RACGP
Royal Australian College
of General Practitioners

13 January 2025

Cancer Australia
Via email: lungcancerscreening@canceraustralia.gov.au

Dear Cancer Australia,

Re: National Lung Cancer Screening Program Guidelines Public Consultation

The Royal Australian College of General Practitioners (RACGP) appreciates the opportunity to provide feedback on the draft *National Lung Cancer Screening Program Guidelines* (guidelines). We highlight challenges and opportunities to ensure the guidelines are effective, equitable and supportive for all health professionals involved in lung cancer screening.

1. The GP role

General practice is central to implementation of the National Lung Cancer Screening program (the program). General practice offers patients a clear route into the program with almost nine in 10 Australians visiting a general practitioner (GP) at least once each year.[1] We also know that a recommendation from a GP is more likely to result in the patient undergoing screening. GPs have knowledge of patients' histories, the ability to field questions specific to individual patient circumstances and undertake shared decision making. GPs are able to follow up on the patient's results and any significant incidental findings (of which there could be many) can be addressed in a timely manner. Ensuring general practice is central to the program and supported in that role will be critical to a successful screening program.

2. Additional workload

As general practice is central to the roll out of the program, GPs (and their teams) will require support to manage the anticipated additional workload, administrative complexity and coordination responsibilities associated with the program. This includes time spent explaining the program to patients, assessing eligibility, managing referrals and following up on results. The impact is likely to be greater in practices who see socioeconomically disadvantaged patients, who are also most likely to be most eligible for screening. These patients often experience multimorbidity at a younger age and have complex mental health and social challenges. This is not an argument against the program, but it does highlight additional workload for GPs is likely underestimated and under-resourced, particularly in practices that already have high and complex workloads.

Recommendation: To address this, we recommend gradual implementation of the program, starting with a soft launch or slow build-up of screening volumes. This could help manage potential increases in workload and allow any issues to be resolved early under lower demand. In addition, the program should evaluate the additional workload of GPs to ensure any future improvements can be considered and implemented.

3. Healthcare provider roles and responsibilities

The professional obligation to follow up test results rests with the initiator of the test. If a non-GP specialist enrols and requests a low-dose computed tomography scan (LDCT) for a patient and identifies the patient's GP to follow up with the patient, it should be clear that the non-GP specialist must do this in consultation with the patient's GP. Ideally the patient should be referred back to their 'usual GP' with whom they have an ongoing relationship to order the LDCT.

4. Communication of results and reminders

- Figure 2 (p26) indicates results will only be communicated by medical practitioners in primary care. There needs to be some clarification on how results will be communicated if the LDCT has been requested by a non-GP specialist.

- Under the section on management of results, follow-up and reminders in Table 1 (p23) - *'Ensure reminders are enabled in participant record in practice software'* implies the GP and not the National Cancer Screening Register (NCSR) is responsible for reminders. Our understanding is that the NCSR sends reminders to participants unless they have opted out. Some clarification will be helpful.

- It will be helpful to include further information on how *'appropriate clinical handover'* (p51) will be achieved. Will the GP be cc'd into the NCSR report and also separately notified that the report is being sent? As an example, issues may arise if correspondence from a hospital outpatient department to the GP is delayed.

5. Radiology provider & respiratory physician list

It is unclear whether GPs will be responsible for collating their own list of radiology providers who offer screening and whether private CT providers will engage in screening. Additionally, GPs may need to spend time finding respiratory physicians who are linked to a lung cancer multidisciplinary team. This potentially places an administrative burden on GPs to ensure the most suitable provider is identified in the best interest of the patient.

Recommendation: To address this, we recommend the government establish and maintain an accessible database of registered screening providers and physicians who are linked to a lung cancer multidisciplinary team.

6. People with serious mental illness and substance use disorders

People with serious mental illness and substance use disorders have not been included in the guidelines. These groups should be included as they often face a life expectancy gap due to cardiometabolic syndromes and high smoking rates. They have historically been hard to reach, and the program should ensure care is provided without stigma, in line with principles underpinning the program.

Recommendation: Consider including people with serious mental illness and substance use disorders within the priority population groups who need to be supported.

7. Incidental findings

It is anticipated that many LDCT scans will return incidental findings such as coronary calcification, emphysema or osteoporotic fractures. International studies have demonstrated clinically significant iincidental findings are picked up on LDCT scans for lung cancer screening, and their potential impact should be considered.[2] Incidental findings could lead to increased patient and health provider anxiety, particularly when there are unclear referral pathways or potential for harms and unaffordable costs to patients (for comments on costs, see point 8 below on 'Ethical concerns and financial barriers')**.** The current guidance to address these findings through '*usual care*' is insufficient. Furthermore, it is unclear what threshold will be used for reporting findings of such incidents.

