be protected
- increase understanding of the multiple risk factors for poor lung health and lung cancer
- promote early helpseeking for symptoms
- reinforce that lung conditions are treatable and that earlier action leads to better outcomes.

The campaign should be evidence-based with its messages, channels and interventions informed by the best available public health research and consumer insights.

Normalising early presentation

Normalising earlier medical presentation is critical. Symptoms such as a persistent cough, shortness of breath, chest discomfort, fatigue, or recurrent infections are often dismissed. These can be frequently attributed to ageing, stress or lifestyle factors, which leads to avoidable delays in seeking care, diagnosis and treatment.

A national lung health campaign can shift this pattern by normalising conversations about lung health and lung symptoms. This helps people recognise when symptoms are persistent, new, or changing, encouraging timely engagement with primary care, and reinforcing the benefits of early diagnosis.

Building prevention literacy

A national lung health campaign should also build prevention literacy. While smoking cessation remains essential, Australians need better awareness of other risk factors. These include, but are not limited to, air pollution, occupational exposures, family history, genetic risk and, as the evidence strengthens, e-cigarettes. By reframing lung disease beyond an exclusive association with tobacco smoking, the campaign can support earlier help-seeking. It will also normalise lung health as part of routine health awareness and conversation.

This campaign must be consumer-informed and supported by parallel efforts within the healthcare system. This includes training for clinicians in stigma-free communication. Together, these actions can reset the narrative around lung health, improve early detection and deliver measurable population-level impact. Given the scale of the challenge, the clear benefits for the community and health system, and the current lack of such campaigns, this investment is both justified and necessary.

1.2 Develop and implement a national clean air strategy

We recommend establishing a coordinated national clean air strategy with clear federal leadership to set strict air quality standards and protect communities from pollution-related health risks.

Air pollution is a major and growing public health threat in Australia. Research indicates there is no safe level of exposure. Even low levels of air pollution can increase the risk of premature death and serious illness, including lung cancer.[51,52]

Despite this, air quality policy in Australia remains fragmented across jurisdictions and portfolios. This division makes it harder to deliver consistent action, track progress and protect communities.

A coordinated national response is essential to improving air quality country wide. Australia urgently needs a national clean air strategy to provide clear national leadership, drive consistent action across jurisdictions and embed a strong public health approach to air quality management.

Main sources of air pollution in Australia[53]

- Motor vehicles and traffic
- Industrial processes
- Power generation
- Domestic wood heaters

Air pollution was the **second leading risk factor** for death globally in 2021[51]

More than **3,000 premature deaths** are attributable to outdoor air pollution each year and costs Australia over **$6.2 billion** annually[54]

Key elements of a national clean air strategy should include:

- **Clear national leadership** and a shared governance structure spanning health, environment, transport, energy and urban planning, to drive coordinated, accountable policy action and deliver measurable improvements in air quality
- **Strengthened national air quality standards**, including the adoption of the 2021 World Health Organization Air Quality Guidelines as the health-based benchmark[55]
- **Enforceable, time-bound emissions reduction targets** for transport, industry and energy generation
- **Dedicated, long-term funding** and clear accountability mechanisms to support implementation of the strategy including; sustained air pollution reduction, monitoring, enforcement, research and ongoing public health protection
- **A strong health and public health focus** across all policy and regulatory settings, recognising that regulation alone is not sufficient to protect health
- **Support for the transition** to cleaner technologies and fuels through sustained investment and regulatory reform
- **Expanded air quality monitoring** and public access to real-time data, enabling communities and decision-makers to understand and respond to local risks
- **Investment in evidence-based household protection measures**, including subsidised portable HEPA filtration for lower-income households and other priority populations
- **Targeted community led health promotion initiatives** to protect communities at highest risk who are disproportionately affected by air pollution.

Every Australian deserves to breathe clean, healthy air. Clean air is a fundamental determinant of health and a matter of equity. Communities experiencing higher exposure to pollution often face overlapping social and economic disadvantage, which compounds their health risks. A national clean air strategy must therefore prioritise reducing inequities alongside lowering overall population exposure.

Investment in cleaner air delivers immediate and longterm benefits, including reduced hospitalisations, lower healthcare costs, improved workforce participation and better quality of life.[56] Critically, it will also reduce the burden of diseases, including lung cancer.

84%

said it was extremely important for government to implement a clear strategy to reduce air pollution and protect lung health[57]

2

Advance equitable lung cancer outcomes for Aboriginal and Torres Strait Islander peoples

Marissa, 58, Queensland

I am a proud Barada Kabalbara woman from Central Queensland and the Chief Executive Officer of Bidgerdii Community Health Service.

In 2025, after attending hospital for an unrelated health issue, I followed up with my GP about elevated blood pressure and a mild cough. Further investigations led to a diagnosis of stage 1B lung cancer.

I was shocked. Apart from a slight cough and some shortness of breath, I felt well. I honestly thought the results would come back benign.

Fortunately, my cancer was detected early and successfully treated with surgery before it spread. Without those early tests, it may not have been found until much later, when treatment options and outcomes could have been very different.

Throughout my treatment and recovery, culturally safe support played an important role. I particularly value the care provided by Indigenous Hospital Liaison Officers, who supported both me and my family during a challenging time. The support my family received was just as important as the support I received. Having people who understood our needs and helped us navigate the health system made a difficult experience much easier.

While my treatment experience was positive, I know many Aboriginal and Torres Strait Islander people face barriers to care, including distance from specialist services, limited awareness of lung cancer, family responsibilities and challenges navigating unfamiliar healthcare systems.

I believe culturally safe, community-led care is critical to improving outcomes for Aboriginal and Torres Strait Islander peoples. We need services that work alongside community, are welcoming, culturally safe and built on trust, and support the whole person and their family.

As a health leader and lung cancer survivor, I am passionate about raising awareness of early detection and the National Lung Cancer Screening Program, and encouraging eligible people not to wait for symptoms before seeking care.

One of the biggest misconceptions is that you will know if something is wrong. Lung cancer doesn't always cause symptoms in its early stages. Mine was found before I became seriously unwell.

Looking ahead, I hope decision-makers continue to invest in early detection, culturally safe care, community-led approaches and Aboriginal Community Controlled Health Services, which play an important role in helping Aboriginal and Torres Strait Islander people access care and support close to home.

If we can find more cancers early, we can save more lives. Screening, education and culturally safe support can make a real difference for mob.

My message to mob is simple: don't wait until you get sick. Looking after your health isn't just about you – it's about your family, your community and future generations. Early detection can save lives.

2 Advance equitable lung cancer outcomes for Aboriginal and Torres Strait Islander peoples

Aboriginal and Torres Strait Islander peoples experience a disproportionate burden of lung cancer and poorer health outcomes, driven by later diagnosis, barriers to culturally safe care and systemic inequities such as racism, geographic isolation and the broader social determinants of health.

Deliberate, sustained action led by Aboriginal and Torres Strait Islander communities is urgent. Key priorities include embedding culturally safe, community-led care, strengthening early detection and diagnostic pathways, improving timely access to curative and specialist treatment, removing structural barriers, and building a culturally safe workforce.

Why these actions are needed

Despite national commitments to health equity, systemic barriers continue to undermine lung cancer outcomes for Aboriginal and Torres Strait Islander peoples. Achieving equitable outcomes requires evidence-informed reforms that embed cultural safety and strengthen Aboriginal and Torres Strait Islander community leadership and self-determination. We must also improve early detection, ensure access to best-practice care and support continuity of care across the full lung cancer pathway- from screening, diagnosis, treatment, survivorship and end-of-life care.

This reform demands coordinated national action, sustained investment and genuine partnership with Aboriginal Community Controlled Health Organisations (ACCHOs) and communities. Without this, we face a significant risk that Australia will fail to reduce existing inequalities, and may even inadvertently widen them.

The consequences of inaction include:

- Persistent late-stage diagnosis and reduced population impact of the National Lung Cancer Screening Program
- Ongoing experiences of racism and culturally unsafe care within mainstream cancer services, contributing to reduced confidence in, and access to, timely and appropriate care
- Reduced access to timely, curative and life-extending treatments
- Worsening survival disparities for Aboriginal and Torres Strait Islander peoples
- Increased health system costs through avoidable hospitalisations, delayed diagnoses and fragmented care
- Failure to achieve national commitments under the *Australian Cancer Plan*, the *Aboriginal and Torres Strait Islander Cancer Plan*, and priority reforms under the *National Agreement on Closing the Gap*.[6,7,58]

Evidence of inequity and missed opportunity

Lung cancer is the most frequently diagnosed cancer among Aboriginal and Torres Strait Islander peoples and the leading cause of cancer death, responsible for one quarter (26%) of all First Nations cancer deaths.[23] National datasets demonstrate persistent and profound inequities across prevention, early detection, diagnosis, treatment and outcomes:

- **Higher incidence, at younger ages:** Age-standardised lung cancer incidence among Aboriginal and Torres Strait Islander peoples is more than twice the non-Indigenous rate, and consistently emerges around a decade earlier – *First Nations incidence in the 40s is more than four times higher (36.4 compared to 8.0 per 100,000),* and rates from the 50s onward match those of non-Indigenous people ten years older[23]
- **Higher mortality:** Age-standardised lung cancer mortality is more than twice the non-Indigenous rate[23]
- **Lower survival:** Five-year relative survival rate for lung cancer among Aboriginal and Torres Strait Islander peoples is around a quarter lower than for non-Indigenous people – 20.9% compared to an age-adjusted 30.1%[23]
- **Smoking prevalence:** Daily smoking rates among Aboriginal and Torres Strait Islander peoples aged 15 and over fell from 37% in 2018–2019 to approximately 29% in 2022–2023.[19] While this downward trend is positive, smoking rates remain important context for lung cancer risk and outcomes.

