THE AUSTRALIAN LUNG FOUNDATION

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The Inquiry Secretary
Standing Committee on Ageing
Parliament House
CANBERRA ACT 2600

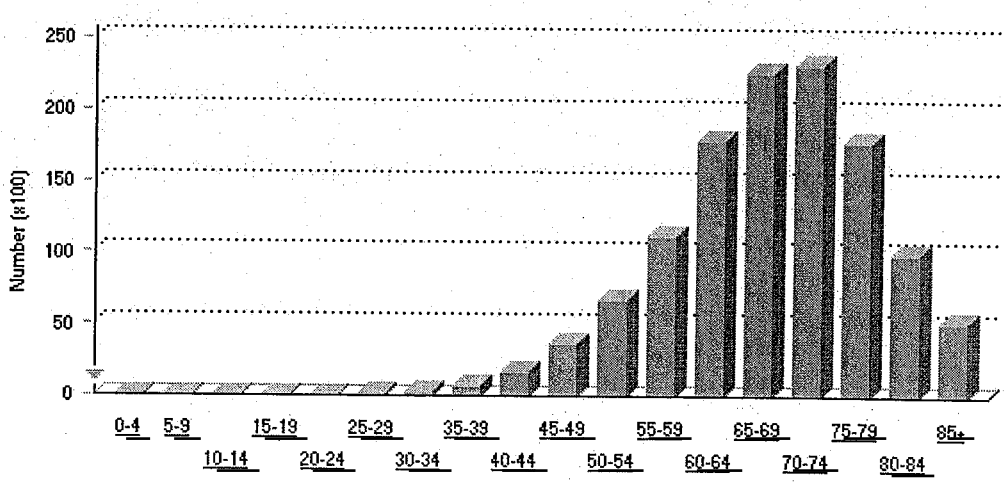
Dear Chairman,

Re: Submission for Inquiry into long-term strategies to address the ageing of the Australian population over the next 40 years.

Lung cancer is the leading cause of cancer death in Australia and worldwide. In 1996 it was ranked 3rd in terms of burden of disease for males and 11th for females. By 2016, it is expected to rank 4th for males and 5th for females. Lung cancer is currently estimated to cost the Australian health system $107 million per annum in direct costs, and is likely to increase over time. This figure is conservative in that it does not acknowledge the many indirect costs of lung cancer, such as lost earnings and productivity.

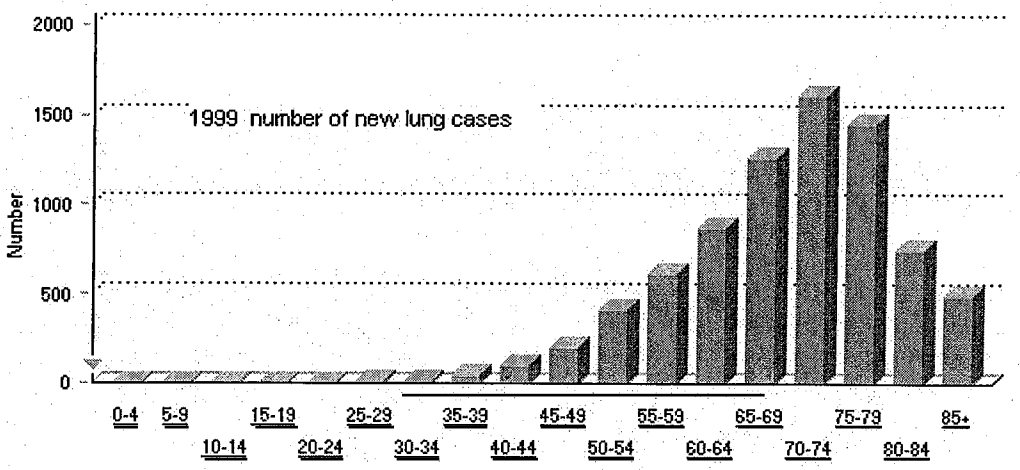
Over 7000 new cases of lung cancer are diagnosed in Australia each year and, despite advances in treatment, survival after diagnosis is less than with any other common tumour. The overall survival rate five years after diagnosis is about 12%. The following graph of the number of new cases of lung cancer confirms the huge number of Australians directly suffering, apart from the burden it places on their families and nation.

Figure 1: Number of new cases of lung cancer by 5 year age groups between 1983 and 1999 (data from AIHW (www.aihw.gov.au) – accessed 9.10.2003)



As lung cancer tends to affect older Australians, lung cancer will become an important and increasing burden on the ageing Australian population over the next 40 years. This trend is already apparent if we compare lung cancer rates in 1983 to 1999.

Figure 2: Number of new cases of lung cancer by 5 year age groups in 1983 compared to 1999 (data from AIHW (www.aihw.gov.au) – accessed 9.10.2003).
For example, the peak incidence has increase from the 65-69 year age group to the 70-74 year age group, and there are substantial increases in the number of cases of Australians over 75 with lung cancer.



The Australian Lung Foundation (ALF) and its Lung Cancer Consultative Group have published a Case Statement on Lung Cancer. As the document outlines, lung cancer needs our serious attention and work needs to be done now to reduce the burden from lung cancer in the future.