There is an opportunity for the information collected from the lung cancer screening test to provide additional information about a patient's health and wellbeing (for example other lung disease or coronary calcium score). Although this isn't the primary objective of the screening program consideration should be made to provide a comprehensive report from diagnostic imaging. This would maximise its value and of the screening program resources.

Recommendation: To address this, we recommend developing accessible guidelines for managing common incidental findings, tailored to different settings including rural and regional areas. These guidelines should be developed with input from GPs to ensure they are practical and relevant to the needs of primary care providers.

8. Ethical concerns and financial barriers

There are concerns surrounding the promotion of lung cancer screening, particularly when financial barriers are not clearly addressed. The mention of *'possible financial costs'* in the shared decision-making process raises issues for patients who may decide not to proceed with treatment purely due to cost, or for those who may struggle to afford follow-up care after a high-risk result. This situation creates an ethical dilemma, as patients could be forced to make decisions based on their financial limitations. This could also apply for incidental findings discussed in point 7 above.

Full financial disclosure must be provided to participants. While the screening scan itself would be free (bulk-billed), additional costs could arise. For example, consultations with GPs before and after the scan, consultations with respiratory physicians, subsequent CT scans, and any investigations or referrals for incidental findings may not always be bulk-billed, resulting in out of pocket expenses. This is especially concerning in rural and regional areas, where patients may need to travel long distances for follow-up care, potentially leading to further financial strain.

9. Integration with My Health Record and general practice clinical information systems

While we are pleased to note this program will be supported in the NCSR, the RACGP has previously noted ongoing issues with integration of the NCSR into general practice clinical information systems. If not already addressed, there needs to be appropriate attention and rectification of any issues to ensure seamless access and reporting is achieved. Clinical information system vendors will also have to implement relevant updates to accommodate this

Uploading to the My Health Record would be part of usual care when ordering any radiological investigations, but the guidelines do not clearly state that radiology providers will need to upload screening results to My Health Record.

Recommendation: The guidelines clearly state there should be an automated upload of results to My Health Record.

10. Aboriginal and Torres Strait Islander peoples

As the guidelines highlight the importance of culturally safe care, these statements must be accompanied by practical guidance or resources. Without this, the guidelines may not result in meaningful changes.

Recommendation: To improve delivery, the program should provide tools, training and accountability measures to ensure culturally safe care is effectively operationalised in services.

11. General comments

- The program does not direct much resourcing towards providing ongoing care as part of the program. It is not clear what plans are in place to ensure increased capacity in general practices, ACCHOs, radiology services, respiratory specialists, oncology departments or lung function services to accommodate the additional workload, when we know that services (with probably the exception of ACCHOs) are distributed in inverse proportion to need.

- The term '*30 pack year*' is not clearly defined. As this is a key metric for determining eligibility for screening, it is important that it is clearly explained, especially for individuals who smoke. It may also be helpful to provide links to a relevant calculator.

- It is unclear if the reporting of LDCT findings from radiology providers will be comprehensive enough to address additional clinical questions that may arise. For example, if there is concern over possible interstitial lung disease. We recommend comprehensive reports are provided to avoid the need for duplicate lung imaging.

- It may be more appropriate to use the wording *'a bulk-billed low dose CT'* instead of *'free low dose CT'* to indicate there is no out of pocket expense for the patient.

- Healthcare providers across secondary and tertiary healthcare settings are integral for the recruitment and delivery of the program but are not all authorised to request a LDCT – how will the LDCT scan be requested in such circumstances?

- p31 Practice points – Reassessment – It may be helpful to include a reminder in the electronic medical record on when to reassess the patient

- p32 Resources section– Consider including a link to a calculator and tobacco equivalents chart in the section for healthcare providers

Thank you again for the opportunity to provide feedback. If you have any questions regarding our submission, please contact Mr Stephan Groombridge, National Manager, e-health, Quality Care & Standards at stephan.groombridge@racgp.org.au or (03) 8699 0544.

Yours sincerely

Dr Michael Wright
President

References

1. AIHW (2020b) Medicare-subsidised GP, allied health and specialist health care across local areas: 2013–14 to 2018–19, AIHW.

2. Morgan L, Choi H, Reid M, Khawaja A and Mazzone PJ. Frequency of Incidental Findings and Subsequent Evaluation in Low-Dose Computed Tomographic Scans for Lung Cancer Screening; Ann American Thoracic Society 2017;14(9):1450-1456