Australian Government
Australian Institute of Health and Welfare

National Bowel Cancer Screening Program monitoring report 2026

Web report | Last updated: **18 Jun 2026** | Topic: Cancer screening | Media release

About

This report presents statistics on the National Bowel Cancer Screening Program (NBCSP) using key performance indicators. Of those who were invited to participate in the NBCSP between 1 January 2023 and 31 December 2024, 42% undertook screening. Among those who screened in 2024, 6% had a positive result warranting further assessment. Of the participants who underwent a follow-up diagnostic assessment, 1 in 29 was diagnosed with a confirmed or suspected cancer.

Cat. no: CAN 172

Key findings

- 42% of the 6.4 million people invited to screen between January 2023 and December 2024 participated in the NBCSP
- 1 in 29 people assessed after a positive NBCSP screen were diagnosed with a confirmed or suspected bowel cancer in 2024
- Aboriginal and Torres Strait Islander people had a higher positive screen rate, but a lower follow-up assessment rate
- 17,378 bowel cancers have been detected through the NBCSP since it began in August 2006

Summary

It is estimated that in 2025 about 6,941 people aged 50–74 were diagnosed with bowel cancer (around 47% of all bowel cancers diagnosed) and 1,779 people in this age group died from the disease (around 34% of all bowel cancer deaths).

The National Bowel Cancer Screening Program (NBCSP) began in 2006. It aims to reduce the morbidity and mortality from bowel cancer by actively recruiting and screening the target population, aged 45–74, for early detection or prevention of the disease.

This report presents the latest data on eligible Australians aged 50-74 years against the NBCSP key performance indicators (AIHW 2014). While the latest data are to December 2025, the year for which each performance indicator are reported can vary to ensure that the most recent data are used for each indicator.

Currently, the NBCSP mails a free bowel screening kit to eligible Australians aged 50-74 years every two years. Since 1 July 2024, those aged 45–49 have also been eligible to participate in the NBCSP by requesting a kit from the National Cancer Screening Register. This newly eligible cohort are not included in the main NBCSP key performance indicators presented in the report, but initial data on their interaction with the program are included under Data at a glance.

How many people participated?

Of the 6.4 million people invited between January 2023 and December 2024, 42.0% participated in the program. The national participation rate was slightly higher than the previous rolling 2-year period (41.7% in 2022–2023). The re-participation rate for those who took part in their previous invitation round and received a subsequent screening invitation was 83.5% (83.0% in 2022–2023). For those who had ever previously participated, the re-participation rate was 73.4%.

Screening results in 2024

In 2024, 73,745 Australians returned a positive screening test, giving a 5.8% screening positivity rate. Of those who received a positive screening test, 85.4% reported a follow-up diagnostic assessment. The median time from positive screening test result to diagnostic assessment was 62 days.

Cancers and adenomas detected in 2024

Matched national cancer diagnosis data were not available for those who screened later than 2019. However, of the outcome data available from NBCSP assessment form return, for participants who had a diagnostic assessment in 2024, 1 in 29 were diagnosed with a confirmed or suspected cancer (195 and 470, respectively) and 1 in 3 were diagnosed with an adenoma (5,911 participants). Adenomas are benign growths with potential to become cancerous; their removal lowers the risk of future bowel cancers developing.

Variation across population groups

Participants who identified as being of Aboriginal and/or Torres Strait Islander origin, those who lived in *Very remote* areas, and those who lived in low socioeconomic areas, all had higher rates of positive screens (warranting further assessment), but lower rates of follow-up diagnostic assessment, and a longer median time between a positive screen and assessment.

Since the NBCSP began

Since the program began in August 2006, about 14.3 million NBCSP screening tests have been completed, with about 5.4 million people participating at least once. Due to the improvement in bowel cancer outcomes data in the previous report, it is now known that at least 17,378 bowel cancers have been diagnosed through screening in the NBCSP.

The AIHW has previously conducted studies of people diagnosed with bowel cancer between 2006 and 2010. These studies showed that NBCSP invitees (particularly those who participated) who were diagnosed with bowel cancer had a lower risk of dying from the disease and were more likely to have less advanced bowel cancers when diagnosed. These findings show that the NBCSP is contributing to reducing morbidity and mortality from bowel cancer in Australia (AIHW 2018a, 2018b).

References

AIHW (2014) *Key performance indicators for the National Bowel Cancer Screening Program: technical report*, AIHW, Australian Government, accessed 09 May 2022.

AIHW (2018a) *Analysis of bowel cancer outcomes for the National Bowel Cancer Screening Program 2018*, AIHW, Australian Government, accessed 09 May 2022.

AIHW (2018b) *Analysis of cancer outcomes and screening behaviour for national cancer screening programs in Australia*, AIHW, Australian Government, accessed 09 May 2022.

Data at a glance

Latest NBCSP performance indicator results

To ensure that the most recent data are used for each indicator, the time frame in which each is analysed can vary. However, where possible, analysis for indicators includes the period from 1 January 2023 to 31 December 2025.

Table 1: NBCSP performance indicator and latest results, Australia

Performance indicator (PI)[a]	Previous period	Current period	Trend
PI 1 - Participation rate The percentage of people invited to screen through the NBCSP between **1 January 2023 and 31 December 2024** who returned a completed screening test within that period or by **30 June 2025**.	41.7%	42.0%	Increase 
PI 2 - Screening positivity rate The percentage of people who returned a valid NBCSP screening test and received a positive screening result (warranting further assessment) between **1 January 2024 and 31 December 2024**.	5.9%	5.8%	No change 
PI 3 - Diagnostic assessment rate The percentage of people who returned a positive NBCSP screening test (warranting further assessment) between **1 January 2024 and 31 December 2024** and had follow-up diagnostic assessment within that period or by **31 December 2025**.	85.9%	85.4%	No change 
PI 4 - Time between positive screen and diagnostic assessment For those who received a positive NBCSP screening test (warranting further assessment) between **1 January 2024 and 31 December 2024**, the median time between the positive screen and a follow-up diagnostic assessment within that period or by **31 December 2025**.	62 days	62 days	No change 
PI 5a - Adenoma detection rate The proportion of people who returned a valid NBCSP screening test between **1 January 2024 and 31 December 2024** who were diagnosed with an adenoma within that period or by **31 December 2025**.	n.a.	n.a.	Status not known 
PI 5b - Positive predictive value of diagnostic assessment for detecting adenoma The percentage of people who returned a positive NBCSP screening test (warranting further assessment) between **1 January 2024 and 31 December 2024** that underwent a diagnostic assessment and were diagnosed with an adenoma by **31 December 2025**.	n.a.	n.a.	Status not known 
PI 6a - Bowel cancer detection rate The proportion of people who returned a valid NBCSP screening test between **1 January 2019 and 31 December 2019** and were diagnosed with a screen-detected bowel cancer by **31 December 2020**.	n.a.	20.3 per 10,000 screened	Status not known[b] 
PI 6b - Positive predictive value of diagnostic assessment for detecting bowel cancer The percentage of people who returned a positive NBCSP screening test (warranting further assessment) between **1 January 2019 and 31 December 2019** that underwent a diagnostic assessment and were diagnosed with cancer by **31 December 2020**.	n.a.	3.8%	Status not known[b] 

PI 7 - Interval cancer rate The proportion of people who returned a NBCSP screening test between **1 January 2018 and 31 December 2018** who were diagnosed with bowel cancer (not involving a positive NBCSP screen and positive assessment) in the following 24-month period, or before their next screen, whichever comes first.	n.a.	6.3 per 10,000 negative/ inclusive screens	Status not known[b] 
PI 8 - Cancer clinico-pathological stage distribution The percentage of people who had received a NBCSP invite and were later diagnosed with bowel cancer between **1 January 2024 and 31 December 2024**, by clinico-pathological stage (either Stage I, Stage II, Stage III, Stage IV, Stage unknown or inadequately staged).	n.a.	n.a.	Status not known 
PI 9 - Adverse events – hospital admission The rate at which people who had a diagnostic assessment between **1 January 2024 and 31 December 2024** were admitted to hospital within 30 days of their assessment.	0.4 per 10,000 assessments	0.5 per 10,000 assessments	Status not known[c] 
PI 10 - Incidence of bowel cancer The (estimated) age-standardised incidence rate of bowel cancer per 100,000 estimated resident population aged 50–74 in **2025**[d].	96 cases per 100,000 people	91 cases per 100,000 people	Decrease 
PI 11 - Mortality from bowel cancer The (estimated) age-standardised mortality rate of bowel cancer per 100,000 estimated resident population aged 50–74 in **2025**[d].	23 deaths per 100,000 people	23 deaths per 100,000 people	No change 

a. PI – performance indicator. Hereafter in this report, the abbreviation is used when referring to a specific indicator (for example, PI 3 Diagnostic assessment rate); otherwise, the full expression is used.
b. These data not updated from the 2025 monitoring report. Previous period data not available to allow trends.
c. Data are not complete enough to allow trends.
d. Age-standardised rates for 2025 are estimated based on 2012–2021 data for incidence and 2014–2023 data for mortality. See Appendix A for further details.

Notes:

1. PIs 3–9 rely on information being reported to the National Cancer Screening Register (NCSR). As the return of NBCSP forms is required (ACSQHC 2020) but not mandated by the NBCSP, there may be incomplete form return and incomplete data. However, Participant follow-up function (PFUF) data are now used to supplement missing colonoscopy form data. See Current reporting limitations for more details.
2. PI 5a (adenoma detection rate), PI 5b (positive predictive value, or PPV, of diagnostic assessment for detecting adenoma and PI 8 (cancer clinico-pathological stage distribution) are not reported due to data incompleteness or unavailability. See Current reporting limitations for more details.

References

ACSQHC (Australian Commission on Safety and Quality in Health Care) (2020) *Colonoscopy Clinical Care Standard*, Australian Commission on Safety and Quality in Health Care, Sydney, accessed 14 May 2025.

Kit requests for those aged 45–49, July 2024–December 2025

Those aged 45–49 became eligible to request an immunochemical faecal occult blood test (iFOBT) screening kit from the National Cancer Screening Register from 1 July 2024. This newly eligible age group is reported separately from the 50–74 age group in this report. Data for kit requests, returns and available assessment outcomes are presented in Tables 2 and 3. However, outcome data for those who requested or returned their screening kit later in the timeframe reported will be incomplete.

Table 2: iFOBT kit requests and screening outcomes of eligible people aged 45–49, by 6-month period, sex, age and state or territory, Australia, July 2024–December 2025

Group		Kit requests	Kits returned (%)	Positivity (%)
Period	Jul–Dec 2024	78,079	62.7	4.9
	Jan–Jun 2025	95,919	55.7	4.6
	Jul–Dec 2025	62,423	48.9	4.6
Sex	Males	114,029	55.2	5.3
	Females	122,392	57.2	4.2
Age	45	57,912	57.0	4.5
	46	49,231	54.7	4.5
	47	47,808	55.6	4.7
	48	45,645	56.0	4.8
	49	35,825	58.2	5.2
State or territory	NSW	69,188	55.0	4.5
	Vic	62,454	57.4	4.7
	Qld	47,011	54.3	4.9
	WA	27,729	57.4	5.0
	SA	18,250	58.9	4.5
	Tas	5,468	57.9	5.6
	ACT	5,495	58.5	3.9
	NT	826	50.1	6.1
Total	**Australia**	**236,421**	**56.2**	**4.7**

Source: Table A5.1.

Table 3: Known assessment outcomes of people aged 45–49, by sex, Australia, July 2024–December 2025

Category	Males (Number)	Males (%)	Females (Number)	Females (%)	Persons (Number)	Persons (%)
Assessments[(a)]	630	.	577	.	**1,207**	**.**
No issue[(a)]	178	28.3	216	37.4	**394**	**32.6**
Awaiting histopathology[(b)]	183	29.1	162	28.1	**345**	**28.6**
Other diagnosis[(c)]	18	2.9	15	2.6	**33**	**2.7**
Adenoma[(d)]	231	36.7	165	28.6	**396**	**32.8**
Suspected cancer[(e)]	13	2.1	14	2.4	**27**	**2.2**
Confirmed cancer[(f)]	7	1.1	5	0.9	**12**	**1.0**

a. Excludes 3,654 colonoscopies with no record of outcome, such as those reported by Medicare claim (1,789), or by PFUF only (1,865). 'No issue' recorded when no cancers, adenomas, polyps or other diagnoses were noted at colonoscopy and/or histopathology.
b. Polyps detected at assessment and sent to histopathology for analysis. No histopathology report form received by Register.
c. A non-cancer, non-adenoma diagnosis was recorded at colonoscopy.
d. Confirmed adenoma figures were based on a combination of the assessment and histopathology report forms for a person received by the NCSR.
e. Cancer suspected at assessment but not yet confirmed by histopathology.
f. Cancer confirmed by histopathology.