Cancer control is a National Health Priority Area and lung cancer is one of the eight cancers that have been targeted for action. However while lung cancer is arguably one of the most preventable cancers, expenditure on tobacco control initiatives is disproportionately low.

As we note in the document the elimination of lung cancer through smoking cessation programs and tobacco control strategies must be the principle aim, but in the meantime, there are many people with lung cancer who deserve improved standards of care and better health outcomes. For them, we must all work towards new curative therapy and also invest effort and funding in treatment and research that may lead to extension of life without cure, or more effective disease control without extension of life.

There are several new therapies on the horizon for the treatment of lung cancer that show promise and may be available to Australian sufferers within the next few years. While these agents show promise in terms of improving outcomes for lung cancer patients, they are likely to be expensive.

This challenge – to determine the value that we put on the treatment of incurable disease – will be a great one. And it will only increase as our population ages.

We have attached the ALF Case Statement on Lung Cancer and would be happy to appear before the Committee to discuss lung cancer, and how we can work together to reduce the morbidity and mortality associated with the disease, while we try to reduce its incidence. We would like to follow up regarding a possible appearance before your Committee, and can be contacted on (07) 3357 6388 to arrange a suitable time.

We look forward to hearing from you.

Kind regards

Jensen

pp. Kwun M Fong MBBS(Lon) FRACP PhD
Chair
Lung Cancer Consultative Group

We are pleased to present to you the Australian Lung Foundation's Case Statement on Lung Cancer in Australia.

Lung cancer is the leading cause of cancer death. The number of cases has been steadily rising and more than 7,000 Australian men and women have been diagnosed with the disease each year since 1990. The number of men affected by lung cancer appears to have plateaued but women are increasingly diagnosed with the disease. Survival rates five years after diagnosis are less than 15%.

Tobacco smoking causes the vast majority of lung cancers. Both current smokers and former smokers are at risk. Many of those who are currently being diagnosed with lung cancer began smoking when they were teenagers, at a time when smoking rates were high. The addictive properties of cigarettes make it difficult to stop smoking early enough to prevent cancer development.

Individual and community attitudes to lung cancer have tended to be negative, partly because of the association with smoking. We need to recognise that people with lung cancer may feel they have a self-inflicted illness and that they are perhaps less worthy of medical attention than others. Furthermore, health care providers should take care not to be inappropriately judgemental and we should demand continuing improvements in lung cancer knowledge and care for our patients.

There is now a renewed interest in lung cancer. Lung cancer is largely preventable given effective tobacco control and smoking prevention and cessation strategies. There have been incremental advances in the clinical management of lung cancer and more are expected. Given the currently poor outcomes from lung cancer, there is plenty of scope for improvement.

The Australian Lung Foundation is committed to reducing the prevalence and impact of lung cancer. It is a challenge that will require a collaborative effort from the community, research institutions, health professionals, government and other stakeholders. In order to influence health outcomes, the effort to combat lung cancer will have to be sustained and it will likely be costly. However the costs of inaction, both individually and for the community, mandates this concerted approach.

Lung cancer needs our serious attention. We strongly encourage you to support the Australian Lung Foundation in lung cancer initiatives.

Dr Bob Edwards FRACP
National Chairman
Australian Lung Foundation

Dr Kwun Fong MBBS FRACP PhD
Chairman
Australian Lung Foundation Lung Cancer Consultative Group

4 April 2003

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FOREWORD

A century ago, primary lung cancer was very rare and some experts seriously argued that it did not exist at all. It is now the leading cause of cancer deaths in Australia and worldwide. Despite treatment advances, survival after the diagnosis of lung cancer is less than with any other common tumour. Sadly, our level of support and investment towards strategies to improve this situation have not been commensurate with the impact lung cancer has on affected individuals, their families and the broader community.

If we were able to reduce smoking to very low levels, lung cancer rates would similarly decrease over time. However this will not happen in our lifetime for two reasons. Firstly, the current investment in tobacco control programs is inadequate. Secondly, many former smokers in our community will remain at increased risk of lung cancer for the rest of their lives. Consumers, health care providers and decision makers must all adopt a fresh approach to lung cancer.

We need greater optimism, but an optimism that is based on real commitment and real action. The elimination of lung cancer must be the aim but in the meantime there will be many people with lung cancer who deserve improved standards of care and better health outcomes. For them, we all must work towards new curative therapy but also invest effort and funding in treatment and research that may lead to extension of life without cure or more effective symptom control without extension of life. This challenge - to determine the value that we put on the treatment of incurable disease - will be a great one.

There is an unfortunate and inappropriate stigma surrounding smoking-related diseases, as if people who made poor lifestyle choices in their youth have somehow elected to have a life-threatening disease. Nobody chooses or deserves to get lung cancer. Lung cancer is not and will never be an attractive disease. Lung cancer patients do not make the covers of glossy magazines. Those who are affected should have our sympathy for their immediate suffering and our reassurance that as a community we are doing all we can to find solutions.

Associate Professor Matthew Peters FRACP
Chairman, Action on Smoking and Health
ALF representative, Global Lung Cancer Coalition

LUNG CANCER: A CONSIDERABLE LONG-TERM BURDEN

Lung cancer was ranked 3rd in terms of burden of disease for males and 11th for females in 1996. By 2016, it is predicted to rank 4th in terms of burden of disease for males and 5th for females.[1]

The burden of disease is a measure of the healthy years lost due to an illness or injury. It includes not only an assessment of number of years lost due to premature mortality but also the number of years of healthy life lost due to disability.

