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australian healthcare & hospitals association

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Professor Dorothy Keefe
Chief Executive Officer
Cancer Australia
Email: lungcancerscreening@canceraustralia.gov.au

Dear Prof Keefe

**Re: Lung Cancer Screening Enquiry Report**

The Australian Healthcare and Hospitals Association (AHHA) welcomes the opportunity to provide this response to the findings presented in the *Lung Cancer Screening Enquiry Report*.

AHHA is Australia's national peak body for public hospitals and healthcare providers. Our membership includes state health departments, Local Hospital Networks (LHNs) and public hospitals, community health services, Primary Health Networks (PHNs) and primary healthcare providers, aged care providers, universities, individual health professionals and academics. As such, we are uniquely placed to be an independent, national voice for universal high-quality healthcare to benefit the whole community.

To achieve a healthy Australia supported by the best possible healthcare system, AHHA recommends Australia reorientate the healthcare system over the next 10 years by enabling outcomes-focused and value-based healthcare. As described in AHHA's blueprint for health reform, *Healthy people, healthy systems*[1] this requires:

1. A nationally unified and regionally controlled health system that puts patients at the centre;
2. Performance information and reporting that is fit for purpose;
3. A health workforce that exists to serve and meet population health needs; and
4. Funding that is sustainable and appropriate to support a high-quality health system.

The Enquiry report reflects comprehensive consideration across these areas and demonstrates a sound value proposition outlined. AHHA provides the following feedback within this context.

***Risk assessment for participant recruitment***

The report (s3.2) identifies risk assessment tools, 'which use algorithms to calculate an individual's risk of lung cancer based on a combination of a variety of established sociodemographic and health-related factors, appear to perform better in the identification of individuals for targeted lung cancer screening than eligibility criteria of age and smoking alone.'

The report (s5) then proposes four recruitment channels for new participants (self-referral, facilitated entry, opportunistic entry and organised entry), all which are dependent on access via a primary care practitioner of their choice.

[1] https://ahha.asn.au/Blueprint



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While a national information and communication strategy is identified as a key feature to aid recruitment, there is opportunity to better leverage technology available to support self-screening using the proposed risk assessment tool (PLCOm2012) without dependency on access to primary health care. This is consistent with the BreastScreen program, where women who meet criteria can self-refer for a mammogram, and the National Bowel Cancer Screening Program, where invitations to participate are automatically sent based on age.

Recent Australian research reflects that desire to participate in lung cancer screening is associated with worry and perceived seriousness of a lung cancer diagnosis, and not actual risk or screening eligibility.[2] As such, recruitment for lung screening needs to remove as many barriers as possible for those actually at risk. While opportunistic support for primary prevention strategies through primary care practitioner contact (e.g. smoking cessation) can be driven with the proposed recruitment pathways, they should not prevent maximising opportunities for screening uptake.

Freely available and widely promoted calculators should be made available through websites and apps to provide a mechanism for completing the initial risk assessment, where risk factors can also be entered by the patient, family members, carers and others. An option to elect to communicate results with their chosen primary care practitioner could be promoted, to support follow up and smoking cessation support where necessary.

***Smoking cessation***

Primary prevention through smoking cessation is associated with significant health benefits, and AHHA supports that it is an integral component of the screening program proposed. However, it is recognised that there are diverse influences on uptake and prevention and these need to be addressed through a broad range of strategies.

Increasing the cost of tobacco through taxation is strongly supported as an effective strategy for getting people to decrease use or quit, and for preventing uptake, particularly where such revenue is hypothecated and used to increase investment in preventive health measures. AHHA supports continued attention to the level of taxation in Australia to further reduce levels of smoking through regular price increases. This must, however, be done with awareness of lower income populations who do not reduce their smoking and the subsequent socioeconomic impact (i.e. less income available for basic needs). While it should not be an argument not to increase tobacco taxes due to the overall benefits, ensuring the necessary social supports should be considered in this context.

I would be pleased to discuss these views with you in more detail.

Yours sincerely,

Alison Verhoeven
Chief Executive
Australian Healthcare and Hospitals Association

[2] https://openres.ersjournals.com/content/erjor/6/1/00158-2019.full.pdf