

P1.357: Australasian Lung Cancer Workforce and Infrastructure: Landscape Survey Findings in the Era of Lung Cancer Screening

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INTRODUCTION

- Unwarranted variation in lung cancer care¹⁻⁵ may be partially attributable to differences in workforce and infrastructure^{6,7}
- In Australia, the National Lung Cancer Screening Program commenced in July 2025, whilst a business case is ongoing in Aotearoa New Zealand (NZ)
- Since our previous survey, there have been important changes in clinical practice, e.g., wider adoption of systemic mediastinal nodal staging, and funding of neoadjuvant chemoimmunotherapy (in Australia)
- Aim:** to complete an organisational audit of lung cancer workforce, infrastructure and clinical practice across Australia and NZ.

METHODS

- An online survey was developed in Qualtrics and distributed via professional organisations (e.g. Thoracic Society of Australia & New Zealand, Lung Foundation Australia), and personal and professional networks
- One response from every institution treating lung cancer in Australia and NZ was sought
- The survey was available for completion between February - June 2025, and up to 3 reminder emails were sent
- Data were cleaned in Excel prior to descriptive analysis in SPSS
- Proportions and Pearson chi square values were calculated for categorical variables, and median/interquartile ranges calculated for continuous data; P values <0.05 were considered significant.

Curtin University HREC approved the study (HRE2025-0017).

DISCUSSION AND CONCLUSION

Key messages

- There are disparities in the accessibility of critical components of lung cancer care, particularly in non-metropolitan areas
- Responses highlight differences across Australia and NZ, including specialist nurses and neoadjuvant chemoimmunotherapy
- Responses suggest non-guideline concordant care, with inconsistent rates of MDM discussion, diagnostics and staging.

Future directions

- These findings complement the measurement of lung cancer quality indicators and highlight the need to eliminate persistent inequities
- Future research may include an assessment of regional barriers and facilitators to guideline concordant care, and an evaluation of networked approaches to lung cancer care.

REFERENCES & ACKNOWLEDGEMENTS

Acknowledgements

We thank all survey participants and the Thoracic Society of Australia & New Zealand and Lung Foundation Australia for survey distribution. No funding support was received.

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Artificial Intelligence Use Disclaimer

Artificial intelligence was not used during the conduct of this research nor in content development.

RESULTS

In total, responses were received from 89 institutions, of which 75 were in Australia and 14 in NZ. Most institutions were **publicly funded** (74%), located in **metropolitan** areas (71%) and one third (37%) reported caring for **>200 patients** newly diagnosed with lung cancer annually.

Compared to previous surveys, specialty representation at multidisciplinary meeting (MDM) has improved. Overall, 42% of surveyed institutions fulfilled recommended core staffing⁸, with the biggest gaps in **nuclear medicine** (42%) and **specialist lung cancer nursing** (77%) representation.