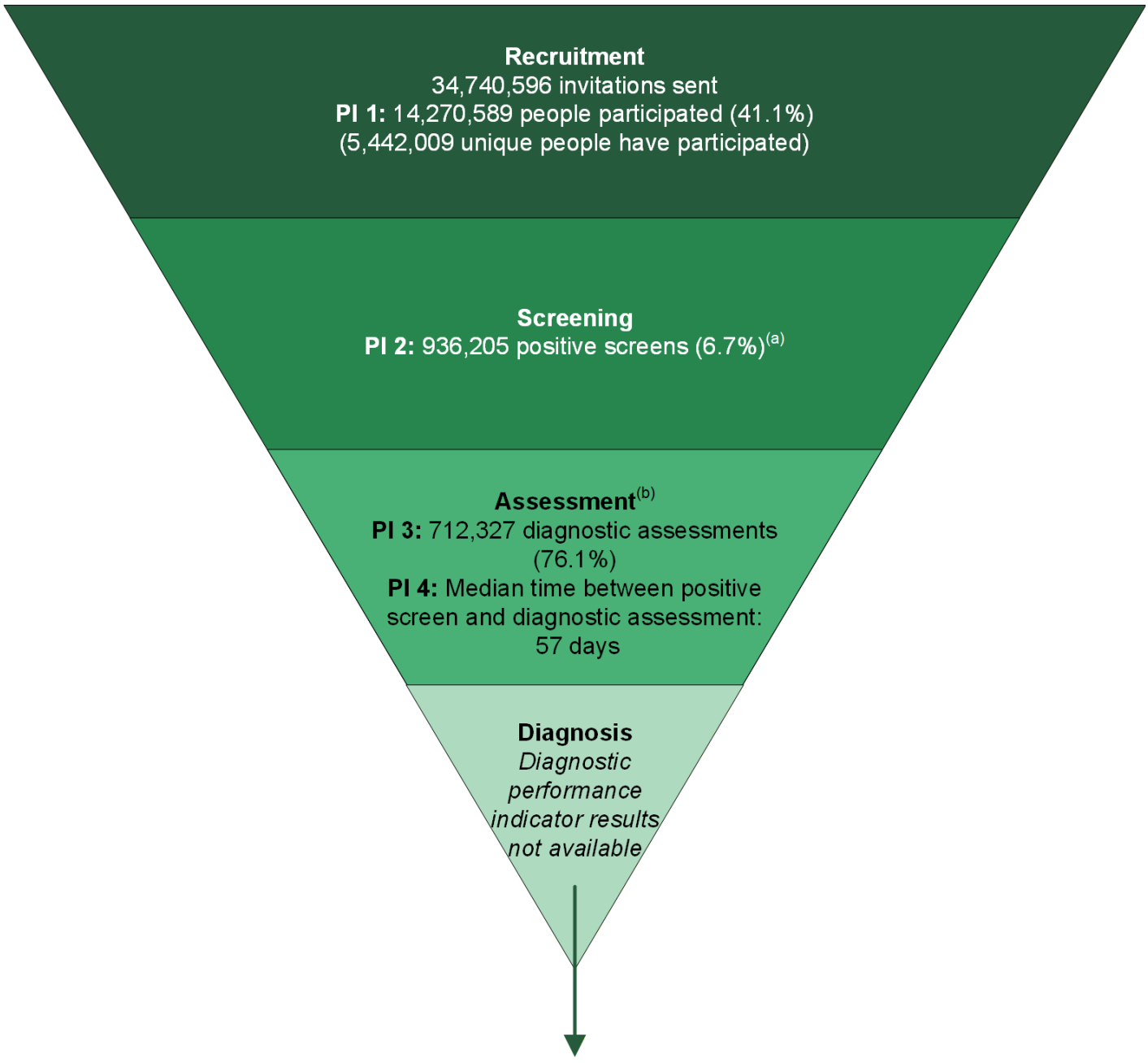
Note: Outcome data for those with a positive screen late in the reporting period may not yet be available.

Source: Table A5.2.

Overall NBCSP outcomes from 2006 to 2025

The Population Based Screening Framework (Standing Committee on Screening 2018) uses 5 incremental stages to describe a population screening pathway. The performance indicator data in this monitoring report have been applied to these stages (Figure 1), and this shows how the indicators relate to the framework over the timeframe of the NBCSP to date (2006 to 2025).

Figure 1: Summary of NBCSP performance indicators between August 2006 and June 2025



***Assessment details*[(c)]**

No issue, or other diagnosis	153,438	(40.5%)
Polyp awaiting histopathology	122,631	(32.4%)
Non-advanced adenomas	35,781	(9.5%)
Advanced adenomas	42,066	(11.1%)
Suspected cancer	7,206	(1.9%)
Confirmed cancer	17,378[(d)]	(4.6%)

a. Based on the 14,045,834 participants who returned a valid iFOBT.
b. Information on colonoscopies known through MBS claim only prior to 2018 is not included; PI 3 and PI 4 may be under-reported. Count also includes colonoscopies, from 2021 onwards, that were notified through PFUF data.
c. Based on available outcome data. Excludes 333,827 assessments with no record of outcome.
d. Includes improved data from notifiable bowel cancer diagnoses (Australian Cancer Database), to 2021 only.

Notes:

1. PI 1: 'people participated' counts the people who participated over the time the NBCSP has been operating. It is not a unique count of people, and people who participated multiple times over several years were counted more than once. 'Unique people participated' counts each unique person who has participated in the program at least once.
2. Assessment and diagnosis (PIs 3–9) rely on information being reported to the NCSR. As return of NBCSP forms is required (ACSQHC 2020) but not mandated by the NBCSP, there may be incomplete form return and incomplete data. See Current reporting limitations for more details.
3. PI 5a (adenoma detection rate), PI 5b (PPV of diagnostic assessment for detecting adenoma), and PI 8 (cancer clinico-pathological stage distribution) are not reported due to data incompleteness or unavailability. See Current reporting limitations for more details.

Source: AIHW analysis of NCSR as at 31 December 2025 (NCSR RDE 6/02/2026).

References

ACSQHC (Australian Commission on Safety and Quality in Health Care) (2020) *Colonoscopy Clinical Care Standard*, Australian Commission on Safety and Quality in Health Care, Sydney, accessed 14 May 2025.

Standing Committee on Screening (2018) *Population Based Screening Framework. Report prepared for the Community Care and Population Health Principal Committee of the Australian Health Ministers' Advisory Council*, Department of Health, Australian Government, accessed 18 April 2023

Introduction

Purpose of this report

This report is the eleventh to monitor data for the National Bowel Cancer Screening Program (NBCSP), based on the current NBCSP key performance indicators (AIHW 2014). To ensure that the most recent data are used for each indicator, the time frame in which each is analysed can vary. However, where possible, analysis for indicators includes the period from 1 January 2023 to 31 December 2025.

Background information and facts on bowel cancer are presented first, then the latest performance indicator results. Also included is a summary chapter focusing on equity across population groups. Lastly, initial information on screening kit requests is presented for those aged 45–49 who, from 1 July 2024, were eligible to request NBCSP screening kits.

Note tables referred to in this report that have an 'A' preceding the table number (for example, Table **A3.1**) can be found in the accompanying Appendix Excel spreadsheet.

References

AIHW (2014) *Key performance indicators for the National Bowel Cancer Screening Program: technical report*, AIHW, Australian Government, accessed 09 May 2022.

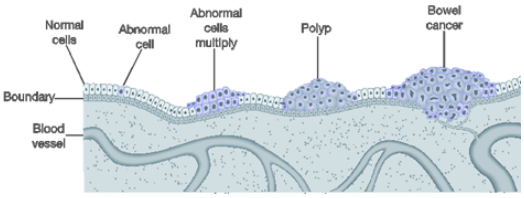
Bowel cancer facts

In this section

Defining bowel cancer

Bowel cancer (or colorectal cancer) generally develops through a multistage process in which a series of cellular mutations occurs over time. Most bowel cancers start in the epithelial cells, which form part of the inner lining of the large bowel (intestinal mucosa layer). Early stages of these mutations result in benign polyps. However, a polyp may mutate further and become a benign adenoma and, ultimately, a malignant bowel cancer (Figure 1.1). Later stages of bowel cancer can spread to other sites in the body through the lymphatic or vascular system.

Figure 1.1: Beginnings of bowel cancer



Cancer stage

Bowel cancer stage describes the extent or spread of cancer in the body at diagnosis. Staging is usually based on the size of the tumour, whether lymph nodes contain cancer, and whether the cancer has spread from the original site to other parts of the body (Brierley et al. 2016). Cancer Australia, in consultation with state and territory cancer registries and the Australian Institute of Health and Welfare (AIHW), developed cancer staging rules for high-incidence cancers (including bowel cancer). These registry-defined cancer stages are closely related to the Tumour, Nodes and Metastasis (TNM) Classification of Malignant Tumours. Prognosis is often related to what stage of development the cancer has reached when first diagnosed, with smaller, less developed cancers having better prognoses than advanced cancers (Table 1.1).

Table 1.1: 5-year relative survival by registry-derived bowel cancer stages, Australia, 2011

Registry-derived Australia stage	Description	5-year relative survival estimates
I	Stage I – equivalent to TNM stage I: early stage Cancer has invaded several layers of the bowel, but has not spread outside the bowel wall	99%
II	Stage II – equivalent to TNM stage II: early stage Cancer has grown through the muscle layer of the bowel or rectum and invaded nearby tissues, but has not spread to the lymph nodes	89%
III	Stage III – equivalent to TNM stage III: locally advanced Cancer has spread to nearby lymph nodes, but not to other parts of the body	71%
IV	Stage IV – equivalent to TNM stage IV: metastatic Cancer has spread from where it started in the colon or rectum to other organs, often the liver and lungs, and/or non-regional lymph nodes	13%

Note: Descriptions and 5-year relative survival estimates were sourced from 2011 Australian stage data (AIHW 2019). While almost all other cancer incidence data are updated annually, more recent incidence data by cancer stage is not yet available.

Risk factors for bowel cancer

A risk factor is any factor associated with an increased likelihood of a person developing a health disorder or health condition. It is not known what causes bowel cancer; however, the risk of the disease increases with increasing age. Several other risk factors have been identified that may increase the chance of developing the disease – see Box 1.1 (AIHW 2021; Bouvard et al. 2015; Dekker et al. 2019; Song et al. 2015; WCRF 2025).

Box 1.1: Risk factors for bowel cancer

Behavioural and biomedical factors

Personal and lifestyle factors associated with an increased risk of bowel cancer include:

- dietary risks (diet high in red meat, processed meat, and sugar sweetened beverages; diet low in whole grains, high-fibre cereals, fruit and vegetables, and foods and beverages containing calcium such as dairy products)
- overweight and obesity
- physical inactivity

- alcohol use
- tobacco use
- long term health conditions, including high blood plasma glucose (including type 2 diabetes) or an inflammatory bowel disease such as Crohn's disease or ulcerative colitis
- occupational hazards and exposures.

Family history and genetic susceptibility

Some genetic mutations increase the risk of bowel cancers, and these can also be passed from parent to child. Between 12% and 35% of bowel cancers can be attributed to a hereditary component (Dekker et al. 2019).

Bowel cancer treatment

The aim of bowel cancer treatment is generally to remove the cancer and any cancer cells that may be left in the bowel or other parts of the body. However, treatment can vary based on individual factors, such as the type of cells involved, the size of the tumour, and the bowel cancer stage. Treatment of bowel cancer commonly involves surgery to remove the cancer, with or without chemotherapy or radiation therapy. Some treatment may also be palliative.

Early diagnosis of bowel cancer can improve treatment outcomes and survival. Further, removal of polyps and adenomas (polypectomy) during a colonoscopy reduces the risk of them developing into bowel cancer. The excision of adenomatous polyps, together with regular surveillance, has been found to reduce bowel cancer incidence and mortality (Dekker et al. 2019).

References

AIHW (2019) Cancer in Australia 2019, AIHW, Australian Government, accessed 09 May 2025. doi:10.25816/5ebcc7a7fa7e9

AIHW (2021) Australian Burden of Disease Study: methods and supplementary material 2018, AIHW, Australian Government, accessed 09 May 2022.

Bouvard V, Loomis D, Guyton KZ, Grosse Y, Ghissassi FE, Benbrahim-Tallaa L et al. (2015) 'Carcinogenicity of consumption of red and processed meat', *The Lancet Oncology*, 16(16):1599–1600.

Brierley JD, Gospodarowicz M and Wittekind C (eds) (2016) *TNM classification of malignant tumours, 8th edn*, Union for International Cancer Control, Oxford.

Dekker E, Tanis PJ, Vleugels JLA, Kasi PM and Wallace MB (2019) 'Colorectal cancer', *The Lancet*, 394:1467–1480.

Song M, Garrett WS and Chan AT (2015) 'Nutrients, foods, and colorectal cancer prevention', *Gastroenterology*, 148:1244–60.e16.

World Cancer Research Fund International (WCRF) (2025) Dietary and lifestyle patterns for cancer prevention: evidence and recommendations from CUP Global. WCRF, accessed 01 May 2026.

Bowel cancer screening

Bowel cancer may be present for many years before a person shows symptoms, such as visible rectal bleeding, change in bowel habit, bowel obstruction, or anaemia. Often, symptoms such as these are not exhibited until the cancer has reached a relatively advanced stage. However, non-visible bleeding of the bowel may occur in the precancerous stages (Figure 1.1) for some time. The relatively slow development of most bowel cancers means that precancerous polyps and adenomas, and early-stage cancers, can potentially be screened for and treated. This makes bowel cancer a valid candidate for population screening (Standing Committee on Screening 2018).

An immunochemical faecal occult blood test (iFOBT) is a common method of bowel cancer screening (Schreuders et al. 2015). An iFOBT is a non-invasive test that can detect microscopic amounts of blood in a sample from a bowel motion, which may indicate a bowel abnormality, such as an adenoma or cancer.

National Bowel Cancer Screening Program

In Australia, government-funded, population-based bowel cancer screening has been available through the NBCSP since 2006. The NBCSP is funded and managed by the Australian Government Department of Health, Disability and Ageing and delivered through the National Cancer Screening Register (NCSR, November 2019 to present), with support from state and territory governments. The NBCSP aims to reduce the incidence of, and illness and mortality related to, bowel cancer in Australia through screening to detect cancers and pre-cancerous lesions in their early stages, when treatment will be most successful.

Target population

The NBCSP's target population list is compiled from those registered on a green Medicare card or a Department of Veterans' Affairs gold card.

The target population is informed by the National Health and Medical Research Council-endorsed *Clinical practice guidelines for the prevention, early detection and management of colorectal cancer* (guidelines). The *Population Screening* chapter of the guidelines was updated in 2023 to recommend that biennial iFOBT screening for the asymptomatic Australian population be offered from age 45 and continue to age 74 (previously 50–74) (CCACCSWP 2023). Since 1 July 2024, eligible people aged 45–49 have been able to request their first NBCSP kit from the program, or their doctor. The eligible 45–49 age group is not included in the performance indicator reporting in this report (which remains focused on the target 50–74 age group) but is reported separately. See Kit requests for those aged 45–49, July 2024 to December 2025.

Table 1.2 outlines the starting dates of each phase of the NBCSP and the target age groups.

Table 1.2: NBCSP phases and target populations

Phase	Start date	Target ages (years)
1	7 August 2006	55 and 65
2	1 July 2008[a]	50, 55 and 65
2[b]	1 July 2011	50, 55 and 65
3	1 July 2013	50, 55, 60 and 65
4	1 January 2015	50, 55, 60, 65, 70 and 74
4	1 January 2016	50, 55, 60, 64, 65, 70, 72 and 74
4	1 January 2017	50, 54, 55, 58, 60, 64, 68, 70, 72 and 74
4	1 January 2018	50, 54, 58, 60, 62, 64, 66, 68, 70, 72 and 74
4	1 January 2019	50, 52, 54, 56, 58, 60, 62, 64, 66, 68, 70, 72 and 74
5[c]	1 July 2024	45–49 (eligible), 50–74 (target)

a. Eligible birth dates, and thus invitations, ended on 31 December 2010.
b. Ongoing NBCSP funding commenced.
c. People aged 45 to 49 can request their first bowel cancer screening kit. People aged 50 to 74 continue to receive a bowel cancer screening kit every 2 years.