There are also persistent gaps in contemporary lung cancer outcomes data for Aboriginal and Torres Strait Islander people. This gap in data reflects systemic underinvestment in Indigenous data sovereignty, governance, monitoring, evaluation and accountability mechanisms required to measure progress and deliver on the aspirations of the *Australian Cancer Plan* and under the Closing the Gap commitments.

These inequities are not inevitable. They are driven by structural and systemic factors, including intergenerational trauma, racism and culturally unsafe care within mainstream health services.[59] Experiences of discrimination and exclusion contribute to reduced access to screening and diagnostic services, delayed help-seeking, lower participation in treatment, and disrupted care.[60,61]

Aboriginal and Torres Strait Islander peoples also face significant barriers to accessing healthcare. Barriers include high costs, travel, separation from family and Country, fragmented care pathways and the burden of navigating complex health systems often without culturally safe and appropriate supports.

The introduction of the National Lung Cancer Screening Program represents a critical opportunity to shift this trajectory. Evidence demonstrates that equitable outcomes are more likely to be achieved through community-led and culturally safe models of care. ACCHOs must be embedded as core partners across the screening and care pathway. Achieving equity also requires removing structural barriers and making sustained investment in the Aboriginal and Torres Strait Islander health workforce across the full lung cancer continuum. This encompasses prevention and early detection through to treatment, survivorship and end-of-life care.

Definition: Cultural safety

"Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities. Culturally safe practice is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism."[62]

Policy recommendations

2.1 Embed culturally safe, community-led lung cancer care

We recommend embedding Aboriginal Community Controlled Health Organisations (ACCHOs) and Aboriginal and Torres Strait Islander leadership as core partners across the lung cancer continuum.

Cultural safety and trust are fundamental to timely engagement with lung cancer services.[63–66] Experiences of racism and culturally unsafe care continue to contribute to delayed diagnosis, less completion of treatment pathways, and poorer outcomes for Aboriginal and Torres Strait Islander peoples.[61,67]

ACCHOs provide community-led comprehensive primary health care, with trusted, holistic and accessible models of care well positioned to support engagement across the lung cancer continuum.[7] Evidence that community-led, culturally grounded care improves early detection, continuity of care, treatment adherence and patient experience, increasing participation across the lung cancer pathway.[60,68–71]

Actions:

- Mandate the collection of Indigenous status on all digital and paper-based forms, with an option for individuals to decline to answer[72]
- Embed ACCHOs as funded, formal partners in lung cancer programs, pathways, and reforms
- Expand Aboriginal and Torres Strait Islander specific roles across hospitals, including Aboriginal Health Workers and Practitioners, Aboriginal Liaison Officers, care navigators and advocates
- Mandate and resource ongoing cultural safety capability building across all lung cancer services and for all staff
- Support cancer treatment on Country, where appropriate, while enabling family presence, cultural practices, shared decision-making and trauma-aware care
- Address the compounded stigma experienced by Aboriginal and Torres Strait Islander peoples with lung cancer – including stigma related to smoking, cancer and prior experiences of racism and discrimination within the health system – through community-led awareness and education strategies.

2.2 Strengthen early detection and diagnostic pathways

We recommend strengthening equitable early detection and diagnostic pathways for Aboriginal and Torres Strait Islander peoples through culturally safe, accessible and community-informed approaches embedded within the National Lung Cancer Screening Program and the broader diagnostic ecosystem.

Late diagnosis is a major contributor to poor lung cancer outcomes for Aboriginal and Torres Strait Islander peoples.[73–75] While early detection has the potential to significantly reduce mortality, it is only effective when pathways are trusted, accessible and supported by culturally safe navigation and care.[63,70,76]

Evidence shows that fast-track diagnostic pathways, community-led outreach and navigator models improve time to diagnosis, while mobile and regional imaging services increase participation among rural and remote communities.[7,63,76,77]

Actions:

- Embed culturally safe smoking cessation supports across the lung cancer screening, assessment, diagnostic and treatment pathways
- Ensure lung cancer screening design and implementation delivers equitable access for Aboriginal and Torres Strait Islander peoples. This includes appropriate prioritisation and an agile, evidence-based approach to screening eligibility and delivery as evidence evolves[78]
- Co-design lung cancer awareness and early symptom campaigns with Aboriginal and Torres Strait Islander communities
- Embed culturally safe navigation from initial imaging or clinical suspicion (whether identified through screening or symptomatic presentation) through to diagnosis and treatment
- Expand mobile imaging, outreach clinics and telehealth-enabled assessment pathways for rural and remote communities
- Integrate culturally safe referral pathways within the National Lung Cancer Screening Program.

2.3 Improve access to curative and specialist lung cancer treatments

We recommend improving equitable access to timely, curative and specialist lung cancer treatment for Aboriginal and Torres Strait Islander peoples through strengthened referral systems, culturally safe care coordination and enhanced regional service capacity.

Aboriginal and Torres Strait Islander peoples experience lower access to surgery and specialist cancer treatments, contributing to poorer survival outcomes.[79–81] These inequities are driven by diagnostic, logistical, cultural and systemic barriers that disrupt continuity of care across the treatment pathway.[60,71,73,82]

Evidence shows that strengthened referral pathways, culturally adapted oncology environments and consistent care coordination increase treatment uptake, while navigation and family support reduce treatment delays and abandonment.[82–84]

Actions:

- Introduce equity-focused referral standards and fast-track pathways for Aboriginal and Torres Strait Islander peoples with defined maximum timeframes from suspicion to diagnosis and treatment across respiratory, surgical and oncology services. Specific actions include, to:
  - embed priority triage, direct-to-imaging pathways, and reserved appointment slots within referral and diagnostic systems
  - guarantee automatic referral to Aboriginal and Torres Strait Islander cancer navigators and inclusion in multidisciplinary care
  - monitor and report on timeliness and outcomes by Indigenous status with clear accountability for reducing delays.
- Ensure equitable access to lung cancer treatments including surgery, radiation, chemotherapy, targeted therapies and immunotherapy. Provide culturally safe treatment coordination and consistent access to Aboriginal and Torres Strait Islander cancer navigators and workforce
- Ensure Aboriginal and Torres Strait Islander health workers and practitioners are present at multidisciplinary meetings
- Ensure treatment scheduling respects cultural obligations, mobility constraints and community responsibilities
- Strengthen regional cancer service capacity and culturally adapted tele-oncology pathways
- Ensure Aboriginal and Torres Strait Islander peoples are informed of and have equitable access to clinical trials.

2.4 Remove structural barriers to care

We recommend removing structural, financial and systemic barriers that prevent timely and continuous access to lung cancer care for Aboriginal and Torres Strait Islander peoples.

Travel distance, cost burdens, separation from family and Country and complex navigation across health systems continue to prevent timely access to lung cancer care.[84,85] In addition, Aboriginal and Torres Strait Islander peoples often experience care fragmentation across multiple providers and settings, leading to delays, repeated storytelling and gaps in continuity of care.[84,85]

Evidence shows that practical supports such as transport, accommodation and patient escort services improve treatment completion while Aboriginal and Torres Strait Islander cancer navigation models can reduce delays in care and psychological distress.[60,83–86] Patient Assisted Travel Schemes (PATS) provide some support for accommodation and travel services, including specific provisions for Aboriginal and Torres Strait Islander peoples. However, these schemes are often inadequate in both financial coverage and cultural responsiveness. Subsidy rates frequently fall short of actual costs and access barriers remain significant, particularly in remote areas.[84,87–90]

Actions:

- Reform patient travel and accommodation assistance schemes to ensure cultural appropriateness and family-inclusive support
- Fund Aboriginal and Torres Strait Islander cancer navigators across the lung cancer pathway, from pre-diagnosis through to treatment, survivorship and end-of-life care
- Establish streamlined referral, case coordination and shared-care models between primary care, ACCHOs and tertiary services
- Develop and strengthen initiatives that support cancer treatment on Country, where appropriate.

2.5 Build and sustain a culturally safe workforce

We recommend building and sustaining a culturally safe and representative lung cancer workforce to improve equity, trust and quality of care for Aboriginal and Torres Strait Islander peoples.

Workforce representation is essential to delivering culturally safe care, strengthening trust and improving communication across the lung cancer pathway. Current workforce shortages and limited cultural capability within the mainstream system contribute to fragmented and culturally unsafe care experiences.

Evidence shows that First Nations workforce leadership improves community engagement, quality of care and system responsiveness, while co-designed workforce strategies also strengthen service capability, continuity of care and cultural safety across settings.[6,7,64]

Actions:

- Invest in and expand Aboriginal and Torres Strait Islander lung cancer workforce pipelines through dedicated funding for scholarships, traineeships, mentorship and leadership pathways – including physicians, navigators, nurses, allied health, palliative care and liaison roles
- Mandate and resource ongoing cultural safety capability across the non-Indigenous health workforce, with clear accountability through professional standards under the National Law and uptake of high-quality, evidence-based training
- Establish a cohort-based training and employment model for Aboriginal and Torres Strait Islander Specialist Lung cancer Nurses at Lung Foundation Australia. This will enable Aboriginal and Torres Strait Islander peoples to access lung cancer information, support and care from culturally connected nurses who share their community and lived experience.

Aboriginal and Torres Strait Islander readers are advised that this content contains images of people who have passed away.