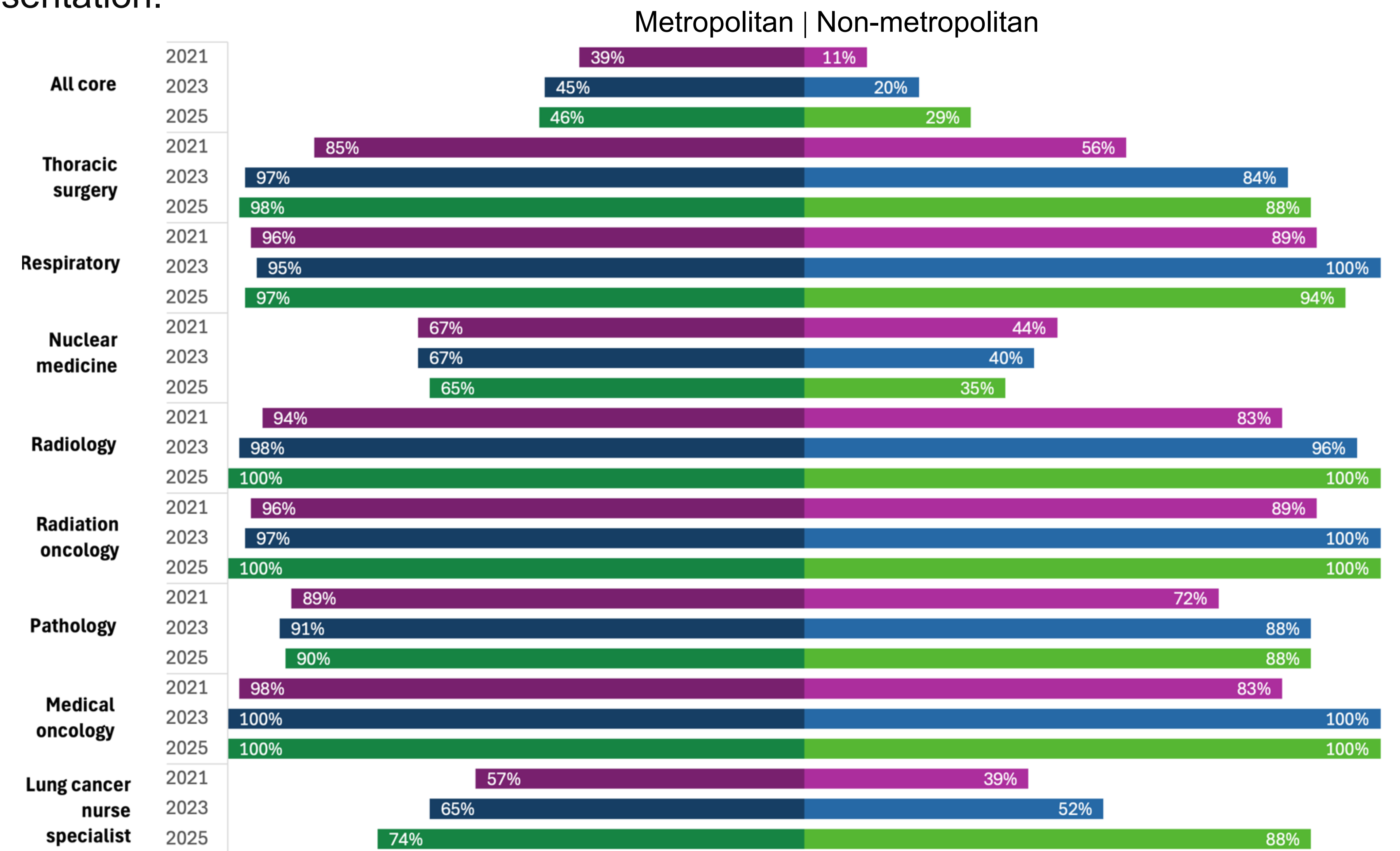


Figure 1: Lung cancer MDM speciality representation, 2021-2025

WORKFORCE AND INFRASTRUCTURE

- 70% metropolitan and 46% non-metropolitan institutions had **on-site PET/CT** (P=0.035)
- Metropolitan sites were more likely to have **linear** (92% vs 46%) and **radial EBUS** (81% vs 27%, P<0.001 for both) available
- More metropolitan institutions had on-site **interventional radiology** (52% vs 15%), **radiation oncology** (84% vs 50%), **thoracic surgery** (81% vs 35%) and **clinical trials** (68% vs 27%, P<0.001 for all)
- Most NZ sites had an on-site **specialist lung cancer nurse** (Aus: 46% vs NZ: 86%, P=0.021).

CLINICAL PRACTICE

- 49% sites reported MDM discussion for **all patients newly diagnosed** with lung cancer; 45% indicated discussion for all patients newly diagnosed with **Stage II-III NSCLC**
- 67% institutions routinely perform **molecular pathology** for all patients newly diagnosed with Stage IV NSCLC planned for treatment
- 10% sites complete **invasive mediastinal nodal staging** for all patients with clinical T2a-T4 or central NSCLC (N0 M0)
- Neoadjuvant chemoimmunotherapy** access is limited in NZ (Aus: 93% vs NZ: 29%, P<0.001).