Note: The eligible population for all Phase 2 and 3 start dates incorporates those turning the target ages from 1 January of that year, onwards.

To participate in the NBCSP, invitees complete the screening test and post completed samples to the NBCSP pathology laboratory for analysis. Results are sent to the participant, to the participant's nominated primary health-care practitioner (PHCP), and to the NCSR. Participants with a positive screening result, indicated by blood in the stool sample, are advised to consult their PHCP to discuss further diagnostic assessment – in most cases, a colonoscopy.

The AIHW conducted a study of people diagnosed with bowel cancer between 2006 and 2008. This study showed that NBCSP invitees who had been diagnosed with bowel cancer through the program had a lower risk of dying from the disease and were more likely to have less advanced bowel cancers when diagnosed than non-invitees. These findings show that the NBCSP is contributing to reducing morbidity and mortality from bowel cancer in Australia (AIHW 2014a). More recent AIHW data linkage projects have further supported these findings (AIHW 2018a, 2018b).

For more information on the NBCSP, see the Department of Health, Disability and Ageing website.

Monitoring the NBCSP

NBCSP participant data come from a variety of sources along the screening pathway. Data are collected electronically, as well as through forms submitted by participants, PHCPs, colonoscopists, pathologists, and other medical staff returned to the NCSR. While health service organisations providing colonoscopy services are required to implement the Colonoscopy Clinical Care Standard (ACSQHC 2020), which includes reporting NBCSP patient results to the NCSR, is not mandated by the NBCSP, therefore these data may be incomplete.

This report is the eleventh to present national data for the NBCSP, using the current key performance indicators (PIs) developed by the National Bowel Cancer Screening Program Report and Indicator Working Group (Table 1). These indicators were endorsed by the Standing Committee on Screening in 2013 and the Community Care and Population Health Principal Committee under the auspice of the Australian Health Ministers' Advisory Council in 2014 (AIHW 2014b). They are consistent with the 5 Australian Population Based Screening Framework steps: recruitment, screening, assessment, diagnosis, and outcomes (AIHW 2014b).

Current reporting limitations

Due to incomplete reporting to the NCSR by health-care providers, data – and results – for PIs 3 to 9 are not complete. In this report colonoscopy form and MBS claim data have been supplemented with Participant follow-up function (PFUF) data for those who had a positive screening test. See Improvements to the known colonoscopy count in Appendix A for further details.

Other limitations of NBCSP data include the lack of reliable population subgroup identification at the time of invitation. Within the 2023–2024 reporting period, NBCSP participants can self-identify as being an Aboriginal and/or Torres Strait Islander person, having a disability, or speaking a language other than English at home by completing and returning the participant details form along with their iFOBT for analysis. The NCSR uses self-reporting from the participant details form and the Medicare Voluntary Indigenous Identifier, along with other sources such as the National Cervical Screening Program (for invitees who participate in cervical screening) to assign Indigenous status. These sources are still not currently sufficient to reliably identify membership of these subgroups for all invitees. Hence, it is not possible to accurately determine NBCSP participation rates for these subgroups due to the lack of denominators (invitations issued). Ways to reduce these limitations are constantly being investigated; Equity in the NBCSP gives estimates of participation for these subgroups using proportions from the 2021 Census.

In the 2025 monitoring report, for the first time, NBCSP records were matched to cancer incidence data to 2021, allowing PI 6a (bowel cancer detection rate), PI 6b (PPV of diagnostic assessment for detecting bowel cancer), and PI 7 (interval cancer rate) to be reported. These data have not been revised in the 2026 monitoring report and match those reported in the previous report.

Four performance indicators remain aspirational, in that there is either a lack of national data or incomplete data. In this report, PI 5a (adenoma detection rate), PI 5b (positive predictive value, or PPV), of diagnostic assessment for detecting adenoma are not formally reported due to incomplete data. These indicators require complete data return from histopathology by health-care providers. Additionally, PI 8 (cancer clinico-pathological stage distribution) requires national cancer staging data, which is not currently available. Lastly, PI 9 (adverse events – hospital admission) requires linkage with complete national hospital admissions data, which is not currently performed. As the NCSR currently has (incomplete) information on adverse events, this will be used until a more complete adverse event data source becomes available.

Invitations to the target age group exclude those who do not have a valid mailing address in the NCSR. These individuals cannot be mailed, or may not receive, their NBCSP invitation which includes the kit until their Medicare address is updated. All users of Medicare are encouraged to update their address details when they move residence.

This is the sixth NBCSP monitoring report to use data extracted from the NCSR. The NCSR is a live database which is constantly being updated meaning later reports using data for the same time period may have a greater level of completeness.

References

ACSQHC (Australian Commission on Safety and Quality in Health Care) (2020) *Colonoscopy Clinical Care Standard*, Australian Commission on Safety and Quality in Health Care, Sydney, accessed 14 May 2025.

AIHW (2014a) *Analysis of bowel cancer outcomes for the National Bowel Cancer Screening Program*, AIHW, Australian Government, accessed 09 May 2022.

AIHW (2014b) *Key performance indicators for the National Bowel Cancer Screening Program: technical report*, AIHW, Australian Government, accessed 09 May 2022.

AIHW (2018a) *Analysis of bowel cancer outcomes for the National Bowel Cancer Screening Program 2018*, AIHW, Australian Government, accessed 09 May 2022.

AIHW (2018b) *Analysis of cancer outcomes and screening behaviour for national cancer screening programs in Australia*, AIHW, Australian Government, accessed 09 May 2022.

CCACCSWP (Cancer Council Australia Colorectal Cancer Screening Working Party) (2023). Clinical practice guidelines for the prevention, early detection and management of colorectal cancer: Population screening, Cancer Council Australia, Sydney, accessed 9 April 2024.

Schreuders EH, Ruco A, Rabeneck L, Schoen RE, Sung JJY, Young GP and Kuipers EJ (2015) 'Colorectal cancer screening: a global overview of existing programmes', *Gut*, 64(10):1637–1649.

Standing Committee on Screening (2018) *Population Based Screening Framework. Report prepared for the Community Care and Population Health Principal Committee of the Australian Health Ministers' Advisory Council*, Department of Health, Australian Government, accessed 18 April 2023

Australian Government
Australian Institute of Health and Welfare

Picture of bowel cancer in Australia

Number of new cases

In 2025, it is estimated that there were 6,941 new cases of bowel cancer diagnosed in people aged 50–74 (around 47% of all bowel cancer diagnoses). Bowel cancer was the fifth most commonly diagnosed cancer in Australians of all ages (after prostate cancer, breast cancer, melanoma of the skin, and lung cancer) in 2025 (AIHW 2025).

Target age group (50–74 years)

6,941 new cases estimated for 2025

91 new cases per 100,000 target-age people (ASR)

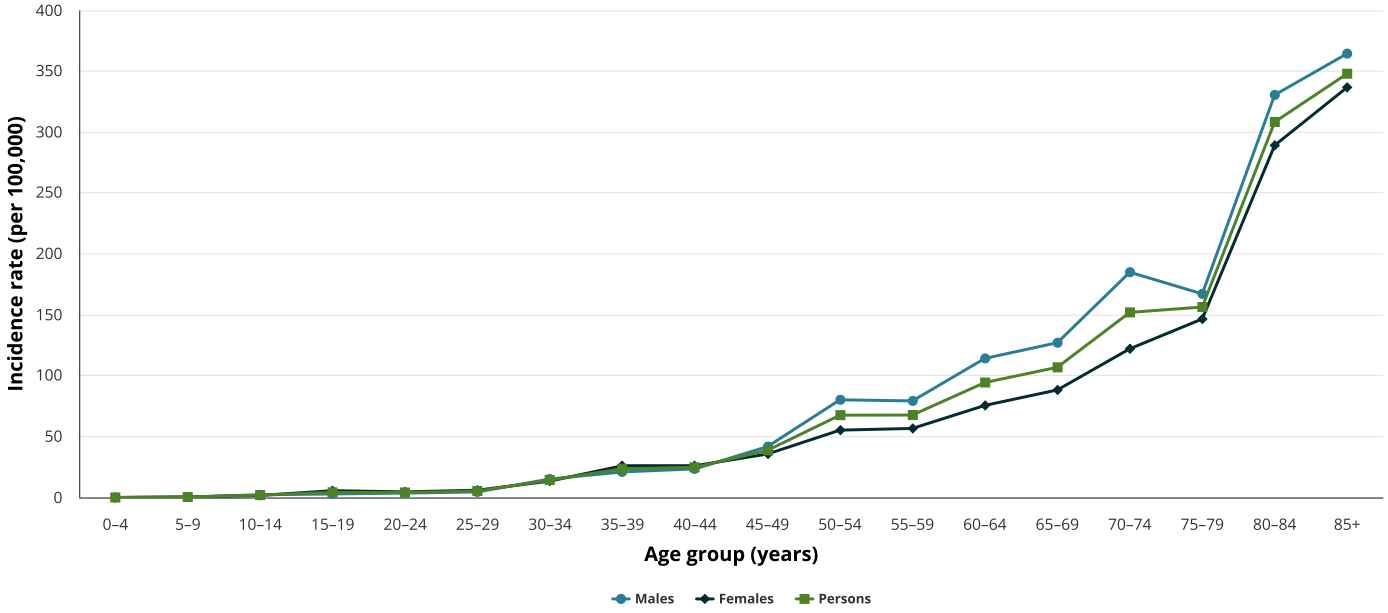
All ages

14,784 new cases estimated for 2025

44 new cases per 100,000 people (ASR)

Bowel cancer risk increases with increasing age group. In 2025, the estimated incidence rate was higher for people aged 45 and over than for younger people (Figure 2.1).

Figure 2.1: Age-specific incidence rates of bowel cancer, by sex, Australia, 2025



Source: Table A3.38.

It is estimated that a person's risk of being diagnosed with bowel cancer (unadjusted for competing mortality) is:

- 6 in 1,000 before age 50
- 24 in 1,000 (1 in 41) for those aged 50–74
- 40 in 1,000 for those aged 75 and over.

Biennial screening began in 2015 with a phased rollout to age groups. It is expected that, once biennial screening has been in place for several years for people aged 45-74, the risk of diagnosis (and death) for those in the target age group and older will reduce further, due to consistent participation in screening.

References

AIHW (2025) *Cancer data in Australia*, AIHW, Australian Government, accessed 5 March 2026

Number of deaths

Box 2.1: Changes to bowel cancer mortality coding

The AIHW uses the National Mortality Database (NMD) to report cancer mortality, a database coded and compiled by the Australian Bureau of Statistics (ABS). ABS advice notes that where the term 'bowel cancer' is recorded on the death certificate, internationally agreed rules state that the cancer should be coded to a less specific International Classification of Diseases and Related Health Problems, 10th Revision (ICD-10) code (C26.0) as the specific site of the cancer is not known (ABS 2016). The ABS advises further that the code C26.0 should be included alongside deaths due to cancers of the colon and rectum (C18–C20) when assessing 'bowel cancer' deaths. For this reason, monitoring reports for the NBCSP from 2019 onwards use C18–C20, and also include C26.0 when reporting deaths from bowel cancer using the NMD.

In 2025, it is estimated that there were 1,779 bowel cancer deaths in people aged 50–74 (around 34% of all bowel cancer deaths). Bowel cancer was estimated to be the second leading cause of cancer death in Australians of all ages (after lung cancer) in 2025 (AIHW 2025). The all-ages bowel cancer mortality rate is lower than that of the target age group due to it containing ages lower than 50.

Target age group (50–74 years)

1,779 deaths estimated in 2025

23 deaths per 100,000 target-age people (ASR)

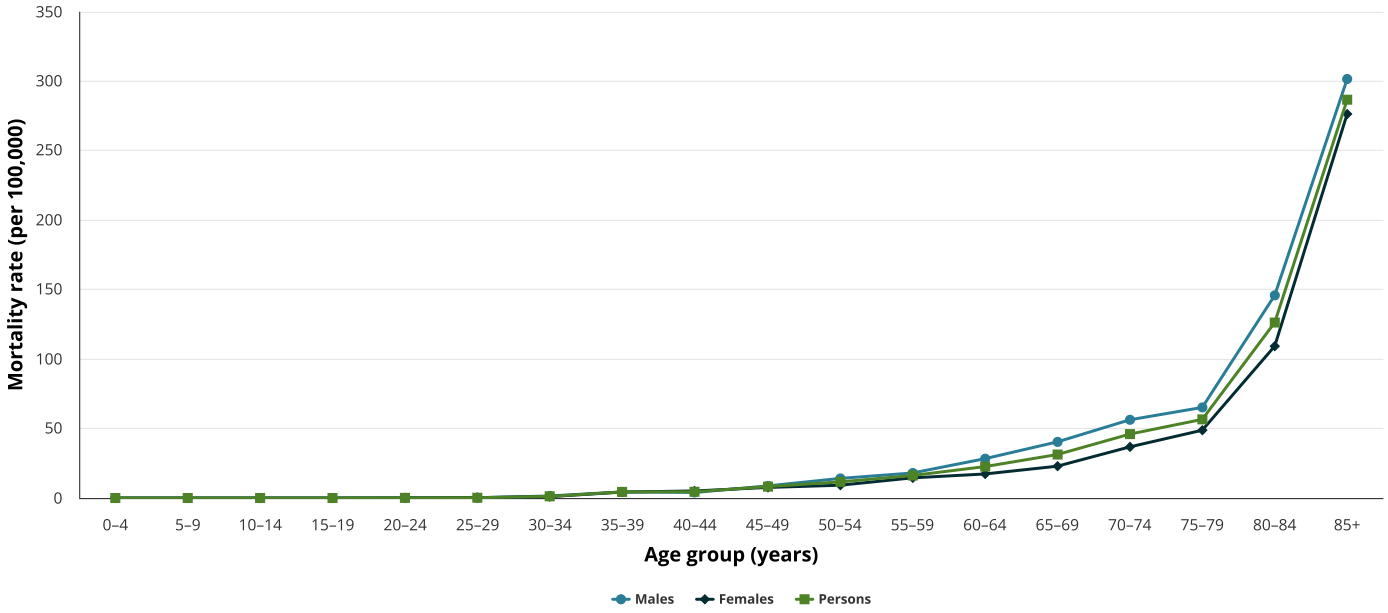
All ages

5,235 deaths estimated in 2025

14 deaths per 100,000 people (ASR)

It is estimated that, in 2025, the mortality rate was higher for people aged 50 and over than for younger people. The rate will increase with age for both men and women (Figure 2.2).