3

End Australia's tobacco epidemic to improve lung health

Sara, 40,
New South Wales

I started smoking when I was young because almost everyone around me smoked. It was normal and, at the time, even seemed cool. Looking back, I can see how much the environment influenced that decision. Cigarettes were everywhere and widely accepted.

I smoked on and off for about 18 years. I knew smoking wasn't good for my health, but I never imagined it would lead to lung cancer at just 34. I thought lung cancer happened to older people. I thought I had more time to quit.

Over the years, I tried to stop smoking many times, but like many people living with nicotine addiction, staying smoke-free was incredibly difficult. It wasn't until I was diagnosed with lung cancer that I quit for good. I have 2 children and a partner; suddenly I had so much to fight for. Even then, it was one of the hardest things I've ever done.

The support I received from Lung Foundation Australia's telehealth nurse played an important role in helping me stay smoke-free. Having someone who understood addiction without judgement made a real difference.

One of the most painful parts of my experience wasn't just the cancer itself, it was the stigma. Almost every time I tell someone I've had lung cancer, the first question I'm asked isn't, "How are you?" It's, "Did you smoke?" That question can make you feel as though your diagnosis needs an explanation before you deserve compassion.

Alongside dealing with my diagnosis, major surgery, fear for my life, concern for my family, and the financial impact of cancer, I often felt judged when I needed support most. That judgement made me feel like my illness was somehow my fault and that I was less deserving of care. Stigma doesn't help people quit smoking. It simply adds another burden to an already devastating diagnosis.

Smoking is an addiction, not a moral failing. If we truly want to reduce smoking rates, we need to understand that nicotine addiction is complex. People need evidence-based support, compassion and encouragement, not shame.

To the decision-makers, my message is this: behind every lung cancer diagnosis is a person, a family, and a future turned upside down. Invest in prevention, stronger tobacco control, compassionate quit support, earlier diagnosis, research, and equitable access to treatment. Just as importantly, help end the stigma surrounding lung cancer. Lung cancer does not discriminate. Whether someone has smoked or not, **no one deserves cancer, and everyone deserves dignity, compassion, support, and the best possible chance to live.**

Sharing this story hasn't been easy. I hesitated because of the stigma surrounding lung cancer and the fear of being judged. But if my story helps reduce stigma, encourages someone to seek support to quit smoking, or leads to even one person being diagnosed earlier, then it is worth sharing.

3 End Australia's tobacco epidemic to improve lung health

Exposure to tobacco smoke remains the leading cause of lung cancer and premature death in Australia, with current measures insufficient to reduce harm quickly and equitably.

Implementing a comprehensive tobacco endgame package to phase out sales, reduce product addictiveness and availability, expand quit support, and protect policy from industry interference, will accelerate reductions in smoking and lung cancer and position Australia as a global leader.

Lung cancer has multiple risk factors, but exposure to tobacco smoke remains the largest and most preventable. Tobacco use is the leading cause of premature death in Australia[27] and contributes substantially to respiratory disease, multiple cancers, cardiovascular disease, infectious disease and endocrine disorders.[27,91] Tobacco control is therefore one of the most powerful levers available to prevent lung cancer and improve health outcomes.

Our current approach will leave too many Australians behind

Australia has long been a global leader in tobacco control. Graphic health warnings, plain packaging and mass media campaigns have significantly reduced smoking rates and improved population health.[92]

However, progress is uneven. Under current policies, daily smoking is projected to decline to around 7.8% by 2030 across the general population. Yet it is expected to remain much higher in the most disadvantaged and remote communities, reaching up to 34.6%.[93] This trajectory risks widening health inequities in Australia.

An equity-focused policy shift is needed. This strategy must target the drivers of tobacco use at a system-level – particularly industry practices and the retail environment – rather than relying primarily on individual behaviour change.

From tobacco control to tobacco endgame

Traditional tobacco control has focused largely on reducing demand, through preventing uptake and helping people quit. While these efforts remain essential, they are insufficient to end the epidemic. Australia needs to tackle the tobacco industry and reshape the environment that allows highly addictive tobacco products to remain widely available. Smoking is not simply an individual choice but a consequence of powerful commercial practices and socioeconomic conditions.

Tobacco endgame policies aim to change the conditions that allow tobacco to remain widely available and highly addictive. In 2025, the World Health Organization (WHO) identified 16 endgame policies spanning 4 areas: supply reduction, market and institutional reform, product regulation, and consumer protection. Many of these measures align with Australia's *National Tobacco Strategy*[9] and are feasible for implementation in Australia.

Australia is well placed to lead a tobacco endgame approach. This readiness is driven by our strong and mature tobacco control policies and our alignment with existing national health strategies. We also benefit from decades of progress in reducing smoking prevalence, and strong public support for decisive action to end tobacco-related harm.

Policy recommendations

Delivering a practical endgame package for Australia

An effective endgame package for Australia should include multiple, complementary components rather than rely on any single policy measure. As evidence continues to evolve and international examples emerge, the Australian Government should remain agile and open to adding further policies that strengthen and complement the package over time. Success will also depend on co-designing programs with the communities most affected, including Aboriginal and Torres Strait Islander peoples and other priority populations, and ensuring implementation is supported by strong enforcement and protection from industry interference.

Public support for stronger tobacco control in Australia is strong and growing[95]

81% support banning the advertising of tobacco products on social media

68% support a national tobacco retailer licensing scheme

65% support making tobacco harder to purchase in retail settings

65% support raising the legal age for the sale of supply of tobacco products

3.1 Introduce a tobacco and vape-free generation policy

We recommend phasing out the legal sale of tobacco and e-cigarettes for younger generations by establishing a tobacco and vape-free generation policy that prevents sales to those born after a specified year.

A tobacco and vape-free generation policy would progressively phase out legal access to recreational tobacco, e-cigarette, and emerging nicotine products for younger cohorts by preventing sales to people born after a specified year.[96]

This approach is supported in the *National Tobacco Strategy* (Priority Area 8) and is gaining international traction,[97] including implementation in the Maldives (2025), the UK (2026), and several US jurisdictions. The UK introduced the *tobacco and vapes act* in 2026, committing to a tobacco-free generation policy aimed at preventing future generations from smoking. This new policy is estimated to avoid 11,165 disease cases – including 400 from lung cancer – and provide cumulative savings to the NHS of £2.8 billion as well as £27.3 billion in economic productivity gains by 2056.[98]

Because the health benefits of this policy accrue over time, it should be paired with measures that deliver immediate reductions in product addictiveness and availability – especially in communities experiencing the greatest harm.[99]

3.2 Explore the potential of denicotinisation of tobacco products

We recommend exploring the introduction of product standards that would reduce nicotine in tobacco to non-addictive levels to lower dependence and prevent uptake.

Nicotine is the primary driver of tobacco addiction. Reducing nicotine to non-addictive levels would substantially reduce dependence, support quitting and prevent uptake.

Evidence for this approach is strong,[100] with particularly large benefits projected for priority populations.[101]

Given its potential, governments should continue to monitor international developments, strengthen the evidence base, and assess the regulatory, implementation and enforcement requirements associated with denicotinisation. This includes considering product standards, surveillance systems and compliance mechanisms for manufacturers.[102] Further exploration of this policy option aligns with the *National Tobacco Strategy* (Priority Area 7).

3.3 Reduce tobacco retail availability

We recommend introducing a national retailer licensing scheme and measures to drastically reduce the over-supply of tobacco products.

Tobacco is vastly over-available relative to actual demand. It is currently sold through more than 40,000 outlets to serve around 10% of the population. By comparison, there are only around 9,500 supermarkets nationwide to serve the majority of the population.[103] A nationally consistent tobacco licensing framework that establishes clear and standardised approaches across jurisdictions is needed. This framework should be multi-layered and could include measures such as caps on retailer numbers and zoning restrictions, such as prohibiting tobacco sales near schools and disadvantaged communities, and stronger governance and compliance measures for license holders, to significantly reduce access. Reducing retail availability is also supported in the *National Tobacco Strategy* (Priority Area 8).

3.4 Strengthen access to effective and culturally safe quit supports

We recommend removing PBS restrictions on smoking cessation treatments and providing free medications alongside behavioural support to make quitting easier.

Endgame policies should make quitting easier, not harder. People deserve practical, stigma-free support to quit, including counselling, culturally safe services and evidence-based pharmacotherapy. While some medicines for nicotine dependence are subsidised through the Pharmaceutical Benefits Scheme (PBS), coverage does not yet fully align with best-practice guidance.[104]

All recommended first-line pharmacotherapies, including combination therapies, should be subsidised through the PBS to ensure equitable access to cessation supports.[104] Where cost is a barrier, people may delay treatment, ration their doses or go without medicines altogether, reducing their chances of quitting successfully.

Current time-limit restrictions - which limit access to 2, 12-week blocks of Nicotine Replacement Therapy (NRT) and up to 6 months of prescription tablets per year[105] – should be lifted. These limits fail to reflect that nicotine dependence is a chronic, relapsing condition that often requires multiple quit attempts.

Quit support should be scaled alongside policy reforms to ensure people are supported rather than burdened by systemic change. Providing free pharmacotherapy, building on successful models in Queensland, Victoria and South Australia where NRT is provided for eligible populations, would strengthen cessation outcomes. Combining behavioural support with pharmacotherapy offers the highest likelihood of successful cessation and should be embedded as standard practice. Aligning this with the National Lung Cancer Screening Program would be a proven, scalable and practical starting point.[106]

3.5 Protect policy from tobacco and vaping industry interference

We recommend implementing strict safeguards across all levels of government to shield public health policies from tobacco and vaping industry lobbying.