WE NEED TO WORK NOW TO REDUCE THE BURDEN FROM LUNG CANCER IN THE FUTURE

- ☐ High prevalence – 7,000 new cases each year
- ☐ High mortality - leading cause of cancer death
- ☐ Health costs: $107 million p.a. and likely to rise
- ☐ Heavy emotional & economic burden on families
- ☐ Increasing health problem for women
- ☐ Negative perceptions
- ☐ Limited treatment options
- ☐ Limited attention from community, health professionals and government

WHAT IS LUNG CANCER?

Lung cancer is a malignant tumour of the bronchi, the tubes through which air flows to the lungs, or a tumour of the spongy lung itself. The lungs can also be affected by so-called secondary lung tumours that have spread from elsewhere in the body such as the breast or bowel. Unchecked, primary lung cancer grows within the lung and spreads to other major organs including the brain, bones and liver. There are two main types of lung cancer, small cell lung cancer and non-small cell lung cancer.

How does lung cancer develop?

All cancers are the result of normal cells undergoing a series of genetic changes that cause uncontrolled growth, invasion and disruption of normal tissue, and spread to other parts of the body. Our understanding of the cellular and molecular events that cause this uncontrolled growth is still developing but we know there is often a sequence of events involving changes in the genes of cells. It is believed that about seven different genes must be abnormal before a lung cancer develops.

Cancer-causing agents such as tobacco smoke can initiate and promote the transformation of healthy cells into malignant cells but other factors are also involved in the progression to a cancer.

We do not know exactly which of the 4,000 chemical substances in tobacco smoke cause the genetic changes that are important for lung cancer. Importantly however, the growing lung in childhood and adolescence may be especially vulnerable to genetic injury. It is clear that the younger the age at commencement of smoking, the higher the later risk of lung cancer.

The clinical course of lung cancer

At present the majority of lung cancer patients die within 12 months of their diagnosis. However treatment options and the outcome of lung cancer depend on the cell type, the extent of the disease, the person's overall health and their suitability for surgery.

Only about 25% of patients have tumours diagnosed early enough for curative surgery to be attempted. However other treatment strategies including chemotherapy, radiotherapy and laser therapy can relieve symptoms and prolong life when a cure is not possible.

Data from New South Wales shows five-year survival with localised lung cancer to be 23.2% compared with 1.0% of cases where the disease had spread to distant organs.[2] Overall five-year survival is about 12% and survival 10 years after diagnosis was only 8.2% for males and 9.2% for females in 1987–1991, the most recent period for which such survival data are available.

Better combinations of chemotherapy and radiotherapy have improved survival one to two years after diagnosis but the long-term benefit is uncertain and the response rarely meets a patient's initial hopes or expectations. Unfortunately, most patients with lung cancer will have advanced disease at the time of diagnosis and their cancer will progress in spite of the best available treatment.

WHO DEVELOPS LUNG CANCER?

Risk factors

Up to 90% of lung cancer is related to active cigarette smoking. Risk is related to the pattern of smoking and increases with:

- ☐ earlier age of commencement
- ☐ longer duration of smoking
- ☐ greater number of cigarettes smoked

Which smoker will develop lung cancer cannot be predicted. People who successfully stop smoking reduce their subsequent risk of lung cancer but remain at higher risk than those who have never smoked. About half of the people currently being diagnosed with lung cancer are former smokers but it is likely that their cancer would have developed at a younger age had they continued to smoke. With regard to lung cancer risks, it is always beneficial to quit smoking.

Smoking causes nearly all lung cancer.

Half of the people currently being diagnosed with lung cancer are former smokers.

Pipe and cigar smoking also increase lung cancer risk but at a lower level than cigarette smoking. Cannabis (marijuana) contains many of the same carcinogens as tobacco and may also increase the risk of lung cancer. Inhalation of environmental tobacco smoke (passive smoking) has been shown to cause lung cancer especially for people heavily exposed in workplaces such as bars and restaurants.

Smokers with other lung disease such as chronic obstructive lung disease (COPD) and diffuse lung fibrosis have a greater risk of lung cancer. Asbestos is the most important occupational risk factor and the risk increases with the level of exposure. Any asbestos-associated risk is greatly increased by smoking. Silica exposure, also common in Australia, is carcinogenic but the effect is less than smoking or asbestos and the interaction with smoking is uncertain.

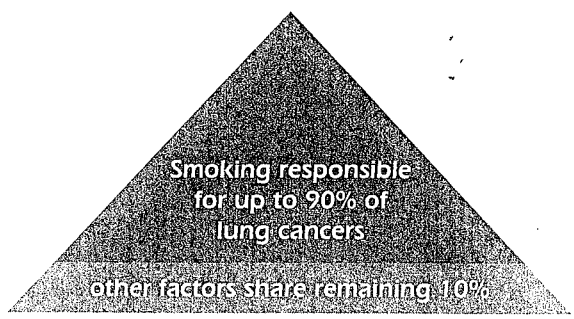
Genetic susceptibility

There is growing evidence that women may be more susceptible to the cancer-causing effects of smoking than men. They develop lung cancer at a younger age than men who have been smoking for the same length of time.