Figure 2.2: Age-specific mortality rates of bowel cancer, by sex, Australia, 2025



Source: Table A3.42.

The risk of dying from bowel cancer increases with increasing age. The risk (unadjusted for competing mortality) is estimated as being:

- 1 in 1,000 before age 50
- 6 in 1,000 for those aged 50–74
- 23 in 1,000 for those aged 75 and over.

As mentioned earlier, once biennial screening has been in place for a number of years, it is expected that the risk of diagnosis and death for those in, and above, the target age group will reduce further, as those people will have been consistently invited to screen.

References

ABS (Australian Bureau of Statistics) (2016) *Causes of death, Australia, 2015: complexities in the measurement of bowel cancer in Australia*. ABS catalogue number 3303.0, ABS, Australian Government.

AIHW (2025) *Cancer data in Australia*, AIHW, Australian Government, accessed 5 March 2026

Survival

Information on survival indicates cancer prognosis and the effectiveness of treatment available. Survival in this report refers to 'relative survival' which is the probability of being alive for a given amount of time after diagnosis compared with the general population, and reflects the impact of a cancer diagnosis. Survival of less than 100% suggests that those with bowel cancer have a lower chance of surviving for at least 5 years after diagnosis than the general population.

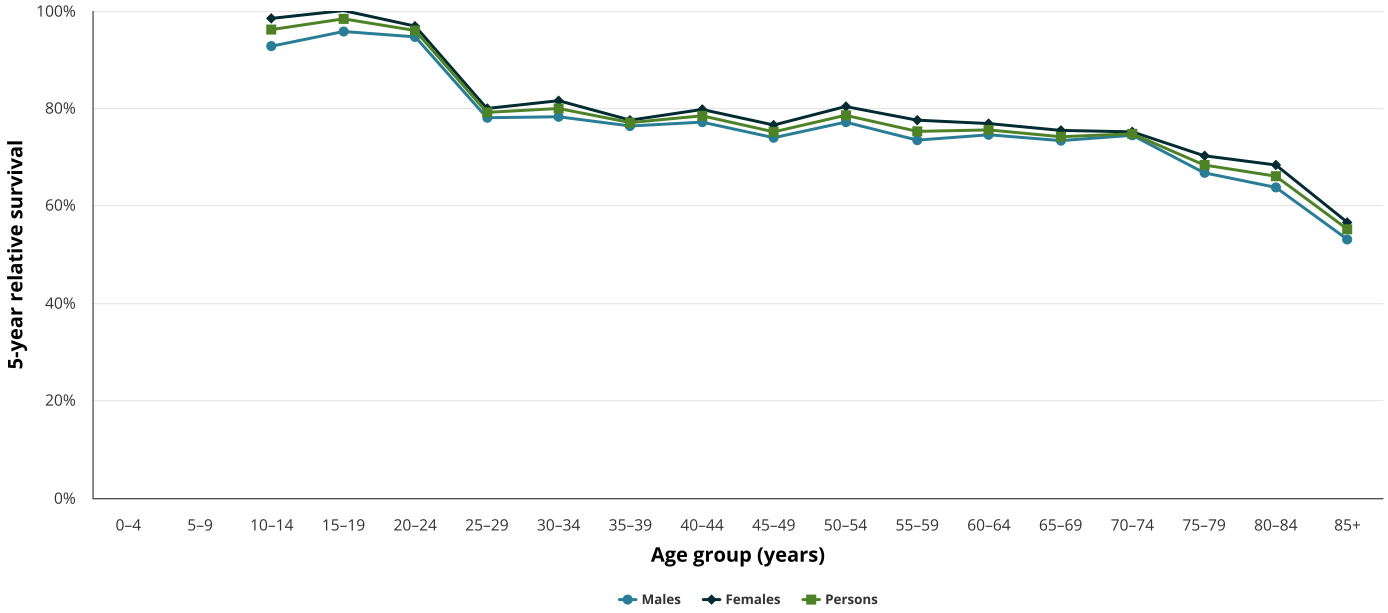
In the period 2017–2021, Australians aged 50–74 who were diagnosed with bowel cancer had a 75% chance of surviving for 5 years compared with their counterparts in the general population.

Target age group (50–74 years)
75% 5-year relative survival (2017–2021)

All ages
72% 5-year relative survival (2017–2021)

In the period 2017–2021, 5-year relative survival was lower for people aged 70 and over than for younger people (Figure 2.3).

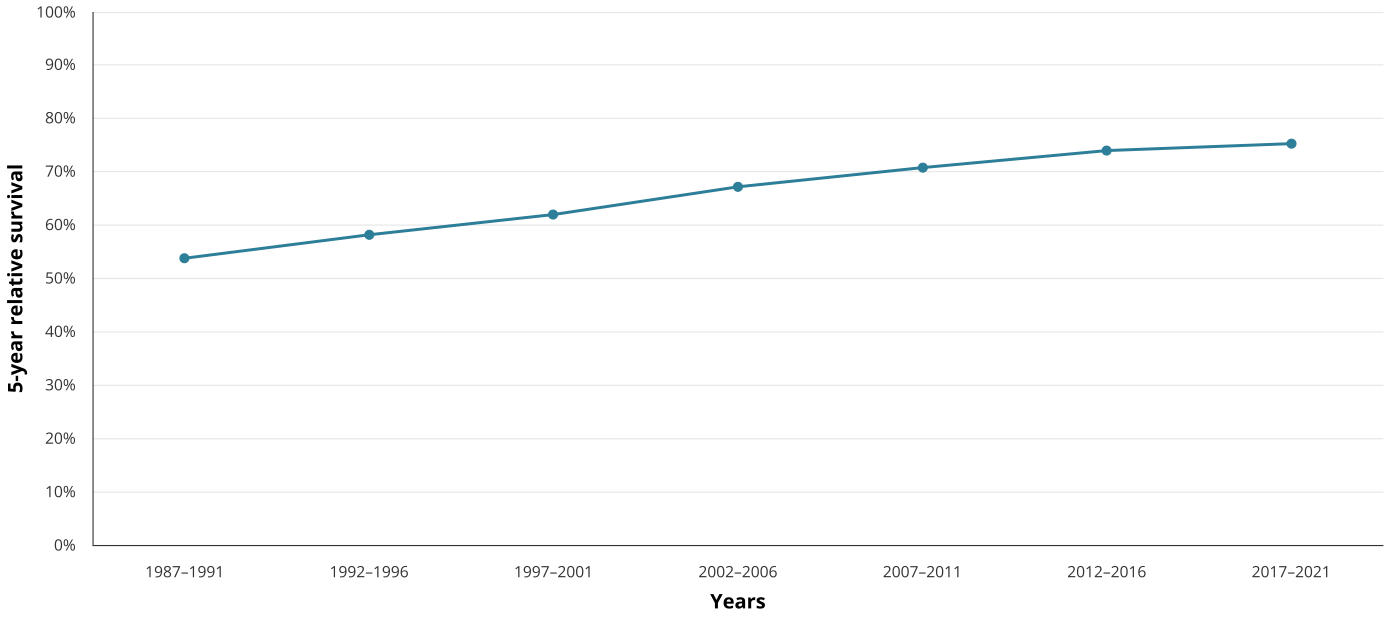
Figure 2.3: Five-year survival from bowel cancer, by age group and sex, Australia, 2017-2021



Source: Table A2.1.

Between the periods 1987–1991 and 2017–2021, the 5-year relative survival rate from bowel cancer for people aged 50–74 at diagnosis rose from 54% to 75% (Figure 2.4).

Figure 2.4: Trend in 5-year relative survival from bowel cancer, people aged 50–74 at diagnosis, Australia, 1987–1991 to 2017–2021

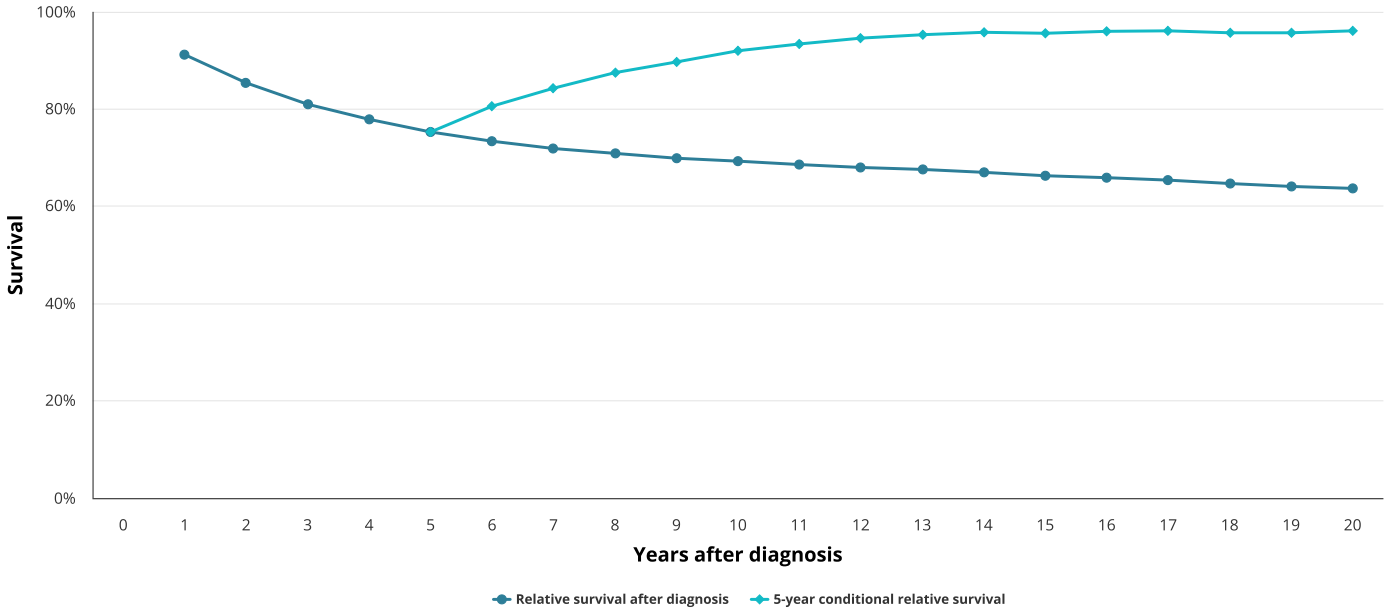


Source: Table A2.2

Relative survival shows the probability of survival at diagnosis. Conditional relative survival estimates show the probability of surviving a given number of years, provided that an individual has already survived a specified amount of time after diagnosis.

While Australians aged 50–74 who were diagnosed with bowel cancer had a 75% chance of surviving for 5 years compared with their counterparts in the general population, among those who had already survived 5 years, the chance of surviving for at least another 5 years (5-year conditional relative survival) was 92% (Figure 2.5).

Figure 2.5: Relative survival at diagnosis and 5-year conditional relative survival from bowel cancer, people aged 50–74 at diagnosis, Australia, 2017–2021



Source: Table A2.3.

Prevalence of bowel cancer

Cancer survivorship focuses on the health and life of a person diagnosed with cancer after treatment until the end of life (NCI 2025). It is more than simply not dying from cancer; it focuses on living with, and life after, a cancer diagnosis (Jackson et al. 2013). Survivorship covers the physical, psychosocial, and economic issues of cancer, including the later effects of treatment, secondary cancers, and quality of life (NCI 2025).

Prevalence is the number of people alive (surviving) after a diagnosis of cancer. At the end of 2021, there were 55,995 Australians alive who had been diagnosed with bowel cancer in the previous 5 years and 95,238 who had been diagnosed in the previous 10 years (Table 2.1). When limited to people aged 50–74 at the end of 2021, there were 28,916 alive after being diagnosed with bowel cancer in the previous 5 years and 47,138 after being diagnosed in the previous 10 years (Table 2.1).

Table 2.1: Prevalence of bowel cancer, by age group and sex, Australia, end of 2021

Age group (years)	Sex	5–year prevalence		10–year prevalence	
		Number	Rate per 100,000	Number	Rate per 100,000
50–74	Males	16,615	480.9	26,911	778.8
	Females	12,301	338.7	20,227	556.9
	Persons	**28,916**	**408.0**	**47,138**	**665.1**
All ages	Males	30,121	235.5	51,035	399.0
	Females	25,874	199.3	44,203	340.6
	Persons	**55,995**	**217.3**	**95,238**	**369.5**

Source: AIHW Australian Cancer Database (ACD) 2021.

References

Jackson J, Scheid K and Rolnick S (2013) 'Development of the Cancer Survivorship Care Plan: what's next? Life after cancer treatment', *Clinical Journal of Oncology Nursing*, 17:280–284.

NCI (National Cancer Institute) (2025) *National Cancer Institute dictionary of cancer terms*, accessed 16 April 2025.

Burden of bowel cancer

Burden of disease analysis is used to assess and compare the impact of different diseases and injuries on a population. It involves determining their impact in terms of the following:

- the number of years of healthy life lost through living with an illness or injury (the non-fatal burden, years lived with disability, or YLD)
- the number of years of life lost through dying prematurely from an illness or injury (the fatal burden, years of life lost, or YLL)
- the number of disability-adjusted life years (DALYs), which combines the non-fatal and fatal burden (or the combined impact of dying early and living with illness). One DALY is equivalent to one healthy year of life lost.

Burden of disease estimates capture both the quantity and quality of life, and reflect the magnitude, severity, and impact of disease and injury within a population. Burden of disease studies can also estimate the contribution of specific risk factors to disease burden (known as the attributable burden) (AIHW 2024).