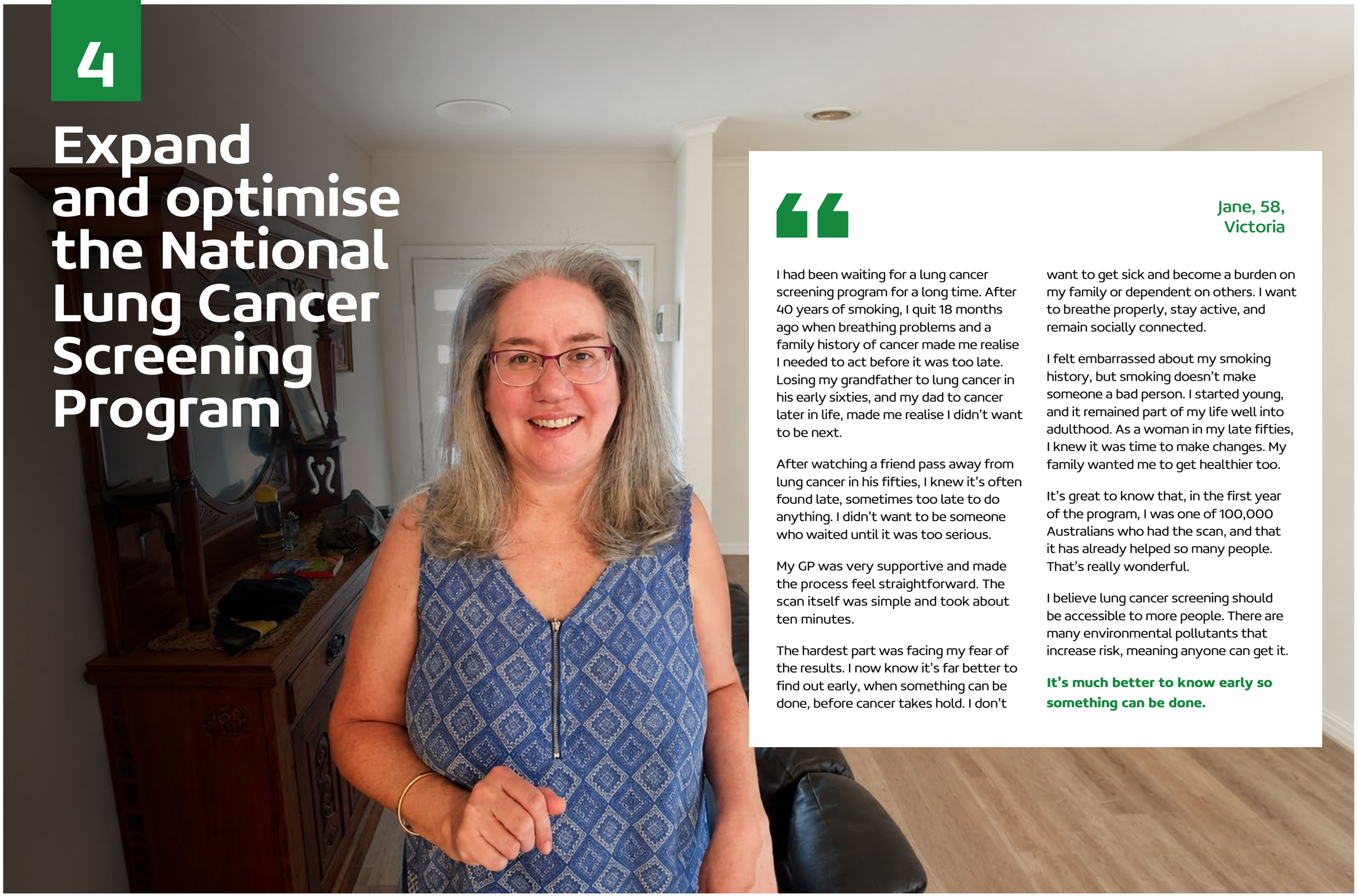
The tobacco industry consistently seeks to delay, weaken and undermine reform through lobbying, misinformation, front groups, litigation and strategic partnerships.[26, 27] These tactics have been observed in New Zealand and other international jurisdictions.[107] Australia is legally obligated under Article 5.3 of the *WHO Framework Convention on Tobacco Control* to protect public policy from industry interference.[94,108,109]

Stronger safeguards are needed across government, including:

- Banning political donations from the tobacco and vaping industries
- Strengthening transparency and lobbying registers
- Implementing stricter conflict-of-interest rules, including post-employment restrictions to prevent “revolving door” hiring practices between government agencies and the tobacco industry.[110–112]

4

Expand and optimise the National Lung Cancer Screening Program



Jane, 58, Victoria

I had been waiting for a lung cancer screening program for a long time. After 40 years of smoking, I quit 18 months ago when breathing problems and a family history of cancer made me realise I needed to act before it was too late. Losing my grandfather to lung cancer in his early sixties, and my dad to cancer later in life, made me realise I didn't want to be next.

After watching a friend pass away from lung cancer in his fifties, I knew it's often found late, sometimes too late to do anything. I didn't want to be someone who waited until it was too serious.

My GP was very supportive and made the process feel straightforward. The scan itself was simple and took about ten minutes.

The hardest part was facing my fear of the results. I now know it's far better to find out early, when something can be done, before cancer takes hold. I don't want to get sick and become a burden on my family or dependent on others. I want to breathe properly, stay active, and remain socially connected.

I felt embarrassed about my smoking history, but smoking doesn't make someone a bad person. I started young, and it remained part of my life well into adulthood. As a woman in my late fifties, I knew it was time to make changes. My family wanted me to get healthier too.

It's great to know that, in the first year of the program, I was one of 100,000 Australians who had the scan, and that it has already helped so many people. That's really wonderful.

I believe lung cancer screening should be accessible to more people. There are many environmental pollutants that increase risk, meaning anyone can get it.

It's much better to know early so something can be done.

4 Expand and optimise the National Lung Cancer Screening Program

The National Lung Cancer Screening Program (the Program) is transformative for lung cancer in Australia. Early results are promising, and show that lives are already being saved. However, realising the Program's full potential will require ongoing investment and refinement, including addressing participation barriers, increasing awareness and uptake, awareness, expanding eligibility, embedding smoking cessation and nurse-led navigation, progressing towards multi-disease screening, and funding translational research.

A significant step forward

Australia's National Lung Cancer Screening Program commenced in July 2025, marking a significant milestone in improving lung cancer outcomes for all Australians.

The Program is funded by a $263.8M commitment from the Australian Government.[113] It includes mandatory bulk billing of the screening test, a low-dose computed tomography (CT) scan. Two specific Medicare Benefits Schedule (MBS) item numbers cover these scan costs: the 2-yearly scan (57410), and the interval low-dose CT scans (57413).[114]

As Australia's first targeted cancer screening program – and the 13th of its kind globally – the Program leverages modern digital health infrastructure and data systems. The screening test is clinically proven to detect disease at an early stage, when curative treatments can be offered, and reduce lung cancer deaths.[115,116]

The Program targets individuals at high risk of developing lung cancer. To be eligible, people must be aged between 50 and 70 years, and:

- show no signs or symptoms suggestive of lung cancer (asymptomatic)
- currently smoke or have quit smoking in the past 10 years
- have a history of tobacco cigarette smoking of at least 30 pack-years.[117]

Requesting practitioners – defined as general practitioners (GPs), nurse practitioners and medical specialists – have responsibilities across the lung cancer screening and assessment pathway, including assessing and confirming Program eligibility, enrolling participants in the National Cancer Screening Register (NCSR)[118] and communicating results and reminders for follow-up scans.

Six priority populations are identified in the Program Guidelines due to their higher burden of lung cancer, driven by smoking prevalence and systemic barriers to accessing healthcare:[119–121]

- Aboriginal and Torres Strait Islander peoples
- People living in rural and remote areas
- People from multicultural communities
- People living with disability
- People experiencing mental health challenges
- People from LGBTIQA+ communities (Lesbian, Gay, Bisexual, Transgender, Intersex, Queer, Asexual, plus other identities).[114]

As the Program becomes established in the Australian healthcare system, we must ensure these priority populations are considered in all efforts to improve the Program. This Blueprint reinforces the Program's focus on equity through engagement with priority populations and coordinated initiatives.

Policy recommendations

4.1 Address barriers to screening participation

We recommend adopting strategies to maximise the impact of the National Lung Cancer Screening Program by reducing barriers and enabling more people to access screening.

We need to systematically identify and address barriers to screening participation. Some are well known, with the most common being lack of awareness of lung cancer screening.[122] System-level barriers include Program and opportunity costs, complex health infrastructure and limited access to CT scanners. There is also a need for education and training for primary care providers and other disciplines.[123]

Participant-level barriers include stigma associated with lung cancer and tobacco cigarette smoking. Fear of a cancer diagnosis and mistrust of healthcare providers and services also deter participation.[124] Practical barriers are also significant, including out-of-pocket costs (such as primary care appointments), travel to primary care or radiology services, and difficulty taking time off work.[124]

For priority populations, there is a growing evidence base around specific solutions for Aboriginal and Torres Strait Islander (see Reform Area 2: Advance equitable lung cancer outcomes for Aboriginal and Torres Strait Islander peoples) and culturally and linguistically diverse communities.[125] However, barriers facing other priority populations in Australia remain poorly documented and must be formally addressed. These data will inform the development of evidence-based solutions and recommendations, detailed below.