There may be other examples of variability in the genetic susceptibility to smoking but more research is needed.

Risk factors for lung cancer

- ☐ **tobacco smoking**
- ☐ **inhalation of environmental tobacco smoke (passive smoking)**
- ☐ **history of previous lung disease**
- ☐ **medical radiation**
- ☐ **occupational exposure to dusts and fibres e.g. asbestos, silica**



THE SIZE OF THE PROBLEM

A global epidemic

Currently about 1.3 million people worldwide are affected by lung cancer and millions more people are at risk. Yet 100 years ago lung cancer was a rare disease. It was not even classified as a separate disease entity until 1930. Dr Alton Ochsner, a thoracic surgeon, was one of the first US figures to associate smoking with the increasing incidence of lung cancer.

Lung cancer is the leading cause of cancer death.

More than half of all lung cancer patients die within the first year after diagnosis

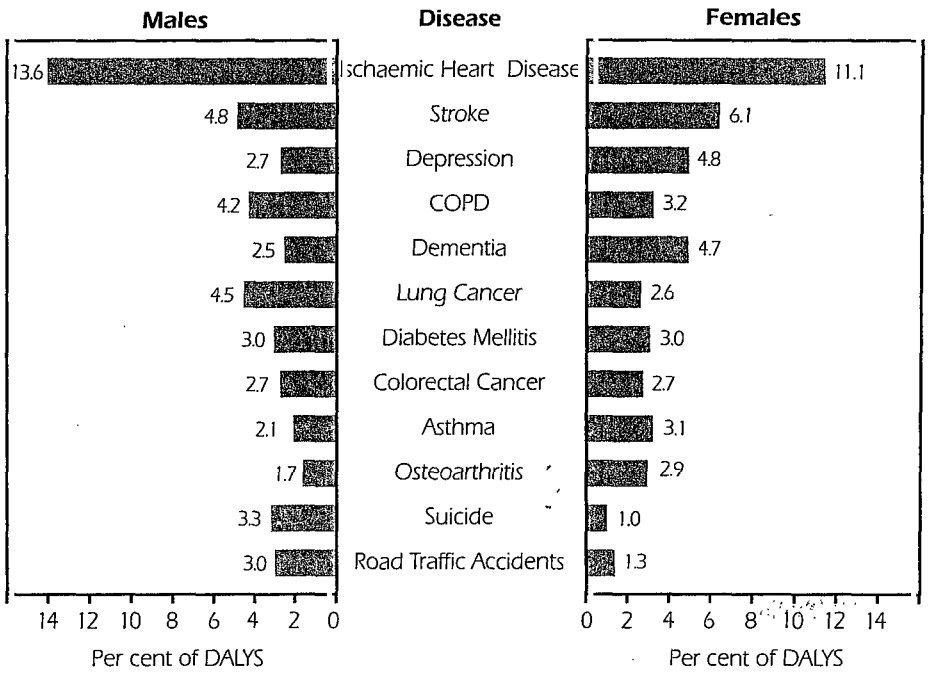
> *"When I was a junior medical student in 1919, the two senior classes were asked to witness the autopsy of a man having died of carcinoma of the lung because ... the Professor of Medicine thought that we might never see another such case as long as we lived. Being young and impressionable this impressed me very much. It was not until 1936, 17 years later, that I saw my next case of bronchogenic carcinoma and then, in a period of 6 months, I saw 9 cases... . All the patients were men, heavy smokers and had begun smoking at the beginning of World War 1."*
>
> *Alton Ochsner, Chest 1971; 59:358-9.*

The impact of lung cancer will escalate worldwide as smoking rates increase in the populous nations of Asia and Africa. It is estimated that 500 million people presently alive will die of smoking-related disease and about 30% of these will be from lung cancer.

Mortality, morbidity & burden of disease

The major impact of lung cancer is through premature mortality rather than as a cause of long-term illness. Each year lung cancer is responsible for about *30,000 years of life lost in males and 15,000 years of life lost in females before* the age of 75.[3]

Leading causes of Disease Burden by Sex, Australia 1996



Note: DALYs are disability adjusted life years. Proportions of total DALYs for each sex are shown.
Source: Mathers C, Vos T, Stevenson C 1999. The burden od disease and injury in Australia. AIHW cat.no PHE 17. Canberra: AIHW.