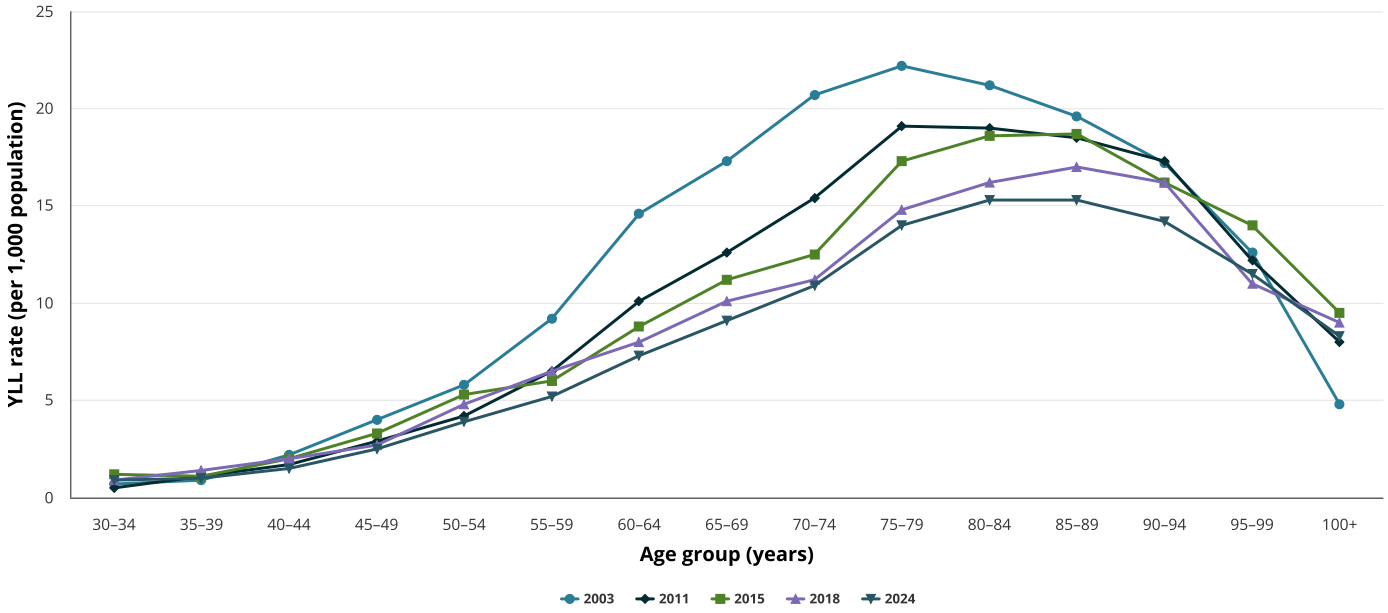
The *AIHW report Australian Burden of Disease Study 2024* (hereafter referred to as the ABDS 2024) found that 97,903 years of healthy life were lost (from fatal and non-fatal outcomes) due to bowel cancer in 2024 (AIHW 2024). This meant bowel cancer accounted for 1.7% of the total disease burden in Australia, making it the 16th most burdensome disease overall (15th in males and 17th in females). Bowel cancer (97,903 DALYs) was the second most burdensome cancer in 2024 behind lung cancer (158,445 DALYs); Australians lost many more years of life due to dying from bowel cancer (92.8% of total bowel cancer burden) than healthy years lost from living with the impacts of the disease (7.2% of total bowel cancer burden) (AIHW 2024).

Changes in burden since 2003

The NBCSP was introduced in 2006; hence, comparisons of the health burden before and after this date, as well as during the full program rollout, are of interest. The ABDS 2024 provides burden of disease estimates best matched to the Australian public health context for the Australian population for 2024. Due to improvements in data sources and methodological changes, published estimates from previous Australian studies are not directly comparable with those for the ABDS 2024. However, estimates for 2018, 2015, 2011, and 2003, revised using the same methods as for 2024, were calculated to enable direct comparisons over time (Figure 2.6).

Between 2003 and 2024, the age-standardised rate (ASR) of total burden from bowel cancer fell 27%, from 4.9 to 3.6 DALYs per 1,000 people. This reduction was primarily due to a drop in fatal burden for all age groups, which lowered the general burden from 4.7 to 3.4 YLL per 1,000 people (AIHW 2024). The change in YLL ASRs was also driven by a shift towards people dying from bowel cancer at older ages. The age group with the highest fatal burden shifted from 75–79 in 2003 (22.2 YLL) to 80–84 and 85–59 (both 15.3 YLL) in 2024.

Figure 2.6: Change in fatal burden - years of life lost (YLL) from bowel cancer, age-specific rate (per 1,000 people), Australia, 2003, 2011, 2015, 2018 and 2024



Sources: AIHW Australian Burden of Disease Database; Table A2.4.

Contribution of risk factors to bowel cancer burden

The ABDS 2024 calculated the proportion of the bowel cancer burden attributable to a number of behavioural, environmental, and metabolic risk factors. For the majority of this analysis, the risk factors were analysed independently, meaning that the estimates cannot be added together without further analysis to take into account that many risk factors are interrelated (AIHW 2021).

After analysis to adjust for interrelated risk factors, the study estimated that 53% of bowel cancer burden in 2024 was attributable to the combined impact of associated risk factors, referred to as the 'joint effect' (AIHW 2021). All dietary risk factors combined were responsible for 26% of bowel cancer burden.

When looking at the individual contribution of each risk factor, a low consumption of wholegrains and high-fibre cereals and overweight and obesity contributed the most individually to bowel cancer burden in 2024 (16% and 14%, respectively). A greater proportion of bowel cancer burden in males was due to overweight and obesity than in females (19% compared with 7%) (Table 2.2). Physical inactivity was responsible for around 11% of bowel cancer burden in 2024.

See *Australian Burden of Disease Study 2024* (AIHW 2024) for more information on the methods used to quantify the impact of specific risk factors.

Table 2.2: Bowel cancer burden attributed to selected risk factors (DALY and %), Australia, 2024

	Males		Females		Persons	
Risk factor	**Attributable DALY**	**Proportion of bowel cancer burden (%)**	**Attributable DALY**	**Proportion of bowel cancer burden (%)**	**Attributable DALY**	**Proportion of bowel cancer burden (%)**
Alcohol use	2,695	4.9	2,860	6.6	5,555	5.7
All dietary risks	14,312	26.2	11,266	26.1	25,579	26.1
• Diet high in processed meat	1,213	2.2	967	2.2	2,180	2.2
• Diet high in red meat	3,182	5.8	2,495	5.8	5,677	5.8
• Diet low in milk	2,578	4.7	2,027	4.7	4,605	4.7
• Diet low in whole grains and high-fibre cereals	8,680	15.9	6,831	15.8	15,510	15.8
High blood plasma glucose	4,003	7.3	2,287	5.3	6,290	6.4
Overweight and obesity	10,574	19.3	2,891	6.7	13,465	13.8
Physical inactivity	5,467	10.0	4,964	11.5	10,431	10.7
Tobacco use	2,511	4.6	3,647	8.4	6,158	6.3
Joint effect	**30,026**	**54.9**	**21,801**	**50.5**	**51,826**	**52.9**

Note: Attributable burden was analysed independently for each risk factor and only the 'joint effect' estimates take into account the complex pathways and interactions between risk factors. Therefore, attributable DALY and percentages for individual risk factors will not sum to the joint effect.

Source: AIHW Australian Burden of Disease Database.

References

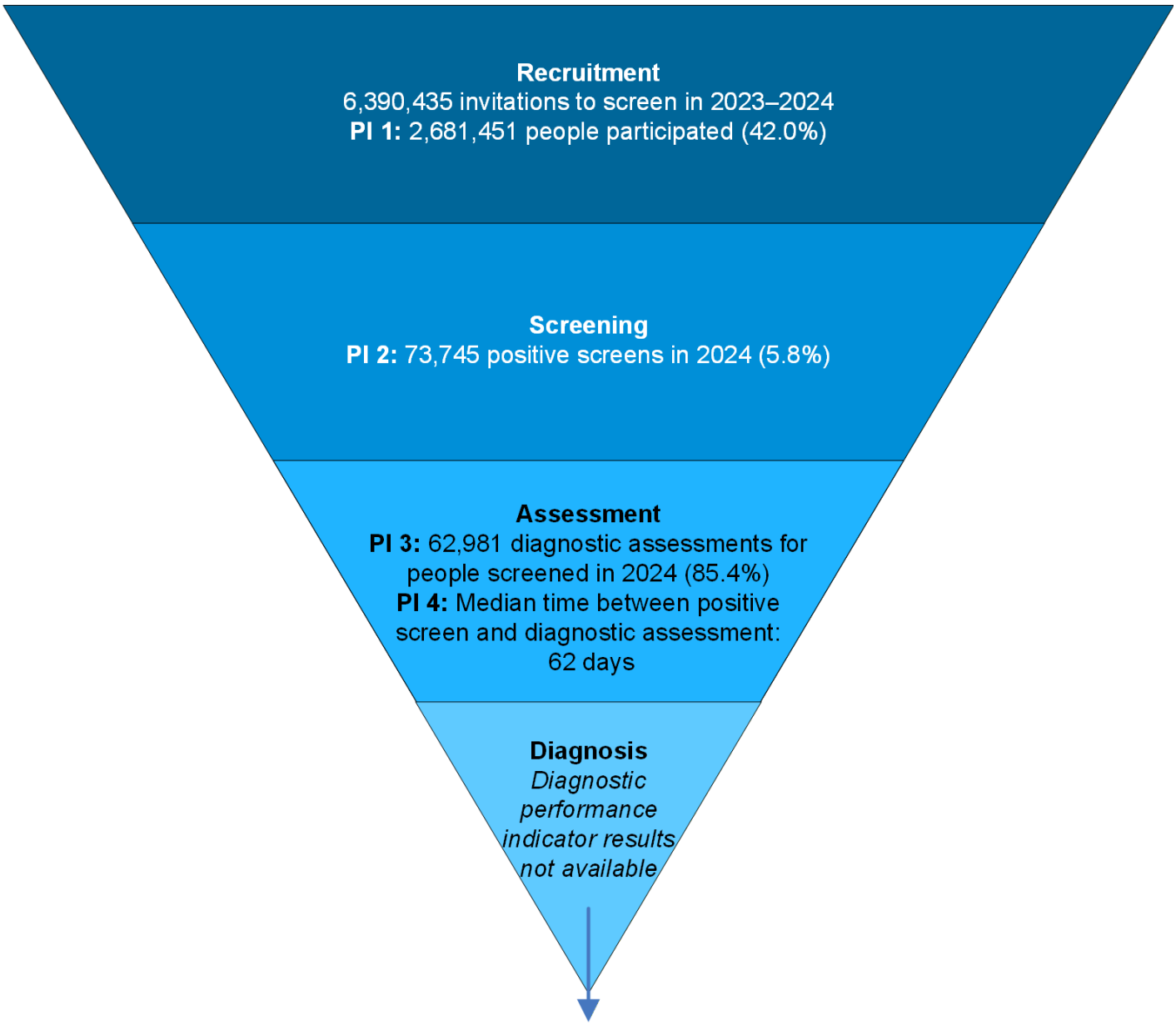
AIHW (2021) *Australian Burden of Disease Study: Methods and supplementary material 2018*, AIHW, Australian Government, accessed 15 May 2025.

AIHW (2024) *Australian Burden of Disease Study 2024*, AIHW, Australian Government, accessed 15 May 2025.

Performance of the screening program

The latest performance indicator data presented in the following pages of this monitoring report have been applied to the 5 incremental stages of the Population Based Screening Framework (Standing Committee on Screening 2018) screening pathway (Figure 3.1).

Figure 3.1: Summary of NBCSP performance indicators for this report, Australia



Assessment details

Those assessed in 2024[(a)]

No issue or other diagnosis	7,018	(36.5%)
Biopsy awaiting histopathology	5,650	(29.4%)
Non-advanced adenomas	2,670	(13.9%)
Advanced adenomas	3,241	(16.8%)
Suspected cancer	470	(2.4%)
Confirmed cancer	195	(1.0%)

Outcomes

For morbidity and mortality

PI 9:	Adverse events	0.5 per 10,000	(2024)
PI 10:	Incidence	91 per 100,000	(2025)
PI 11:	Mortality	23 per 100,000	(2025)

a. Based on available outcome data which does not include matched cancer incidence data for 2024; therefore, confirmed cancers reported here are an underestimate. Percentages may not sum to 100% due to rounding. Excludes 45,495 assessments with no record of outcome.

Notes:

1. The recruitment indicator PI 1 is reported against the 2-year calendar period 2023–2024, with follow-up to June 2025. The screening indicator PI 2 is reported against the year 2024. The assessment and adverse events indicators are reported against the year 2024, with follow-up to December 2025 for assessments and to June 2025 for adverse events. The incidence and mortality rates presented are estimated age-standardised rates for those aged 50–74 in 2025.
2. Assessment, diagnosis, and outcomes (PIs 3–9) rely on information being reported to the NCSR. As return of NBCSP forms is required (ACSQHC 2020), but not mandated by the NBCSP, there may be incomplete form return and incomplete data. However, Participant follow-up function (PFUF) data are now used to supplement missing colonoscopy form data. See Current reporting limitations for more details.
3. PI 5a (adenoma detection rate), PI 5b (PPV of diagnostic assessment for detecting adenoma), PI 6a (bowel cancer detection rate), PI 6b (PPV of diagnostic assessment for detecting bowel cancer), PI 7 (interval cancer rate), and PI 8 (cancer clinico-pathological stage distribution) are not reported due to data incompleteness or unavailability. See Current reporting limitations.

Source: AIHW analysis of NCSR as at 31 December 2025 (NCSR raw data extract (RDE) 6/02/2026).Current reporting limitations

References

ACSQHC (Australian Commission on Safety and Quality in Health Care) (2020) *Colonoscopy Clinical Care Standard*, Australian Commission on Safety and Quality in Health Care, Sydney, accessed 14 May 2025.

Standing Committee on Screening (2018) *Population Based Screening Framework. Report prepared for the Community Care and Population Health Principal Committee of the Australian Health Ministers' Advisory Council*, Department of Health, Australian Government, accessed 18 April 2023

Recruitment

PI 1 – Participation rate

PI 1 Definition

The percentage of people invited to screen through the NBCSP between 1 January 2023 and 31 December 2024 who returned a completed screening test within that period or by 30 June 2025.