4.2 Invest in targeted promotion and awareness to drive screening participation

We recommend investing in long-term, community-led communication campaigns to increase public awareness of the screening program and encourage people to return for repeat checkups.

Many Australians do not yet know about the Program. Participation depends on whether people are aware of the service and understand their eligibility. They must also see the benefits of screening, perceive its relevance and trust the pathway into lung cancer care.[126]

The challenge of creating awareness and optimising engagement is amplified for lung cancer screening. The Program's priority populations may not routinely engage with health services – including people affected by smoking-related stigma, lower health literacy, competing life priorities and historical mistrust of healthcare systems. Without deliberate, sustained and culturally safe communication, these groups are the least likely to hear about the Program, yet are most likely to benefit from it.

Program promotion and awareness-raising are integral to maximising participation[114] and must be treated as a core implementation function, not an adjunct activity. They must be embedded as a system-level responsibility. Genuine co-design with communities is an essential first step, and evidence-informed co-design approaches should guide all engagement to ensure relevance, build trust and increase participation.[127–129]

Participation requires people to return for repeat screening at recommended intervals,[130,131] rather than attending a single screening event. This includes individuals with very low-risk nodules, who may be less likely to return for repeat screening.[130] Maintaining engagement is essential to reducing mortality, improving Program efficiency and ensuring long-term sustainability. Priority actions include sustained, multi-channel messaging and engagement across all communities, with tailored messaging for Program participants.[126]

Consistent with the *National Lung Cancer Screening Program Quality Framework*, equitable and accessible participation across all population screening groups is a core Program standard. Participation and re-screening rates will serve as key performance indicators.

Actions:

- Deliver multi-channel, targeted communication strategies to improve awareness and understanding among individuals, families, and communities - including what the Program means for them and their loved ones
- Expand low-cost, high-reach community-based strategies, including Lung Foundation Australia's Lung Cancer Screening Helpline, funded by the Department of Health and Ageing, and community outreach and public events
- Strengthen workforce capability across the lung cancer screening and assessment pathway through targeted education and training activities. This includes webinars, the Lung Learning Hub and additional supports to enable continuous professional development and quality improvement for all healthcare providers and health support workers.

4.3 Review and expand eligibility criteria

We recommend updating the Program's strict eligibility criteria — expanding age limits, lowering smoking history requirements and adding family history — to include more high-risk individuals.

Australia's eligibility criteria for the National Lung Cancer Screening Program remain among the most restrictive internationally, alongside England and the Republic of Korea.[132] With the 2-year review fast approaching, and to keep the Program agile, we must continue to review eligibility criteria, including:

- **Age criteria**: Review the age eligibility range as part of the Program's 2-year review. In the past 5 years, lung cancer screening programs in the United States have expanded age ranges from 50-75 to 50-80 years, and in Ontario, Canada from 55-74 to 55–80 years.[133,134] This international experience should inform consideration of the upper age limit in Australia. The review should also apply an equity lens to examine whether to adopt a lower entry age for Aboriginal and Torres Strait Islander peoples to address lung cancer inequity, noting that further work is needed to review evidence
- **Equity-based access**: Deliver equitable access for Aboriginal and Torres Strait Islander peoples. This must include evidence-based prioritisation developed through community-led consultation and engagement[78]
- **Smoking history**: Reduce the requirement from 30 to 20 pack-years. This should be supported by digital resources for more accurate and efficient pack-year calculation for participants and healthcare providers[133]
- **Family history**: Introduce family history as an independent eligibility criterion, separate from smoking history. This is particularly important for people with Asian ancestry or a family history of lung cancer among first-degree relatives, as these factors are associated with significantly increased lung cancer risk and higher rates of invasive lung cancer with increasing age[135]
- **Occupational exposure**: Investigate the feasibility of including workers from high-risk industries, given that exposure to known lung carcinogens – such as asbestos and silica – significantly elevates their risk of lung cancer[136–139]
- **Risk-based eligibility**: Evaluate whether eligibility should remain defined by simple categorical criteria, or whether personalised risk assessment tools should be integrated into the Program to improve targeting and equity.

We must critically review emerging international evidence on eligibility criteria to assess its relevance and transferability to the Australian context. Any expansion of eligibility criteria should be carefully balanced against complementary strategies to optimise participation. We must also balance cost-effectiveness and the potential for increased harms among individuals who would not go on to develop lung cancer.

We must continue to advocate for policy changes that improve Program access and equity, including by expanding eligibility to people at high risk who are currently excluded by existing criteria.

4.4 Embed smoking cessation as a core Program component

We recommend integrating a smoking cessation model into the Program to offer free support medications and counselling to every participant upon enrolment.

Consistent with our recommendation to strengthen equitable early detection and diagnostic pathways for Aboriginal and Torres Strait Islander peoples (Recommendation 2.2), smoking cessation should be embedded as an essential component of Program delivery. An agile Program should prioritise a 'hybrid' delivery model, in which dedicated smoking cessation supports are provided within the Program while linking with improved and integrated external cessation resources.[140] Given that more than 97% of Program participants will not have lung cancer[115,116], smoking cessation represents the greatest potential health benefit for most participants, beyond the reassurance of a negative screening result.

Actions:

- Embed dedicated smoking cessation resources within the Program using an opt-out model. Free cessation support should be offered to every participant upon enrolment, with the option to decline
- Fund universal access to free nicotine replacement therapy (NRT) for all Program participants, regardless of jurisdiction. This recognises that cost remains a significant barrier to cessation for people eligible for lung cancer screening, and builds on Queensland's established model and South Australia's government-funded NRT pilot
- Embed smoking cessation supports and counsellors within existing Program infrastructure including Lung Foundation Australia's Lung Cancer Screening Helpline and Heart of Australia's mobile screening trucks, complementing multidisciplinary teams delivering services in remote communities
- Strengthen standardised cessation information and culturally responsive referral pathways within Program materials, tailored to the needs of priority populations
- Upskill healthcare providers across primary, secondary and tertiary care, including Quitline counsellors, to ensure consistent uptake of best-practice guidance on combination NRT and behavioural counselling.

4.5 Progress toward an integrated, multi-disease screening approach

We recommend that the Program move beyond a siloed, single-disease screening model toward a more integrated, multi-disease approach to person-centred secondary prevention.

Evidence indicates that about 50–60% of lung cancer screening participants will have other health conditions identified through low-dose CT screening. These are known as actionable additional findings. A 5-year evaluation of the National Health Service England Lung Cancer Screening Programme highlighted a high prevalence of cardiovascular disease and respiratory conditions such as chronic obstructive pulmonary disease (COPD) and early emphysema.[141] The Program collects data about these findings, which can be leveraged to inform service planning and models of care. For Aboriginal and Torres Strait Islander peoples, multi-disease screening is already in place through the MBS item 715 health check, which supports early detection of diabetes, cardiovascular disease, and other conditions including cancer.[142,143] Harmonising these screening efforts is now needed.

International studies demonstrate that an integrated approach to lung cancer screening provides broader system benefits. These include improved health system efficiency, reduced duplication of CT imaging and an enhanced participant experience through more coordinated follow-up for additional diagnostic investigations.[144–146] These efficiency and cost-effectiveness gains are likely to be applicable to the Australian context.

Actions:

- Commit dedicated policy and funding to support exploration, piloting and evaluation of multi-disease screening approaches in the Australian context
- Review COPD clinical guidelines and care pathways to support the future development and integration of multi-disease screening initiatives
- Develop clear guidance for primary care and medical specialists on pathways for actionable additional findings from the Program, including tuberculosis for Aboriginal and Torres Strait Islander communities, as per the National Lung Cancer Screening Program Additional Findings Guidelines.[147]

4.6 Embed a nurse-led navigation model of care within the Program

We recommend introducing dedicated nurse navigators across the screening system to guide patients through follow-up tests, connect them with primary care and coordinate their medical support.

Patient navigation is an evidence-based, equity-enhancing intervention that improves access, coordination and continuity of care across the screening pathway.[148] Nurse-led navigation models can deliver psychosocial and chronic disease support, improving clinical follow-up, enhancing self-management and reducing anxiety associated with lung cancer and other conditions.[149]

A nurse-led navigation model of care should be embedded across key Program delivery points, including the Lung Foundation Australia's Lung Cancer Screening Helpline and Heart of Australia's mobile screening services and be supported by formalised referral pathways. Nurse navigators will triage participants requiring follow-up investigations and connect them with primary care, specialist services, allied health, community services, smoking cessation supports and psychosocial support.

International evidence shows that navigation models can also help link participants to other cancer screening programs, including breast, cervical and bowel cancer screening, supporting a more coordinated and efficient screening system.[149] With additional targeted cancer screening programs on the horizon – including melanoma, prostate and liver cancers – the demand for skilled navigation and coordination roles is likely to increase, representing a critical future capability for the Australian health system.[150]

4.7 Fund translational research to support Program evaluation and continuous improvement

We recommend increasing funding for consumer-led and practical research while making health data more accessible to help improve screening equity and patient outcomes.

Consistent with the vision of *Lung Foundation Australia's research strategy*[5], research that informs policy, practice and care is central to strengthening lung cancer screening and early detection. Research focused on rapid translation into policy and practice will be critical to maximising Program impact. We advocate for greater investment in research aligned with the Program, including translational research that supports the integration of innovation into routine policy and practice.

Current mechanisms to enable research include access to linked data. However, linked data can often be prohibitively expensive, difficult to access in a timely way, and subject to complex ethical and data governance requirements that present significant barriers to timely research.[151–153] These barriers must be overcome to enable robust monitoring, evaluation and assessment of the Program's impact on identifying lung cancer in people at high risk.