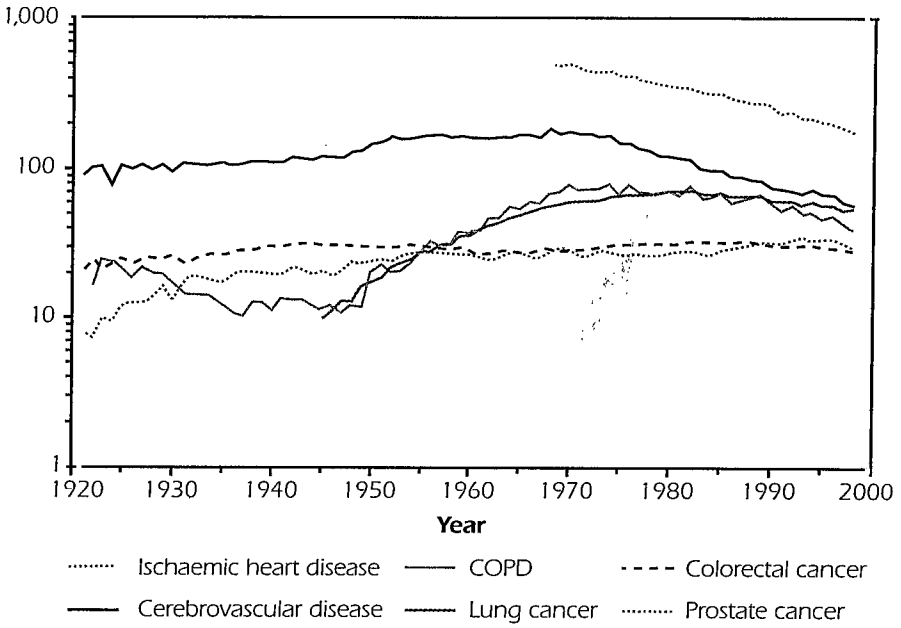
Changing patterns of disease

Lung cancer is no longer a disease confined to older men. Women are increasingly affected.

In 1997, 5,333 Australian males and 2,500 females were diagnosed with lung cancer.[4] In 2000, lung cancer caused the deaths of 4,587 men and 2,291 women. This gender pattern reflects smoking behaviour decades ago when men were almost twice as likely to smoke as women.

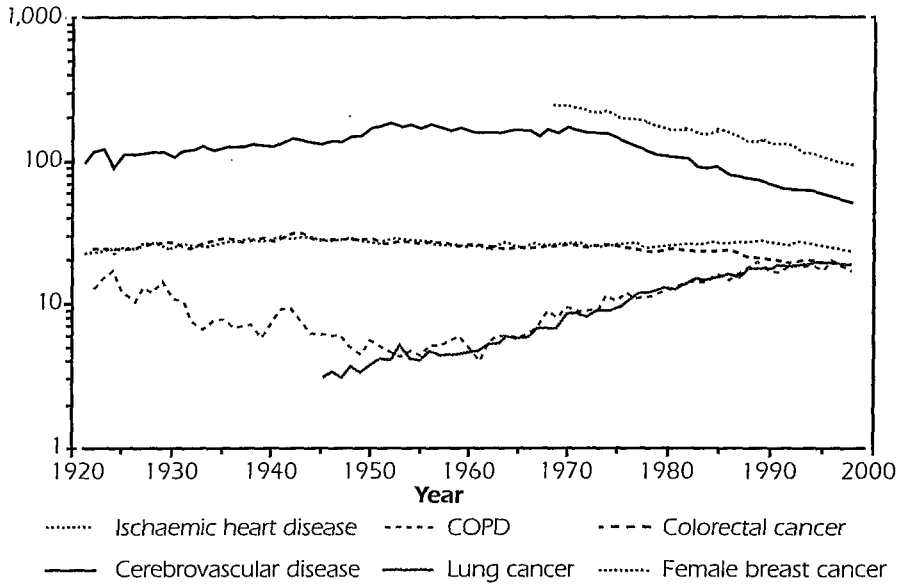
However smoking behaviour has changed and lung cancer statistics provide evidence of the trends. Lung cancer incidence in men has been falling by 1.5% per annum and mortality in men by 2.1% per annum. The decline in incidence has been most marked in younger men.[5] Meanwhile, the incidence of lung cancer in females is increasing by approximately 1.9% per annum and mortality by 1.4% per annum. It is no longer unusual for doctors to see relatively young women with young families affected by lung cancer.

Trends in major causes of death, males, 1921 to 1998



Notes
1.The time series for ischaemic heart disease begins in 1968 due to coding changes between the ICD-8 and previous versions of the ICD.
2. The time series for chronic obstructive pulmonary disease (COPD) breaks at 1979 due to coding changes between the ICD-9 and previous versions of the ICD.
Source: AIHW National Mortality Database

Trends in major causes of death, females, 1921 to 1998
Deaths per 100,000 population



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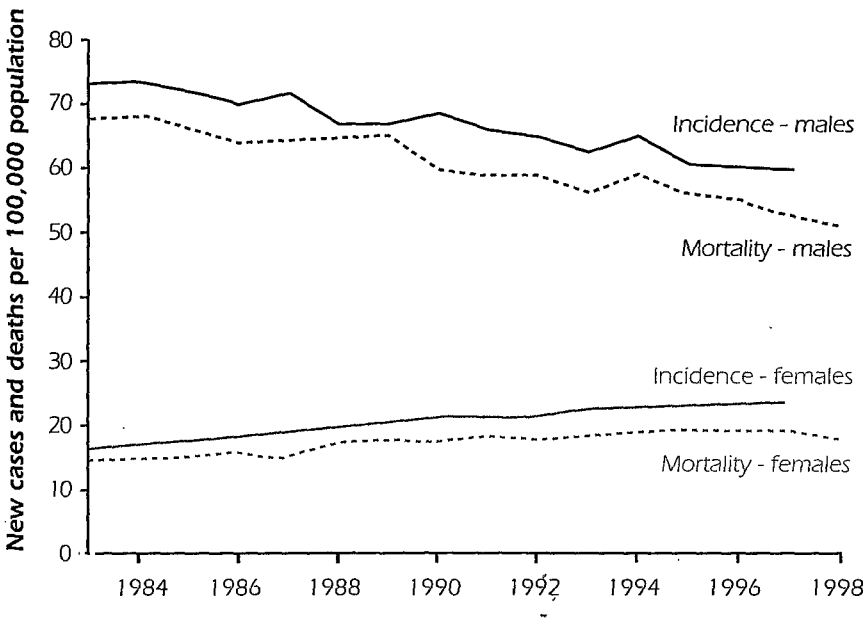
Source: AIHW National Mortality Database