Rationale: Participation should be monitored to ensure acceptability, equity, and uptake, with the aim that reductions in incidence, morbidity and mortality can be achieved. Without participation, the NBCSP cannot achieve earlier detection.

Data quality: All invitations issued and iFOBT kits returned are recorded in the NCSR.

Guide to interpretation: The number of individuals sent a screening invitation excludes those who deferred or opted out without completing their screening test, and those who skipped an invitation round due to a recent colonoscopy. Invitees without a valid mailing address in the NCSR are also necessarily excluded from invitation. A non-valid address may be a result of the NCSR not recognising a current postal address, or a return to sender flag currently recorded against the invitee and their given address. Table A3.1 (online data table) contains details on the number of invitees in these categories.

Data on participation by Indigenous Australians, by preferred language spoken at home, and by disability status are not currently available due to the lack of complete denominators for these subgroups. See Equity in the NBCSP for estimates of participation for these subgroups.

Participation is measured over 2 years to align with the 2-year recommended screening interval. A consequence of this is that there are 'rolling' participation rates, in which there is an overlap of one calendar year between any 2 consecutively reported participation rates.

Those aged 45–49 can now request a screening kit; however, this age group is not reported in this performance indicator.

National participation rate, 2023–2024: 42.0%.

The following apply to the 6,390,435 eligible people invited from 1 January 2023 to 31 December 2024:

Australia-wide: A total of 2,681,451 people participated in the NBCSP, giving an overall Australia-wide participation rate of 42.0% (Table A3.2).

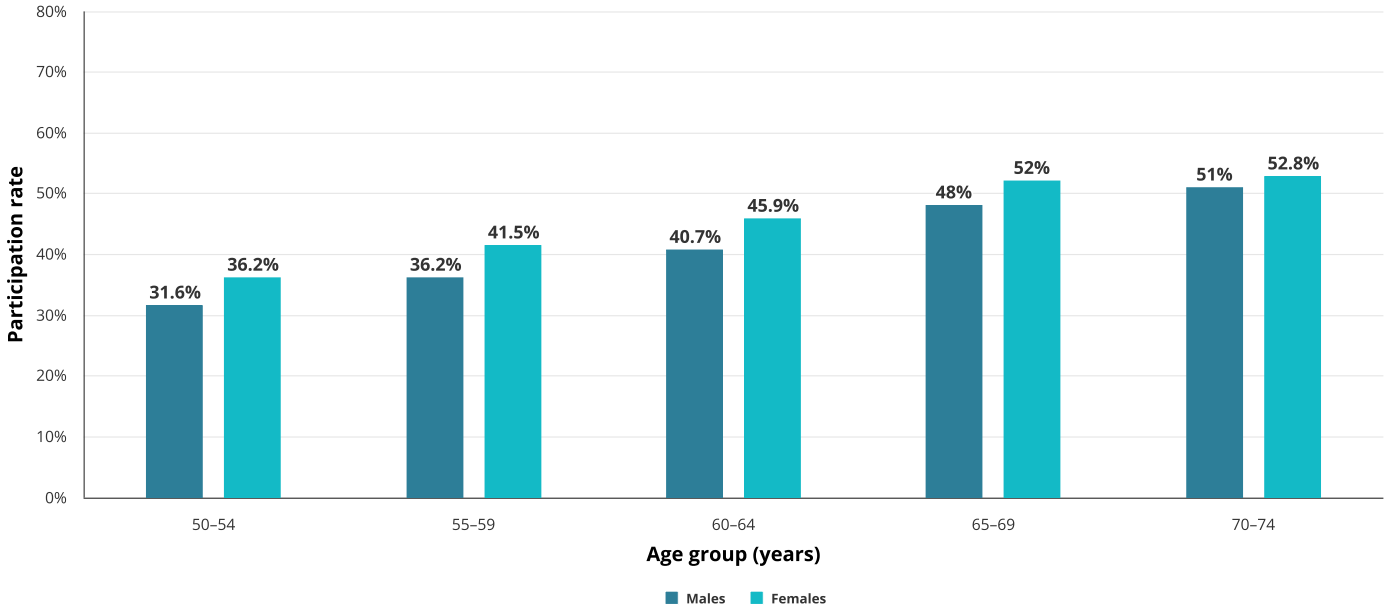
Sex: Female invitees had a higher participation rate (44%) than males (40%) (Table A3.2).

Age: The participation rate increased with each invitation age group, from 34% for people aged 50–54 to 52% for people aged 70–74 (Figure 3.2a).

Invitation round: The participation rate was higher for people who had previously been invited to the program (receiving their second or later screening invitation, 43%) compared with people receiving their first invitation (33%) (Figure 3.2b).

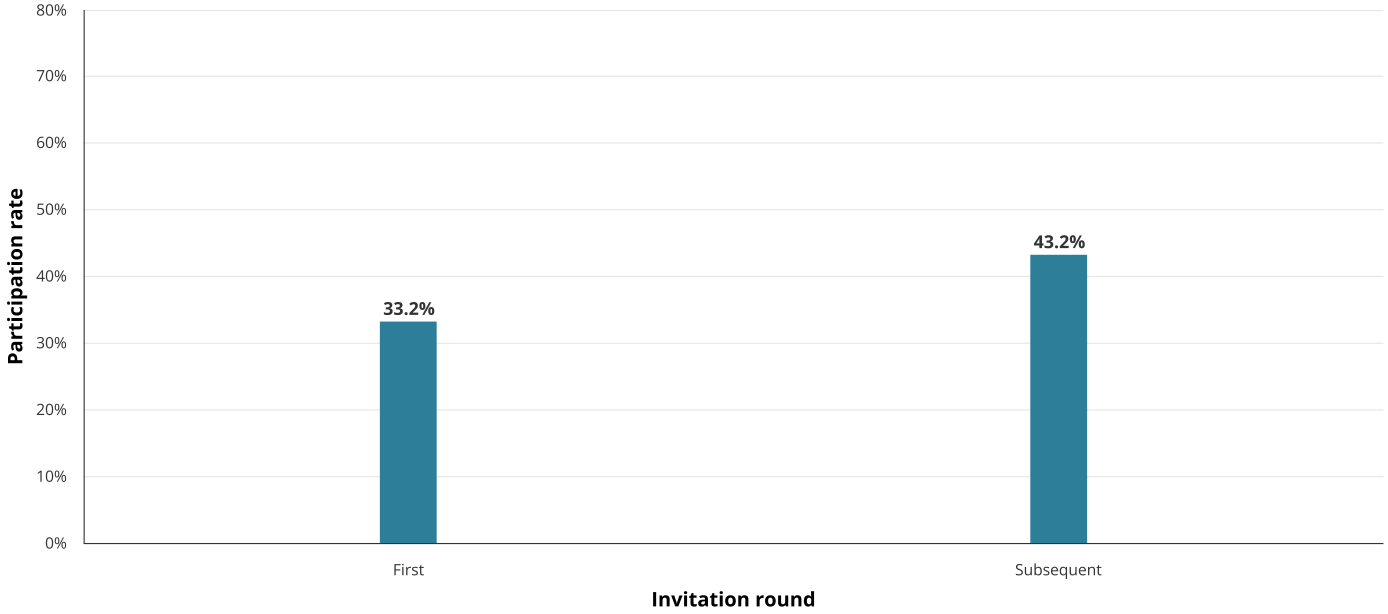
The re-participation rate was higher for those who had participated in their previous invitation round and were receiving a subsequent invitation (84%) compared with those who had ever previously participated (73%) (Table A3.3).

Figure 3.2a: Participation of people aged 50–74, by sex and age, Australia, 2023–2024



Source: Table A3.2

Figure 3.2b: Participation of people aged 50–74, by invitation round, Australia, 2023–2024

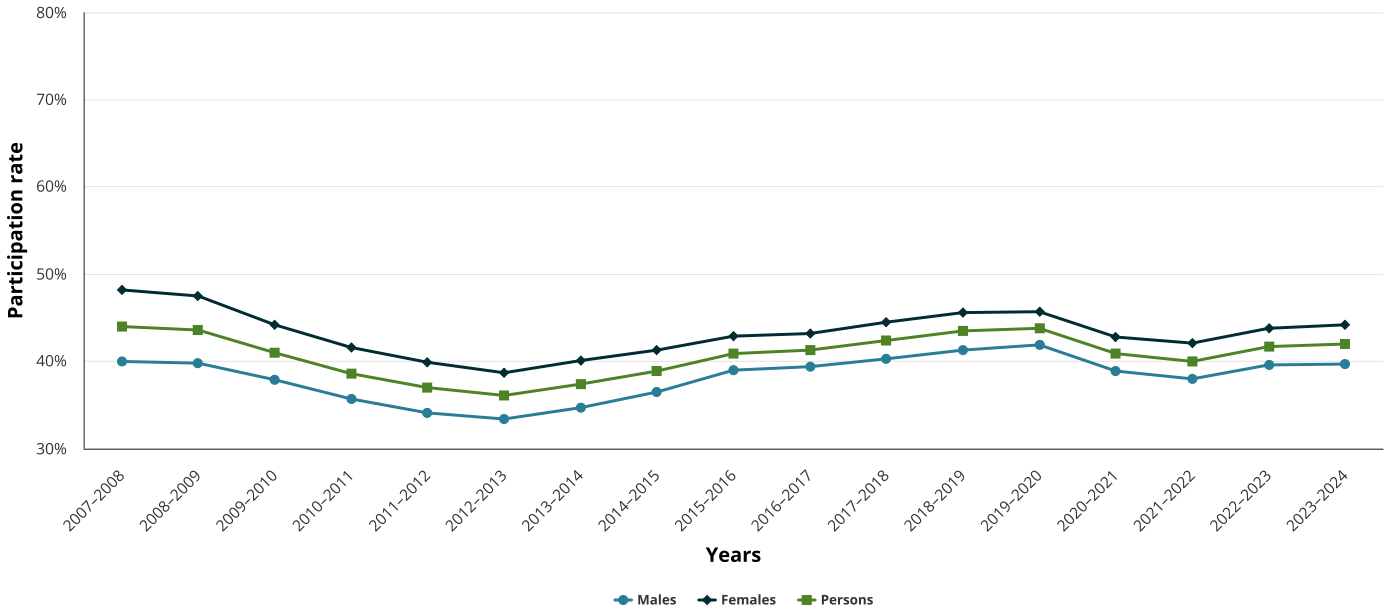


Source: Table A3.3

Trend: Monitoring reports before 2016 analysed participation differently from the indicator used in this report. This means that trend comparisons with rates published in those earlier reports cannot be made. To allow trends to be compared over time, the new participation indicator specifications have been applied retrospectively to earlier years of program data within this report (Figure 3.3).

Using this indicator across all program data to date, the participation rate fell from 44% in 2007–2008 to 36% in 2012–2013, then gradually rose to 44% in 2019–2020. The rate dropped after 2020 before trending up to 42% in 2022–2023 and 2023–2024 (Figure 3.3).

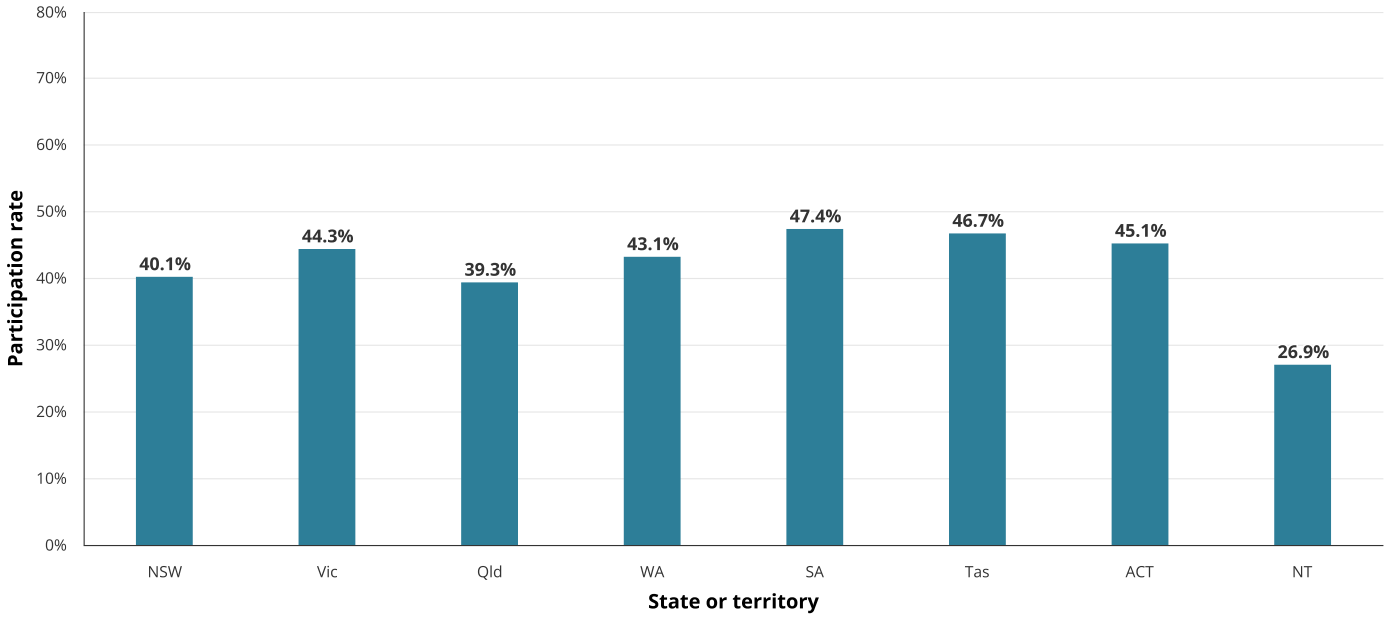
Figure 3.3: Participation of people aged 50–74, by sex, Australia, 2007–2008 to 2023–2024



Source: Table A3.5.

State or territory: The participation rate was highest for people living in South Australia and Tasmania (both 47%) and lowest for people living in the Northern Territory (27%) (Figure 3.4).