Investing in consumer-led research that centres real-world and lived experience perspectives is essential. Together with investments in data infrastructure and system capability, this research will support continuous Program improvement and equity-focused implementation.

Actions:

- Fund research into consumer-led initiatives, digital innovations and workforce development activities that strengthen the Program and drive continuous improvement
- Create clear pathways for researchers to access monitoring and evaluation data from the National Cancer Screening Register (NCSR) and the Australian Institute of Health and Welfare (AIHW), alongside dedicated research funding to support translation of Program data into continuous improvement activities
- Facilitate partnerships between governments, peak bodies, researchers and non-government organisations to accelerate innovative lung cancer screening research. The research partnerships should include consumers and community members as participants, partners and advisors.

Early detection beyond the program

While the National Lung Cancer Screening Program targets people at highest risk, lung cancer will occur outside the eligible population. Screening alone is not enough.

All Australians should be aware of the symptoms of lung cancer and seek medical advice when symptoms arise or change. Earlier presentation increases the likelihood of diagnosis at a stage when curative treatment is possible.

Health professionals should be familiar with Cancer Australia's ***Investigating symptoms of lung cancer*** guide[154] and refer to the ***Optimal care pathway for people with lung cancer***[155] or the ***Optimal care pathway for aboriginal and torres strait islander people with cancer***[76] when investigating and managing of symptomatic patients outside the screening pathway.

5

Strengthen support for people living with lung cancer and their carers

Carly, 46,
New South Wales

I can't even imagine navigating lung cancer without my lung cancer nurse coordinator, Jen.

When I was first diagnosed in 2021, there was a nurse somewhere in the system, but I had yet to meet them. It wasn't until I sought a second opinion in Sydney, a 2-hour drive away, that I met Jen.

Jen is the glue; she holds everything together - I mean everything! She schedules appointments and sends referrals not just to my oncologist, but also to surgeons, radiologists, and even books my scans. Her connections are wide and strong, and she is a true advocate and friend for patients.

Recently, I received an email late at night asking me to move my appointment because my oncologist needed to consult further about the new progression I have and the trial I am on. I panicked, thinking the absolute worst, and replied, "Should I be worried?" Jen responded straight away to reassure me, said she would double-check, and that she would ask the doctor to call me on Monday. She goes above and beyond every time I have a question, even responding when on leave.

But here is the reality: I have never actually had an appointment with Jen. I have only ever met her briefly in passing, as she works out of a small office next to my specialist. Yet, she coordinates almost every aspect of my care behind the scenes.

Before lung cancer, I believed I understood the health system. I went to the GP, had 4 uncomplicated births in the public system, and my youngest had surgery as a toddler. I thought we had the best healthcare in the world.

That changed when I was diagnosed with lung cancer.

I now have to travel 2 hours to access the best care. I waited weeks for a PET scan and biopsy. My first experience in the public system left me feeling unsupported, and I have since moved into the private system at a huge cost to me and my family. As a single Mum, I have had to keep working at my very sickest to keep a roof over our heads while completing my teaching degree.

Having a nurse like Jen, someone who coordinates care, advocates for me, and supports me between appointments, gives me a sense of control in a world where I often have none. Her role is not an extra; it is essential.

We need more nurses like Jen - coordinators, anchors, the glue that holds care together, people who understand lung cancer. Every lung cancer patient deserves access to a nurse like Jen.

5 Strengthen support for people living with lung cancer and their carers

Too many Australians face lung cancer with fragmented support at the very moment they most need clear guidance, especially during critical times.

Key priorities include ensuring timely, coordinated care from first suspicion through to life beyond treatment, with investment in Lung Foundation Australia's Specialist Lung Cancer Nurses, telehealth nurse navigation services, and survivorship support.

Australians diagnosed with lung cancer – and the people who care for them – too often face the most complex parts of the health system with the least coordinated support. The period between a suspicious scan and diagnosis is particularly distressing as people often feel overwhelmed, distressed, unsupported and uncertain about how to navigate complex investigations, appointments and decisions.[155–157]

Our community consistently calls for earlier, clearer and more compassionate support from trusted health professionals. This includes help navigating diagnosis and treatment, tailored information at key transition points, psychosocial and practical support, symptom and side-effect management, and recognition of carers as active partners in care.

Early detection through the National Lung Cancer Screening Program and advances in treatment are increasing the demand for care navigation and specialist nursing support. As more people live longer with lung cancer, survivorship care must also be strengthened. A culturally safe workforce across the lung cancer continuum, including Aboriginal and Torres Strait Islander staff in navigator and care coordination roles, is essential for equitable and appropriate care.

To realise the full benefits of lung cancer screening and ensure people receive timely diagnosis, treatment and supportive care, additional nursing support is needed across the lung cancer pathway. This support should be available from the point lung cancer is suspected through diagnosis, treatment, survivorship and end-of-life care.

Why lung cancer care is uniquely complex[155,156,158,159]

High diagnostic burden: Around twice the diagnostic tests of other common cancers

Advanced testing requirements: Treatment decisions increasingly rely on comprehensive genomic testing before therapy can start

Treatment delays: Around half of lung cancer patients experience treatment delays

Inconsistent nurse access: In-person specialist nurse support remains uneven, especially for people in regional and rural areas and those receiving care across multiple providers and settings

Fragmented post-treatment care: Survivorship support is often fragmented and inconsistent, with many people reporting a sudden drop-off in support once treatment ends

Policy recommendations

5.1 Invest in more Lung Foundation Australia Specialist Lung Cancer Nurses

We recommend the Australian Government scale up Specialist Lung Cancer Nurse capacity by investing to grow the workforce toward at least 100 nurses embedded in multidisciplinary teams, prioritising services and regions currently without coverage.

Our Specialist Lung Cancer Nurses (SLCNs) operate within a unique Model of Care designed to address the unmet needs experienced by patients and carers. We embed nurses earlier in the pathway within respiratory services at the point of referral and diagnosis. This approach improves coordination, timeliness and continuity of care from pre-diagnosis through treatment, survivorship and end-of-life care.[159]

By supporting patients and carers before other cancer services are fully involved, our SLCNs fill a critical gap without duplicating existing cancer nurse roles. They focus on the parts of the pathway where support is often least available. This includes pre-diagnosis, diagnostic workups, staging, surgical pathways and post treatment followup.[2,155,159,164]

International evidence supports early access to specialist lung cancer nurses. For example, UK NICE quality standards state that adults with suspected or confirmed lung cancer should have access to a lung cancer clinical nurse specialist as early as possible and at key transition points.[165]

The role of Lung Foundation Australia Specialist Lung Cancer Nurses[159]

- Triage and expedite referrals
- Coordinate timely diagnostic tests
- Reduce delays in diagnosis and treatment
- Assist with symptom management
- Help navigate complex care decisions
- Provide psychosocial support
- Increase smoking cessation
- Advocate within multi-disciplinary care teams
- Reduce avoidable emergency presentations
- Provide information and support tailored for carers

Addressing the specialist nurse shortfall

Australia has a clear shortfall in specialist lung cancer nursing capacity. There are only around 55 SLCNs nationally (48 full-time equivalent), and only 11 of these work to our specific Model of Care.[159] This small workforce must support an estimated 15,100 new lung cancer cases each year,[23,24,166,167] meaning there is only one specialist nurse for every 314 newly diagnosed people each year. This represents a significant national workforce shortage of 120 SLCNs. With the significant mortality and morbidity burden of lung cancer, this represents a significant underinvestment compared to other cancers like breast or prostate cancer.

This shortage of SLCNs is also reflected in inconsistent access across lung cancer services. Our latest Lung Cancer Landscape Survey was conducted with the Thoracic Society of Australia and New Zealand. The 2025 survey found that fewer than half of institutions treating lung cancer had access to a SLCN (34 institutions, 46%). Only 38% of these met recommended core multidisciplinary team workforce requirements. The availability of SLCN support varied across treatment modalities. It was highest for public patients receiving medical oncology systemic therapies and lowest for patients undergoing surgery outside the public sector. Crucially, only 54% of institutions had SLCNs available during diagnostic testing.[168]

Investment in **ONE of our Specialist Lung Cancer Nurses** generates more than **$1 million** in net cost savings and quality-of-life gains.[169]

Investing in SLCNs working to our Model of Care – while growing capacity to support its adoption – is a high-value investment. It reduces downstream pressure on the health system while directly improving patient outcomes, experience and quality of life.[2,159]

5.2 Sustain and strengthen the Lung Foundation Australia Lung Cancer Specialist Nurse telehealth service

We recommend funding Lung Foundation Australia's nurse-led telehealth service so every person, especially those living in rural and remote areas, can access timely, expert support and referral.

The face-to-face lung cancer nurse workforce is limited and unevenly distributed. This means many people, especially those in regional, rural and remote areas can miss out on specialist support.[2,23,24,159,160,166,167] Our Lung Cancer Specialist Nurse telehealth service provides a scalable national solution. It offers end-to-end support from pre-screening through diagnosis, treatment, survivorship and end-of-life care, and has capacity to support more patients and carers through additional investment.