Trends in age-standardised incidence and mortality rates for cancer of the lung, Australia



Source: Cancer in Australia 1997, AIHW & AACR 2000

Lung cancer in indigenous Australians

Aboriginal smoking rates are twice that of the general population.

About half (54% in males, 46% in females) of the adult Aboriginal population are smokers compared to about 25% in the general community. With many smoking by 14 years of age, the age of uptake of smoking is also younger in Aboriginal communities compared to the general population.[6] However lung cancer is not the major smoking-related health issue for indigenous Australians. This is not to say it does not occur, but reflects the multitude of other health problems that cause illness and claim lives at a young age. Importantly, access to services is a major practical constraint for remote indigenous patients.

COST TO THE COMMUNITY

Health system expenditure on lung cancer: $107 million per annum. This will increase as better treatments become available and lung cancer patients survive longer.

Direct costs

The Australian Institute of Health and Welfare ranks lung cancer as the fourth most expensive cancer type behind skin, colorectal and breast cancers. Health system expenditure directed to lung cancer in 1993-94 was estimated at a total of $107 million.[7] More than three quarters of that expenditure was in the provision of hospital care.

Estimated direct costs of lung cancer	($million)
Hospital - public and private hospitals	81
Medical	7
Pharmaceutical	3
Other - includes prevention and research	17
Total	**107**

Lung cancer is almost entirely preventable.

Two major factors reduce the costs associated with lung cancer. The first is that the lack of availability of effective treatment for the majority of patients limits expenditure to relatively cheap forms of supportive care. Secondly, survival from lung cancer is so short that costs are constrained. If the costs per death for lung cancer matched those for colon cancer, the $107 million would blow out to over $300 million.

Indirect costs

Estimations of direct health expenditure do not represent the total economic impact of a disease. Substantial indirect costs can include those related to absenteeism, lost productivity or early loss from the workforce; out of pocket expenses in accessing health services; and the economic and emotional burden of premature mortality and reduced quality of life on family and carers. These costs are difficult to quantify but should not be forgotten when we consider the impact of lung cancer in Australia.

Lung cancer in the context of tobacco-related diseases

Tobacco smoking is responsible for the vast majority of lung cancers. Smoking costs the community about $12.7 billion each year in health care and other related costs.[8] It is the risk factor associated with the greatest burden of disease in Australia, responsible for an estimated 10% of total disease burden, 12% in males and 7% in females.[9] About one-third of the 21,000 deaths estimated to be caused by smoking in Australia each year are from lung cancer.

Impact on the individual

Lung cancer is so common that almost everyone knows someone who has suffered with the disease and probably died. Therefore, the prospect or reality of a diagnosis of lung cancer can be a very distressing experience for both the individual and their family. Because quitting smoking reduces the lung cancer risk substantially, but not entirely, development of lung cancer is particularly cruel for the many former smokers who have responded to public health messages and managed to quit.

People will react differently to their diagnosis. Some may find it difficult to cope and become anxious, depressed or angry. The reality of advanced disease at the time of diagnosis and rapid progression in all too many cases is a huge psychological challenge to those affected. Emotional support, as well as being informed about the disease, its treatment, and the necessity or otherwise of hospitalisation, can be very helpful in assisting patients and their families to come to terms with the diagnosis.

WHAT ISSUES DOES THE LUNG HEALTH COMMUNITY BELIEVE TO BE IMPORTANT?

Delays in diagnosis and treatment, limited treatment options and inadequate investment into lung cancer research have contributed to the poor outcomes experienced by most lung cancer patients. The Australian Lung Foundation has consulted medical and allied health professionals with a special interest in lung cancer on the issues that need to be pursued more vigorously in a national effort to improve lung cancer management.

Prevention is paramount but cannot be the only approach taken. To improve lung cancer outcomes we also have to focus on improving both survival and quality of life.

Where there is effective lung cancer treatment the attitude to treatment of lung cancer patients must be positive. There must be:

- ☐ elimination of inappropriately negative attitudes about the value of treating lung cancer patients in general
- ☐ appropriate early referral to accessible high quality treatment
- ☐ multidisciplinary collaboration in the consideration of treatment options
- ☐ safe delivery of effective care.

Relevant diagnostic tests and treatment should be promptly available.

The fundamental need of post-operative patients with high risk of relapse, and the many people who present with advanced disease, is for more effective treatments both to modify the course of the disease and to improve symptom control.