Figure 3.4: Participation of people aged 50–74, by state or territory, Australia, 2023–2024

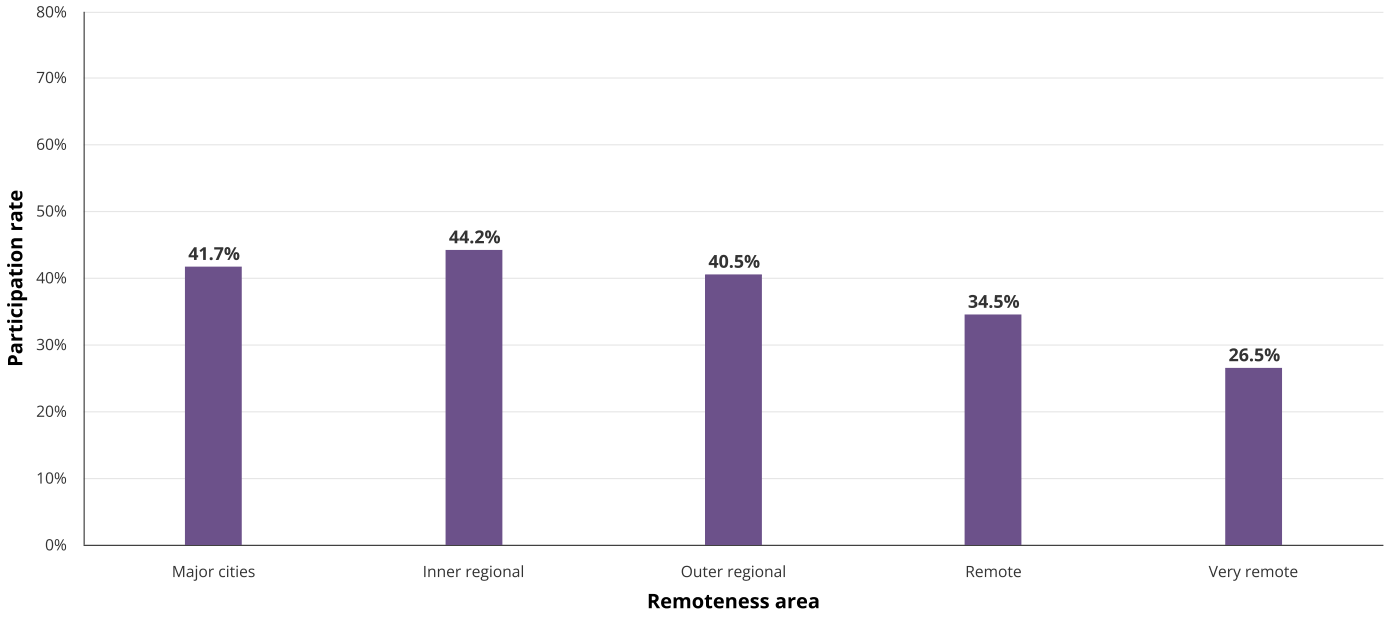


Source: Table A3.4.

Remoteness area: The participation rate was highest for people living in *Inner regional* areas (44%) and lowest for people living in *Very remote* areas (27%) (Figure 3.5a).

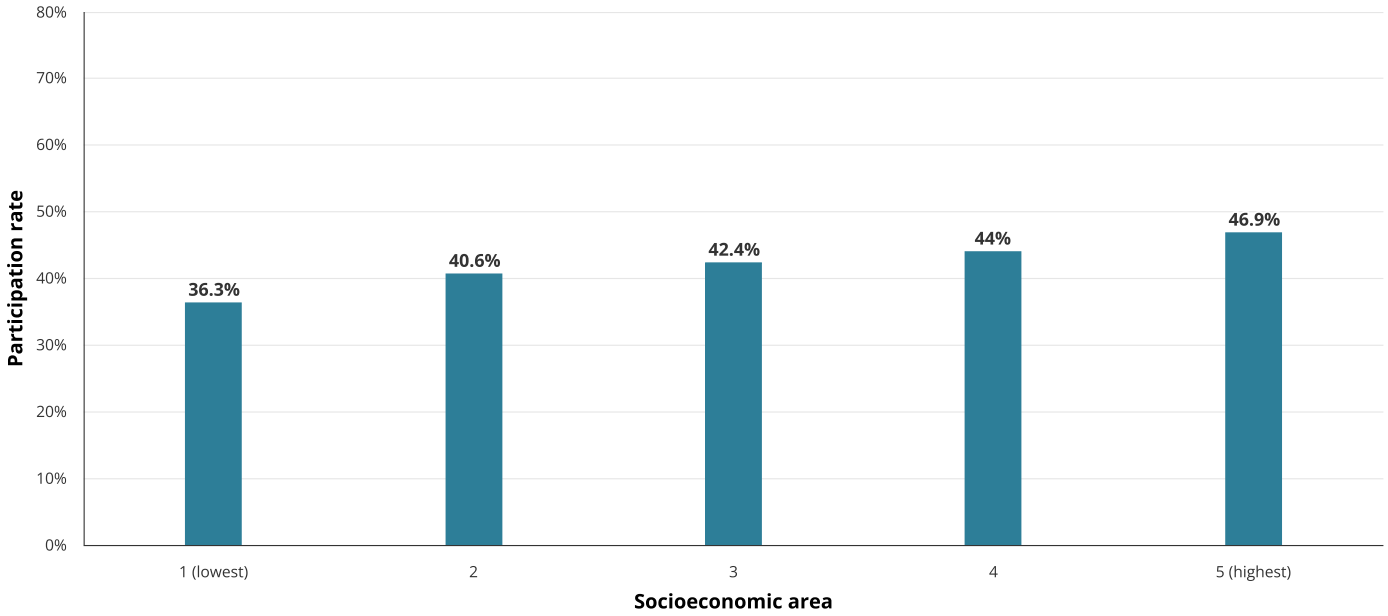
Socioeconomic area: The participation rate was highest for people living in the highest socioeconomic areas (47%) and lowest for those living in the lowest socioeconomic areas (36%) (Figure 3.5b).

Figure 3.5a: Participation of people aged 50–74, by remoteness area, Australia, 2023–2024



Source: Table A3.4.

Figure 3.5b: Participation of people aged 50–74, by socioeconomic area, Australia, 2023–2024



Source: Table A3.4.

Screening

PI 2 – Screening positivity rate

PI2 Definition

The percentage of people who returned a valid NBCSP screening test and received a positive screening result (warranting further assessment) between 1 January 2024 and 31 December 2024.

Rationale: The positive screening test rate determines the diagnostic assessment workload and lesion detection rate. It is important that the accepted positivity range is reviewed and revised (to improve lesion detection rates while limiting 'false' positive results) if necessary. Monitoring this is important for program planning and quality assurance. Further, monitoring the positivity rate by various stratifications may reveal emerging positive or negative trends that need to be investigated, and rectified.

Data quality: All valid iFOBT results are recorded in the NCSR.

Guide to interpretation: This indicator counts all tests analysed in the defined period, not tests analysed from those invited in the defined period; therefore, the cohort monitored is different from the cohort monitored in the participation indicator.

Those aged 45–49 can now request a screening kit; however, this age group is not reported in this performance indicator.

National screening positivity rate, 2024: 5.8%.

The following apply to the 1,274,203 invitees who had a screening test analysed in 2024:

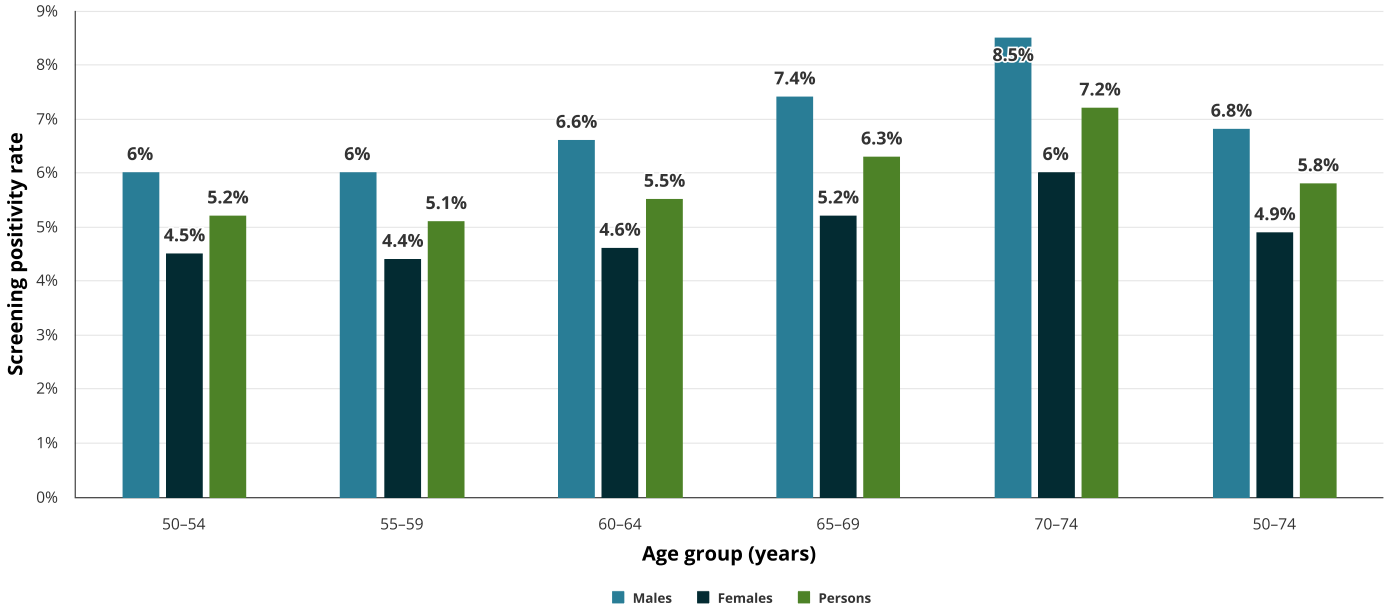
Australia-wide: A total of 73,745 people received a positive screening test result, giving an overall Australia-wide screening positivity rate of 5.8% (Table A3.6).

Sex: Male participants had a higher screening positivity rate than females (7% compared with 5%, respectively), across all age groups (Figure 3.6).

Age: The screening positivity rate increased with each age group, from 5% for people aged 50–64 to 7% for those aged 70–74 (Figure 3.6).

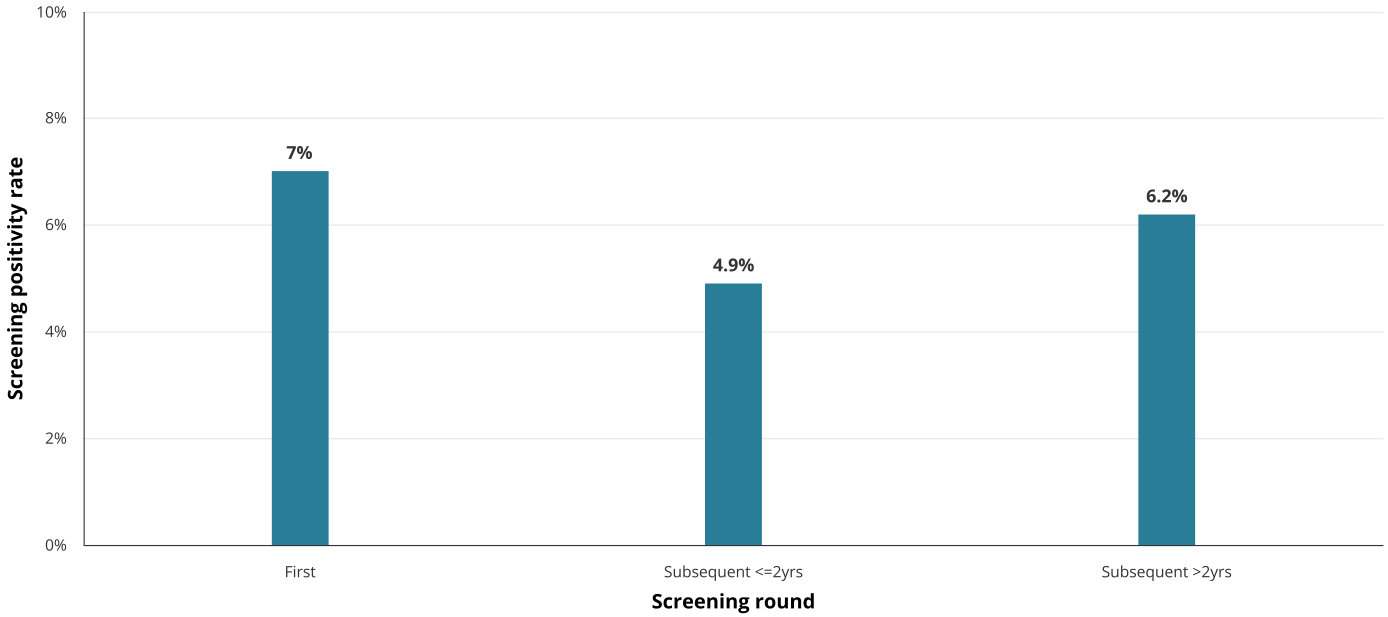
Screening round: The screening positivity rate was highest for people during their first round of screening (7% compared with 6% for those whose subsequent screen was more than 2 years after their first screen) (Figure 3.7). Those who screened at their next biennial invitation had the lowest screening positivity (5%).

Figure 3.6: Screening positivity rate of people aged 50-74, by sex and age, Australia, 2024



Source: Table A3.6.