Our nurse-led telehealth model reaches people who lack access to a local lung cancer nurse. It provides patients and carers with trusted information, navigation support, symptom and side effect self-management tools, and psychosocial and practical assistance across the lung cancer continuum. The service supports people considering participation in lung cancer screening, those enrolled in the National Lung Cancer Screening Program, individuals with pulmonary nodules or incidental findings and people with suspected or confirmed lung cancer.[159,160]

Strengthening this service is increasingly important in the context of the National Lung Cancer Screening Program. Screening will identify more early-stage lung cancers, alongside people with nodules or incidental findings who need navigation, education and psychosocial support rather than immediate cancer treatment.[157,161,170–172]

Importantly, specialist nurses are not embedded within the National Lung Cancer Screening Program, creating a significant support gap for participants and primary care providers. A strengthened telehealth service can provide equitable access to specialist nursing support. It will help people understand screening eligibility, interpret results and navigate next steps. All while facilitating timely connection to primary care, respiratory services, smoking cessation programs, diagnostic pathways and lung cancer treatment services.[157,160,161,171,172]

This service must have evaluation and health economic analysis built in to demonstrate impact, inform future scale-up, and support long-term integration into national lung cancer pathways.[2,159,160,164]

5.3 Build dedicated survivorship support and lung cancer specific resources

We recommend establishing dedicated survivorship support through a specialised stream of the Lung Foundation Australia telehealth service alongside evidence-based resources to ensure support does not end when active treatment finishes.

More Australians are living longer with lung cancer due to earlier detection and treatment advances. However, survivorship care remains fragmented and inconsistent, with many people reporting a sudden drop-off in support once their treatment ends.[156,162,163]

Without planned follow-up and practical information, people are often left completely alone to manage ongoing symptoms, side effects, fear of recurrence, financial stress and return-to-work challenges. This isolation raises the risk of avoidable deterioration and poorer quality of life.

Survivorship support should include care planning, symptom monitoring and self-management, psychosocial support, and lifestyle advice. This can include nutrition, physical activity, smoking cessation, sleep and fatigue management. It should also help people to understand follow-up and surveillance plans, recognise warning signs and how to navigate primary care, specialists and community services when needed.[160,162,163]

A dedicated telehealth survivorship stream, embedded within Lung Foundation Australia's Specialist Lung Cancer Nurse telehealth service, would provide a practical and scalable way to extend specialist nursing support beyond active treatment and improve continuity of care.

This should be complemented by evidence-based, lung cancer-specific survivorship resources and care planning tools tailored to treatment type, stage of disease and ongoing needs. These resources would support more consistent follow-up, self-management, symptom monitoring and referral across specialist, primary care and community settings.[162,163]

Dedicated survivorship support directly addresses persistent symptoms, treatment side effects, fear of recurrence or progression, breathlessness, fatigue and emotional distress. This support also addresses practical challenges such as returning to work or usual roles, financial stress, and access to ongoing care and support. Carers would also benefit from continued information, support and connection to relevant services.[156,162,163]

Together, these initiatives would improve continuity of care, strengthen quality of life, and support better longterm outcomes for people living with and beyond lung cancer, regardless of where they live.[160,162,163]

6

Increase investment in lung cancer research and innovation

Charmaine, 57, Victoria

My lung cancer story began unexpectedly in October 2023 when I saw the GP for an earache. Because she had recently treated my son for pneumonia, she ordered a chest X-ray. That decision changed my life. It revealed something suspicious in my lung, and further scans confirmed a 37 mm tumour. The following week, a cardiothoracic surgeon told me the words no one ever wants to hear: "It most definitely is cancer."

I was shocked. I had never smoked. I was healthy, active, and loved walking. I remember thinking: would I live long enough to see my children graduate and build their adult lives? Would I still get the chance to travel the world with my husband?

Research and innovation have shaped my lung cancer journey, giving me options and hope. After surgery, genomic testing identified my tumour as RET fusion-positive, a rare and aggressive subtype of lung cancer. Without that testing, my treatment pathway would have looked very different. Precision medicine allowed my medical team to identify the mutation driving my cancer and opened the door to targeted treatments and clinical trials.

One of the hardest realities I faced was learning that even after surgery and chemotherapy, I still had approximately a 50% chance of recurrence within 2 years. I could not emotionally accept simply waiting for the cancer to return. I needed to be proactive, so I chose to join a clinical trial for patients with RET fusion-positive lung cancer after curative surgery. I hoped it might help me and future patients facing the same diagnosis. It gave me purpose and hope when recurrence statistics felt overwhelming.

Taking part in a clinical trial is not easy even with support from the research doctors and nurses. I travel 2 hours each way, with telehealth appointments in between. The travel is exhausting, especially while recovering from treatment. Participating requires time, courage, and commitment, but I know access to innovation often comes with challenges.

The trial results are promising, showing improved event-free survival and reduced recurrence risk. For patients like me, this research represents hope and highlights the importance of genomic testing and precision medicine. Without it, this treatment opportunity would not have existed.

I want decision-makers to understand that investing in research saves lives. Clinical trials are not abstract – they are real opportunities for patients like me to live longer, experience fewer recurrences, and continue being present for our families.

I've done my part by taking part. Now it's time for governments to do theirs by funding the research that makes these trials possible. Patients cannot participate in life-saving innovation if those opportunities are never funded.

Behind every diagnosis is a person trying to survive, love their family, and live as fully as possible. **Research gave me options. Research gave me hope. Research may give me more time with my family.**

6 Increase investment in lung cancer research and innovation

Lung cancer research investment has not kept pace with disease burden, and access to advances in screening, diagnostics, genomics and precision medicine remains inequitable, particularly for rural, remote, Aboriginal and Torres Strait Islander and culturally diverse communities. The National Lung Cancer Screening Program creates a critical opportunity for change. Key priorities include strengthening the research workforce, establishing a national clinical quality data platform, expanding biobanking and precision medicine infrastructure, and prioritising optimal diagnostic pathways and precision diagnostics.

Lung cancer is Australia's leading cause of cancer death, yet research investment has not kept pace with disease burden. Funding allocated to lung disease and lung cancer remains disproportionately low relative to its share of Australia's total burden of disease. This funding disparity has persisted over time.[173]

Strategic alignment and a clear imperative for reform

The Australian Government's strategic alignment of the National Health and Medical Research Council (NHMRC) and the Medical Research Future Fund (MRFF)[174] – alongside the *National Health and Medical Research Strategy 2026-2036*[175] – is reshaping Australia's research funding landscape. This reflects a shift towards a more coordinated, priority-driven system. It strengthens the full pipeline from discovery to implementation, reduces duplication and aligns investment with national health priorities based on burden, equity and system need.

The growing emphasis on translation, real-world impact, consumer involvement, equity, workforce sustainability and measurable health system outcomes is reinforced by the *Australian Cancer Plan*.[6] It calls for targeted investment in areas of unmet need, a national cancer data ecosystem and equitable access to clinical trials and innovation.

For lung cancer, these converging frameworks create both opportunity and imperative. Low survival rates, inequitable outcomes and the transformative potential of early detection position lung cancer as a major national health priority. Realising this will require moving beyond disease-specific advocacy to demonstrate measurable impact, lead implementation-focused research and build a strong, evidence-based case for investment proportionate to disease burden. Lung cancer research is central to Australia's ambition for a high-performing, equitable and data-enabled health system.

Priority areas for national investment

We recommend national investment for lung cancer research and innovation to:

- strengthen Australia's lung cancer research workforce and capability
- establish a national lung cancer clinical quality data platform
- expand lung cancer biobanking and precision medicine infrastructure
- prioritise optimal diagnostic pathways and access to precision diagnostics.

These priorities directly align with Pillar 4 of *Lung Foundation Australia's corporate plan 2026-2030* and *Lung Foundation Australia's research strategy*.[127] They are guided by the *NHMRC's Statement on Consumer and Community Involvement in Health and Medical Research*[15], embedding lived experience, carer, and community perspectives across research priority-setting, design, implementation, and translation.

Why these recommendations are needed

Lung cancer remains Australia's leading cause of cancer death and contributes substantially to the national burden of disease, healthcare expenditure, and avoidable hospitalisations.[23–28,30,31,47,176–178] Survival rates have improved through advances in targeted therapies, immunotherapy and multidisciplinary care – yet overall outcomes remain poor relative to other cancers, and unacceptable variation persists in access to timely, high-quality care.[179–182] These inequities are most pronounced for priority populations, reinforcing the need for research and system reform that improve outcomes for these groups.

Australia currently lacks an integrated national research and clinical quality infrastructure for lung cancer that can reliably support continuous quality improvement and equitable implementation of innovation. There is limited systematic national data on adherence to evidence-based care, timeliness of diagnosis and treatment, patient-reported outcomes and variation in access to diagnostics and treatment. This limited data constrains the ability to identify inequities, benchmark performance and drive data-driven reform.

The implementation of the National Lung Cancer Screening Program further increases urgency. Screening will enable earlier detection and improved survival, but will also increase demand across diagnostic pathways, molecular testing, multidisciplinary care, and longitudinal follow-up. Without coordinated investment in workforce, data systems, biobanking and diagnostics, benefits risk being unevenly distributed and inequities could widen.

At the same time, rapid advances in AI, radiomics, liquid biopsy, robotic bronchoscopy and genomic profiling require strong translational and implementation capabilities to ensure safe, effective and equitable adoption into routine care.

International experience demonstrates the value of coordinated national approaches. Evidence from the United Kingdom, Denmark and the Netherlands shows that investment in clinical quality registries, translational research networks and precision medicine infrastructure improves outcomes. It also reduces variation in care and accelerates innovation, with systems increasingly moving toward linked, interoperable national data ecosystems.[183–187]

Australia currently lacks an integrated national research and clinical quality infrastructure for lung cancer, although it does possess important foundational assets, including the Lung Cancer Clinical Quality Data Platform (LUCAP) and the TRACKER Biobank. However, these initiatives remain fragmented and under-resourced relative to broader system needs. They require coordinated national expansion to deliver their full potential impact.