Prevention

Smoking

Smoking cessation reduces the risk of lung cancer and is beneficial in every individual of any age. Patients who have already developed lung cancer also benefit. Effective tobacco control and smoking prevention strategies are required to reduce lung cancer prevalence and deaths in the short and long term.

Effective smoking cessation measures will deliver benefits more quickly than solely preventing younger people from commencing smoking.

Fewer than 5% of doctors smoke. The Australian Lung Foundation believes that recent community smoking targets of 20% of the general population are clearly inappropriate. We can do better. Well-funded comprehensive tobacco control programs in California and Massachusetts have seen tobacco consumption fall at twice the rate elsewhere in the US.

Strategies such as reducing the affordability and availability of tobacco products, restrictions on tobacco advertising and promotion, and regulation to reduce exposure to environmental tobacco smoke should continue and are largely supported by the community. These strategies can be effective without stigmatising smokers. Well funded, planned and carefully analysed public media campaigns are essential as is the availability of affordable access to nicotine replacement therapies and other pharmaceutical support for smoking cessation. New approaches are clearly needed where smoking prevalence is extremely high such as in Aboriginal and Torres Strait Islanders, young people, those from culturally and linguistically diverse backgrounds and low-income earners.

Other risk factors

Effective ongoing minimisation of exposure to other known risk factors, such as asbestos exposure, is essential.

Early detection

Given the often devastating consequences of late diagnoses of lung cancer, we need to increase our efforts towards early detection. However mass screening by chest x-ray has failed to show a conclusive benefit. More recent studies using computerised tomography (CT) scans to screen for lung cancer have been more promising. CT scans can detect early lung cancers in both current and former smokers and these are generally operable. However the effectiveness of CT can be diminished in populations where there are many benign nodules.

Early detection should improve survival. Screening for lung cancer needs urgent evaluation and would complement tobacco control efforts.

It is premature to advocate mass screening for lung cancer by CT scan in Australia. However the absence of effective treatment for advanced lung cancer increases the moral imperative for the earliest possible evaluation of lung cancer screening in high-risk populations in Australia. It is critical that we begin to evaluate screening in Australia, initially to determine whether or not benign nodules compromise the efficiency of such screening.

Meanwhile, there is no data that supports a role for commercial chest CT scans on the basis that early cancer will be detected. Ad hoc screening contributes nothing to our understanding of effective early detection and, in the absence of effective algorithms for management, may be hazardous.

An issue related to early detection is the need for research that might identify smokers, past or present, at particularly high risk of subsequent lung cancer. By narrowing down the search, other means of early detection will become feasible, more effective and safer.

Management

There have been improvements in the management of lung cancer over the last decade and these are driving the change from a largely nihilistic approach to more active, positive and holistic management of the disease. Yet doctors who face patients with lung cancer are still frustrated that they cannot offer curative treatment to more people. Symptom control and quality of life are important considerations for patients with incurable disease but even these modest goals are not achieved in a significant proportion of patients.

Recent advances

- Overseas evidence suggests access to multidisciplinary management of lung cancer can improve survival. Multidisciplinary care includes physical and psychological treatments, palliative care and other supportive therapy.
- Positron Emission Tomography (PET) scanning is much more effective than CT or bone scans in identifying cancer that has spread beyond the lungs. Research at the Peter McCallum Cancer Institute in Melbourne has found that up to 30% of lung cancer patients thought to have local disease before assessment with PET, actually had metastases in the bone or other organs. PET scanning allows more accurate staging of disease ensuring that patients are offered the most appropriate choice of treatment.
- Different regimens of chemotherapy and radiotherapy (e.g. dose, duration of treatment, time between treatments) and combinations of surgery, chemotherapy and radiotherapy are producing better chances of cure. Doctors and nurses are more skilled in administering these treatments so that side effects are minimised.

- A number of new and targeted biological agents that interfere with tumour cell growth are in clinical trials. Their specific mode of action should help improve treatment outcomes with less toxicity than traditional therapies.
- Minor surgical techniques such as laser therapy and the use of stents are now available to unblock or maintain airways. These treatments can alleviate distressing symptoms and extend life.
- The development of Australia's *Guidelines for the Management of Lung Cancer* provides a useful resource for health practitioners and helps ensure all patients receive optimal treatment.

Issues to be resolved

- Although it has been shown to be a cost-effective management strategy in lung cancer staging, PET is not widely available due to the high cost and limitations to access.
- There is an undersupply of radiotherapy equipment which delays treatment for many cancer patients including those with lung cancer.
- Infrastructure to support a specific clinical trials group for lung cancer would facilitate the design and conduct of research necessary to extend the clinical evidence base.
- New biological agents to treat lung cancer will be expensive. The challenge for the community will be to ensure equity of access to effective new treatments.
- Access to specialist treatment services is a generic problem for people from regional and rural Australia.
- The Australian health care system with its emphasis on fee-for-service does not have an easy means of funding multidisciplinary care. There may be no funding at all for important allied health services.

Treatment advances are happening but access and resource issues will also influence health outcomes.

Closing the funding gap

At present, lung cancer does not generate health costs nor attract research funding commensurate with its importance as the leading cause of cancer deaths. There is a funding gap that needs to be bridged via the prompt availability of new cancer treatment agents and increased funding for lung cancer research.

WHAT IS BEING DONE ABOUT LUNG CANCER?

Global response

Lung cancer is the leading cause of cancer deaths worldwide yet there is no political environment in which it is accorded an appropriate level of priority.

In order to address this problem, the Global Lung Cancer Coalition (GLCC) was established in September 2001. The GLCC and its member organisations such as the Australian Lung Foundation have recognised the burden of this disease and are committed to increasing awareness about this important public health problem.

The GLCC has set specific objectives that include:

- ☐ placing lung cancer squarely on the global health agenda
- ☐ reducing the stigma of lung cancer
- ☐ empowering lung cancer patients to take a more active role in their care
- ☐ effecting change in legislative and regulatory policies to optimise treatment and care of lung cancer patients.

The World Health Organisation has promoted the Framework Convention for Tobacco Control to assist all countries with guidance as to a minimum effective strategy for reducing the future lung cancer burden.

Local response

Cancer councils around the nation have for many years provided information about lung cancer and treatment options as well as support groups for patients and their carers. We are all aware of the important role that survivors of breast cancer play in effective lobbying for improved services for breast cancer patients. Frailty, progressive illness and early mortality mean that it is not easy to assemble a similar group for lung cancer and these issues have denied interested organisations and the community, the compelling advocacy that survivors of other common cancers have been able to provide.

The need to improve access to effective management strategies for early and established disease is pressing. National *Guidelines for the Management of Lung Cancer* were produced in draft form in September 2002 by a multidisciplinary working party of the Australian Cancer Network.[10] These clinical practice guidelines cover topics such as prevention and screening, initial assessment, treatments for non-small cell lung cancer and small cell lung cancer of all stages, alternative and complementary therapies, supportive care and palliative care. Uniform implementation of these guidelines should improve the decisions of healthcare professionals, empower consumers and provide direction for further research and funding.

What is the Government's current view of lung cancer?

Cancer control is a National Health Priority Area and lung cancer is one of eight cancers that have been targeted for action. However while lung cancer is potentially one of the most preventable cancers, expenditure on the tobacco control strategies that could help achieve that goal is disproportionately low.

The federal budget commitments to major public health programs (average annual commitments for 1994-95 to 2002-03), compared with deaths from associated causes, 1998, were[11]:

- $264,706 per death from AIDS on AIDS control
- $20,172 per death from breast cancer on breast cancer-related programs
- $4,525 per death from asthma on asthma management
- $1,438 per death from falls on falls prevention
- $337 per death from tobacco-related disease on tobacco control.

In 1999-2002 the budget commitment to tobacco control decreased further to $112 per death. Despite the recent deaths from lung cancer of some high profile public figures, there has been no funding stimulus. The governmental response has been one of relative inaction.

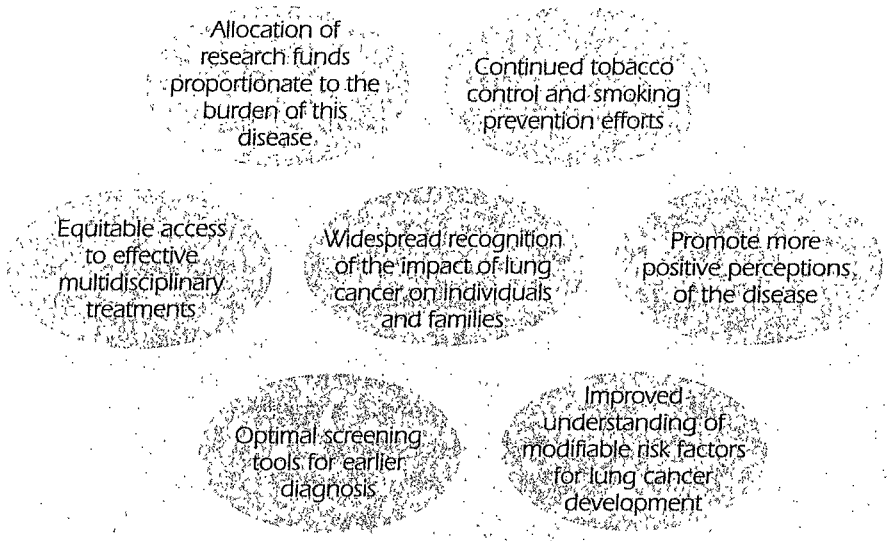
ACTION BY THE AUSTRALIAN LUNG FOUNDATION

In making the comparisons in this document, there is no intent to understate the importance of other diseases. However, the Australian Lung Foundation has a longstanding interest in lung cancer and is committed to furthering the collaborative effort necessary to reduce the impact of this disease.

Initiatives include:

- **LungNet** (established 1997) – an information service and network of lung support groups (currently 85 nationwide). Services include a toll free 1800 number for information and referrals to support groups and pulmonary rehabilitation programs, assistance with establishment of support groups, state-based education seminars and a self-help newsletter for patients and carers.
- **Lung Cancer Consultative Group** (established 2001) - a multidisciplinary group assisting the ALF with the development of lung cancer-related projects. It has a broader based Lung Cancer Advisory Group to ensure that all views are represented.

LUNG CANCER - WHERE DO WE WANT TO GO?



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