Policy recommendations

6.1 Strengthen Australia's lung cancer research workforce and capability

We recommend a coordinated national investment to strengthen Australia's lung cancer research workforce and capability, proportionate to the disease burden. The goal is to build a skilled, sustainable and nationally connected workforce capable of delivering high-quality, evidence-based and innovative care.

Consistent with *Lung Foundation Australia's corporate plan* and *research strategy*, priority should be given to supporting early-and mid-career researchers and healthcare professionals from basic science, health services and public health research backgrounds. Targeted investment is required in consumer-led research, including Indigenous-led research and research co-designed with priority populations. We must strengthen sector-wide research capabilities, workforce development and education across the lung cancer care continuum.

Investment in workforce capability will strengthen respiratory research capability and productivity. It will improve integration between research and clinical care and accelerate the translation of advances. This will occur across screening, diagnostics, genomics, precision medicine and person-centred care, translating into improved and more equitable outcomes for people affected by lung cancer in Australia.

Actions:

- Expand professional opportunities: Grow research fellowships, travel scholarships, collaboration grants, mentoring and professional development opportunities to support the next generation of lung cancer researchers and clinician academics- including consumer researchers as named recipients of fellowship and capacity-building funding
- Prioritise regional and Indigenous health: Target fellowships, scholarships and education initiatives to rural and remote clinicians and researchers, and Aboriginal and Torres Strait Islander health professionals to build workforce capability where it is most needed
- Support best-practice education: Deliver workforce education and training focused on best-practice lung cancer care
- Drive collaboration: Strengthen multidisciplinary and cross-sector research collaboration, including opportunities for Australian researchers and clinicians to engage with international leaders in lung cancer research and care
- Build connected networks: Foster national research and clinical networks across lung health and lung cancer
- Include lived experience: Embed consumer and lived experience perspectives into research and translation, including community-led priority setting to ensure research reflects the needs and preferences of those most affected.

6.2 Establish a national lung cancer clinical quality data platform

We recommend establishing a nationally coordinated lung cancer clinical quality data platform to improve the quality, equity and efficiency of lung cancer care across Australia.

Australia has multiple tumour-specific clinical quality registries. However, the current system remains fragmented across jurisdictions and care pathways. National policy is now moving toward a connected cancer data ecosystem rather than standalone registries. A Lung Cancer Clinical Quality Data Platform (LUCAP) would be a key building block in this transition, linking screening outcomes, diagnosis, treatment and research into a single national learning health system.

LUCAP seeks to utilise clinical data from around the time of diagnosis to benchmark care against agreed clinical quality indicators. It feeds these results back to medical centres and health systems using a near real-time interactive dashboard.

Establishing LUCAP as a national program would position Australia as a global leader in data-driven, equitable and person-centred cancer care. Unlike the National Cancer Screening Register – which focuses on screening participation and outcomes – LUCAP would capture real-world data across the full care pathway, including the timeliness of care, diagnosis, molecular testing, treatment, multidisciplinary care, and potentially, patient experience and outcomes.

The platform should integrate public and private sector data and link with health service providers, biobanks and research programs.

This would support continuous quality improvement, innovation and rapid translation of innovations in care into practice. Crucially, it should also capture early outcomes from the National Lung Cancer Screening Program, providing real-world evidence on stage shift, treatment effectiveness and equity of access. It would also identify unwarranted variation in care and strengthen system accountability and efficiency.

A national platform would:

- identify and feedback on unwarranted variation in care and outcomes
- benchmark services against evidence-based standards
- support continuous quality improvement and accountability
- monitor outcomes from the National Lung Cancer Screening Program
- strengthen data assets for planning, policy and research
- improve equity, value and person-centred care.[188-190]

This aligns with the *National Strategy for Clinical Quality Registries and Virtual Registries 2020–2030*[191], the Australian *Framework for National Clinical Quality Registries 2024*[192] and the *Australian Cancer Plan*[6], including community-led priority setting to ensure research reflects the needs and preferences of those most affected. Together, these frameworks support the development of world-class, data-enabled health systems.

6.3 Expand lung cancer biobanking and precision medicine infrastructure

We recommend prioritising national investment in a coordinated lung cancer biobank to advance precision medicine, build research capability, and fast-track personalised, biomarker-driven care.

What is a biobank?

A biobank is a secure facility that collects, stores, and manages human tissue, blood, and fluid samples for ethically approved medical research. Linked with clinical data, biobanks support the development of new diagnostic tools, targeted therapies and more personalised approaches to lung cancer care.

Limited access to high-quality, clinically annotated lung cancer tissue and blood samples continues to constrain biomarker discovery. This limits understanding of tumour evolution and treatment resistance, the development of precision therapies and clinical trial participation. Small biopsies, inconsistent sampling techniques and lack of longitudinal collections limit comprehensive molecular analysis. This reduces how well samples represent real-world populations, contributing to inequities in access to innovation and care.

High quality lung cancer biobanking – particularly longitudinal tissue and blood collection linked to clinical data – is essential to accelerating research discovery and advancing precision oncology. The TRACKER Biobank, established with $3 million MRFF investment provided by the Australian Government, demonstrates the value of national-scale standardised serial sampling across the disease course. TRACKER enables multi-omics research spanning genes, proteins and metabolites to inform personalised diagnostic and therapeutic approaches.

A critical funding gap requires urgent action

Current MRFF funding concludes in 2027, with no secured investment beyond this date. Without continued investment, this nationally significant infrastructure – built over years of coordinated effort across 5 states – faces an uncertain future. Underinvestment would slow biomarker and treatment discovery, reduce research innovation, delay translation into practice, and ultimately, worsen outcomes for Australians living with lung cancer.

Continued investment would maintain a nationally coordinated source of lung cancer tissue, blood samples and linked clinical data. This would reduce duplication, improve protocol standardisation, maximise the value of scarce biospecimens and strengthen the return on initial government investment.

This infrastructure aligns with the *Australian Cancer Plan's* genomics and precision medicine priorities by supporting integration of genomic, clinical and pathology data into research and care.

Priority areas for ongoing investment include:

- **Long-term sustainability:** Secure existing TRACKER sites (VIC, NSW, QLD, SA, WA) and national expansion to the NT, ACT, and TAS
- **Cohort expansion:** Expand recruitment toward 1,000 participants nationally (currently at approximately 250), including longitudinal sample collection, enrolment of people with screening-detected lung cancer and targeted recruitment of priority populations
- **Targeted research access:** Extend biobanking into priority research areas, including early detection and lung cancer with brain metastases
- **Culturally safe governance:** Embed consumer and Aboriginal and Torres Strait Islander governance and engagement, including co-design of culturally safe biobanking protocols
- **Infrastructure standardisation:** Upgrade tissue processing, laboratory capability and data infrastructure to support a nationally coordinated platform with standardised protocols, interoperability, and equitable researcher access. This includes reducing cost barriers for accessing specimens and data
- **Advanced diagnostic research:** Support cutting-edge translational research using robotic bronchoscopy-acquired specimens.

Strengthening national biobanking capability will accelerate discovery, improve translation into clinical practice, and ensure Australians benefit equitably from advances in precision lung cancer care. The foundation has been built. Now, continued investment is required to secure its future.

6.4 Prioritise optimal diagnostic pathways and access to precision diagnostics and affordable medicines

We recommend prioritising equitable access to optimal, timely lung cancer diagnostic pathways. These include advanced bronchoscopy techniques, liquid biopsy, AI-enabled diagnostics and timely next-generation sequencing (NGS) to improve diagnostic accuracy, reduce delays and enable earlier access to treatment.

Timely and accurate diagnosis is essential to improving lung cancer outcomes for systemic anticancer therapy (SACT)[193] and surgery.[194] Established and emerging technologies can improve diagnostic performance and reduce invasiveness, but require equitable implementation across the health system and throughout Australia.

Robotic and navigational bronchoscopy improves diagnostic yield for peripheral lesions and reduces complication rates compared to CT-guided biopsy. These technologies enable combined diagnosis and staging in a single procedure, reducing repeat procedures, shortens time to diagnosis and preserves lung tissue.[195,196]

These benefits require demonstration in the Australian health system. Implementation research into optimal pathways is required to identify patients who will benefit most and ensure equity of access. Liquid biopsy and AI-enabled approaches, including radiomics, may further reduce reliance on invasive sampling and support earlier detection of actionable mutations.[197]

Access to NGS is critical for precision medicine, but remains variable across Australia.[166] Data from Europe demonstrates that delays in access can slow the initiation of targeted therapies and immunotherapy.[198]

Strengthening diagnostic capability and equity will reduce time to diagnosis, improve access to precision therapies and improve outcomes for people with lung cancer.

However, diagnostic advances will not translate into better outcomes if access to new medicines remains delayed; Australians can wait almost 2 years between treatment registration and subsidised PBS access, reinforcing the need for faster HTA and reimbursement pathways.

Actions:

- Evaluate and integrate robotic and navigational bronchoscopy into optimal diagnostic pathways as a standard of care
- Expand use of liquid biopsy and AI-enabled diagnostic tools where evidence supports benefit
- Improve equitable access to timely NGS, including reducing turnaround times
- Embed diagnostic innovations within nationally consistent lung cancer care pathways
- Implement the HTA Policy and Methods Review recommendations to ensure Australians can access innovative, affordable medicines sooner.

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