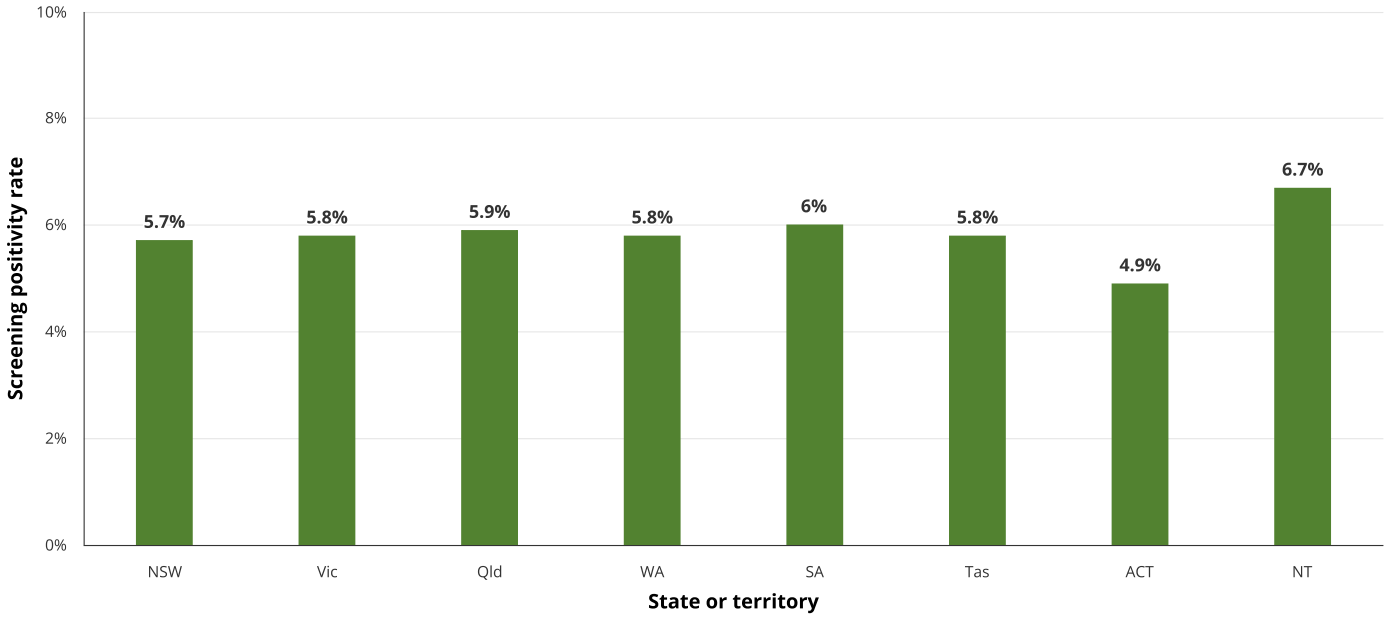
Figure 3.7: Screening positivity rate of people aged 50-74, by screening round, Australia, 2024



Source: Table A3.7.

State or territory: The screening positivity rate was 6% in all jurisdictions except the Australian Capital Territory (5%) and the Northern Territory (7%) (Figure 3.8).

Figure 3.8: Screening positivity rate of people aged 50-74, by state or territory, Australia, 2024

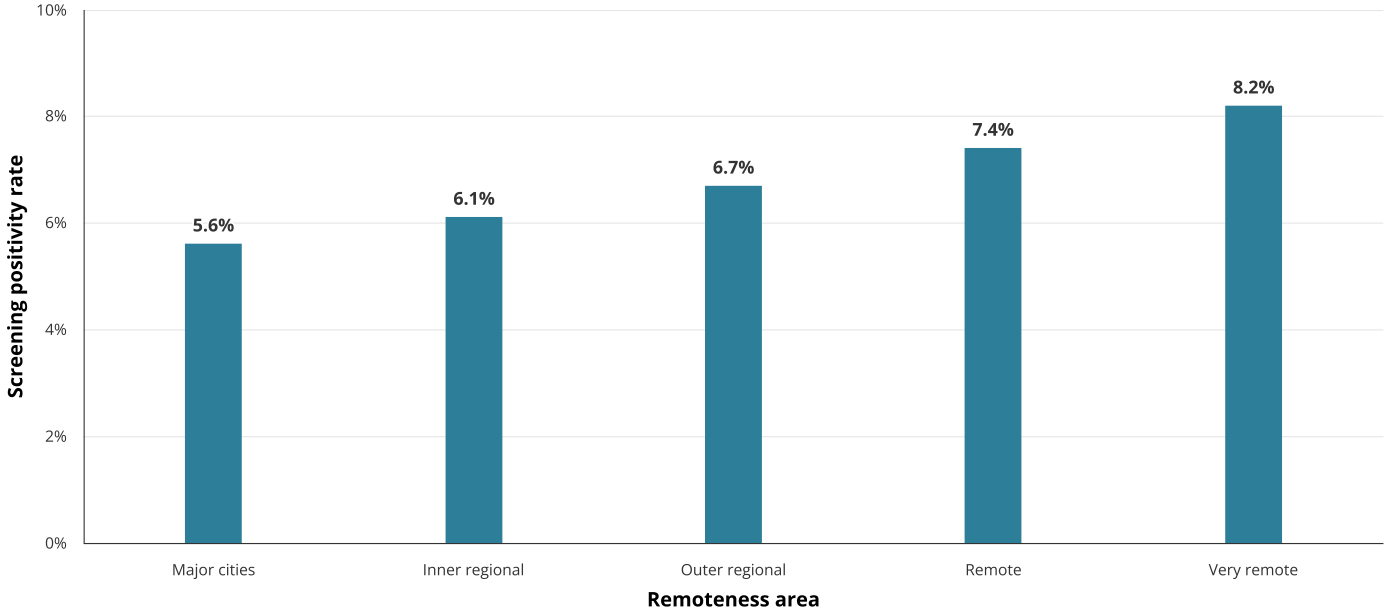


Source: Table A3.8.

Remoteness area: The screening positivity rate was highest for people living in *Very remote* areas (8%) and lowest for those living in *Major cities* (6%) (Figure 3.9a).

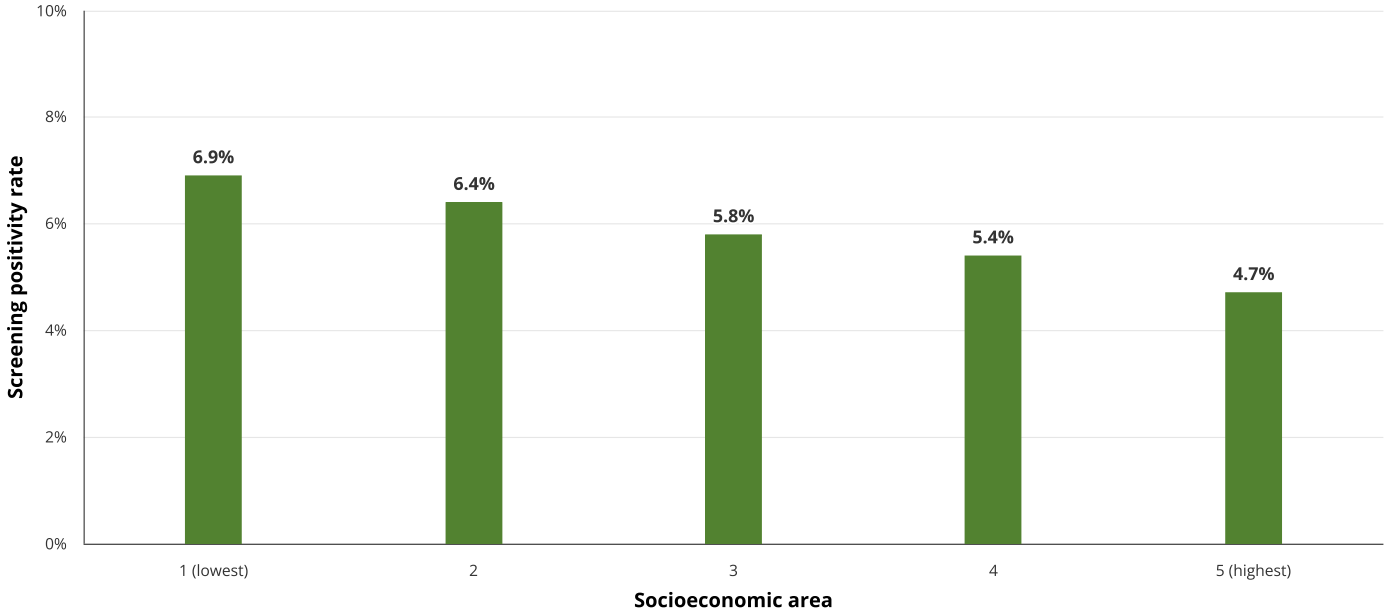
Socioeconomic area: The screening positivity rate was highest for people living in the lowest socioeconomic areas (7%) and lowest for those living in the highest socioeconomic areas (5%) (Figure 3.9b).

Figure 3.9a: Screening positivity rate of people aged 50-74, by remoteness area, Australia, 2024



Source: Table A3.8.

Figure 3.9b: Screening positivity rate of people aged 50-74, by socioeconomic area, Australia, 2024



Source: Table A3.8.

Indigenous status: Indigenous Australians had a higher screening positivity rate than non-Indigenous Australians (8% compared with 6%, respectively) (Table A3.9).

Preferred language spoken at home: Those who preferred to speak a language other than English at home had the same screening positivity rate as those who spoke English at home (6% for both) (Table A3.9).

Disability status: Those reporting severe or profound activity limitation had a higher screening positivity rate than those not reporting such limitation (11% compared with 6%, respectively) (Table A3.9). Reasons for this difference are not well understood but may include a lower level of physical activity (Wolin et al. 2011) or comorbidities and medications that increase the likelihood of a positive iFOBT screening result in people with severe or profound activity limitation. Note that from 2025 the simplified participant details form mailed with the bowel screening kit no longer asks for self-reported disability status. This disaggregation will be phased out in future reports in favour of future data linkage projects collecting disability status.

References

Wolin KY, Yan Y and Colditz GA (2011) 'Physical activity and risk of colon adenoma: a meta-analysis', *British Journal of Cancer*, 104:882–885.

Assessment

In this section

PI 3 – Diagnostic assessment rate

PI 3 definition

The percentage of people who returned a positive NBCSP screening test (warranting further assessment) between 1 January 2024 and 31 December 2024 and had follow-up diagnostic assessment within that period or by 31 December 2025.

Rationale: The appropriate movement of people from participation to diagnostic assessment is a key indicator of the efficiency of the program and its impact in reducing morbidity and mortality from bowel cancer. While not all participants with a positive screen will necessarily have an assessment, according to the Population Based Screening Framework (Standing Committee on Screening 2018), systems should be in place to ensure timely follow-up to diagnostic assessment for individuals with a positive screening test.

Data quality: This indicator relies on information being returned to the NCSR (ACSQHC 2020); however, this reporting is not mandated by the NBCSP and is known to be incomplete. Therefore, there is an unknown level of under-reporting for this indicator, and levels of under-reporting may differ across groups (for example, across jurisdictions, and across remoteness and socioeconomic areas). Participants with only an MBS claim for colonoscopy services are included (and assumed to have been performed in a private health-care setting), though outcomes from this colonoscopy source are not known, and MBS claim data prior 2020 are incomplete. In this report, colonoscopy data have also been supplemented with Participant follow-up function (PFUF) data for those who had a positive screening test. See Improvements to the known colonoscopy count in Appendix A for further details.

Guide to interpretation: This indicator includes all people with a positive screen in the defined period, not all those invited in the defined period. Those aged 45–49 can now request a screening kit; however, this age group is not reported in this performance indicator.

National diagnostic assessment rate, 2024: 85.4%.

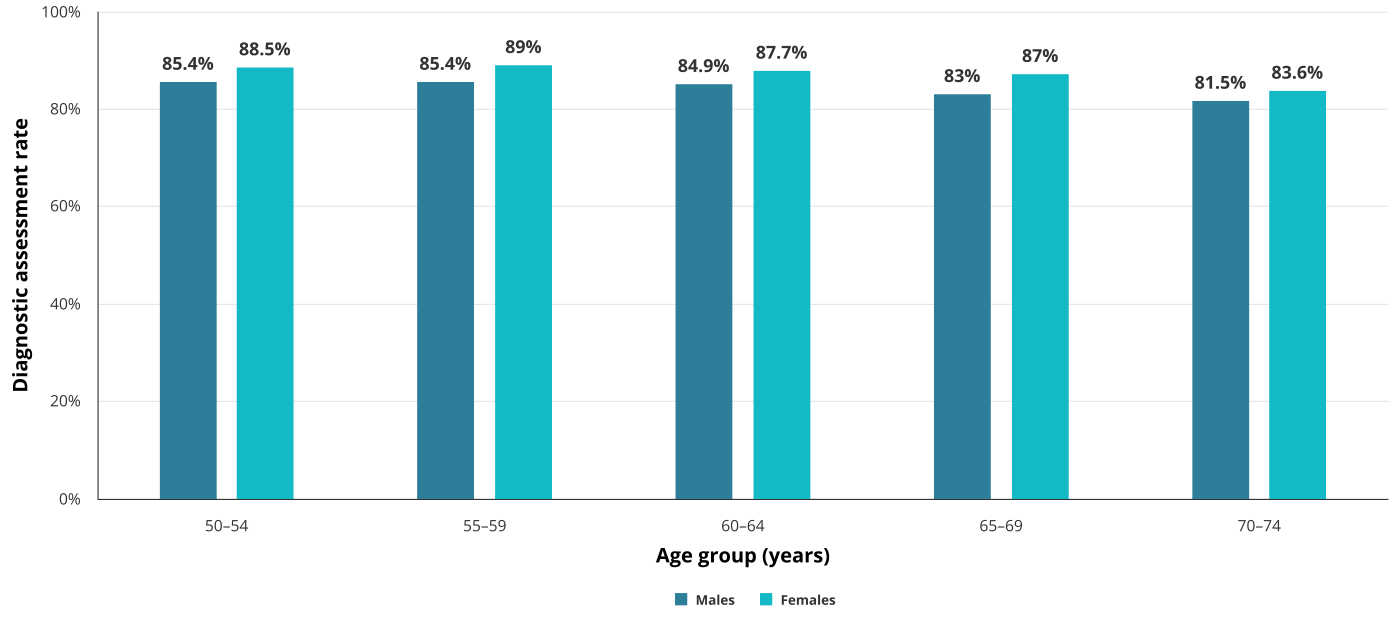
The following apply to the 73,745 participants with a positive screening test in 2024:

Australia-wide: A total of 62,981 people had a follow-up diagnostic assessment (colonoscopy) recorded – an overall Australia-wide diagnostic assessment rate of 85.4% (Table A3.10).

Sex and age: Diagnostic assessment rates were higher for females (87%) than males (84%) and were slightly lower for people aged 70–74 (82%) than for younger target age groups (87%–85% for age groups 50–64 to 65–69) (Figure 3.10).

Health-care provider: Most diagnostic assessments (57%; 35,979) recorded were performed through the private health-care system, with an additional 29% (18,343 assessments) recorded through the public health-care system (Table A3.11). The remaining 14% (8,659 diagnostic assessments) did not state through which system (public or private) the follow-up assessment was performed. As this indicator relies on information being reported to the NCSR (ACSQHC 2020), and because reporting is not mandated by the NBCSP, differences in the performance of diagnostic assessments by public and private providers should be considered in light of these limitations.

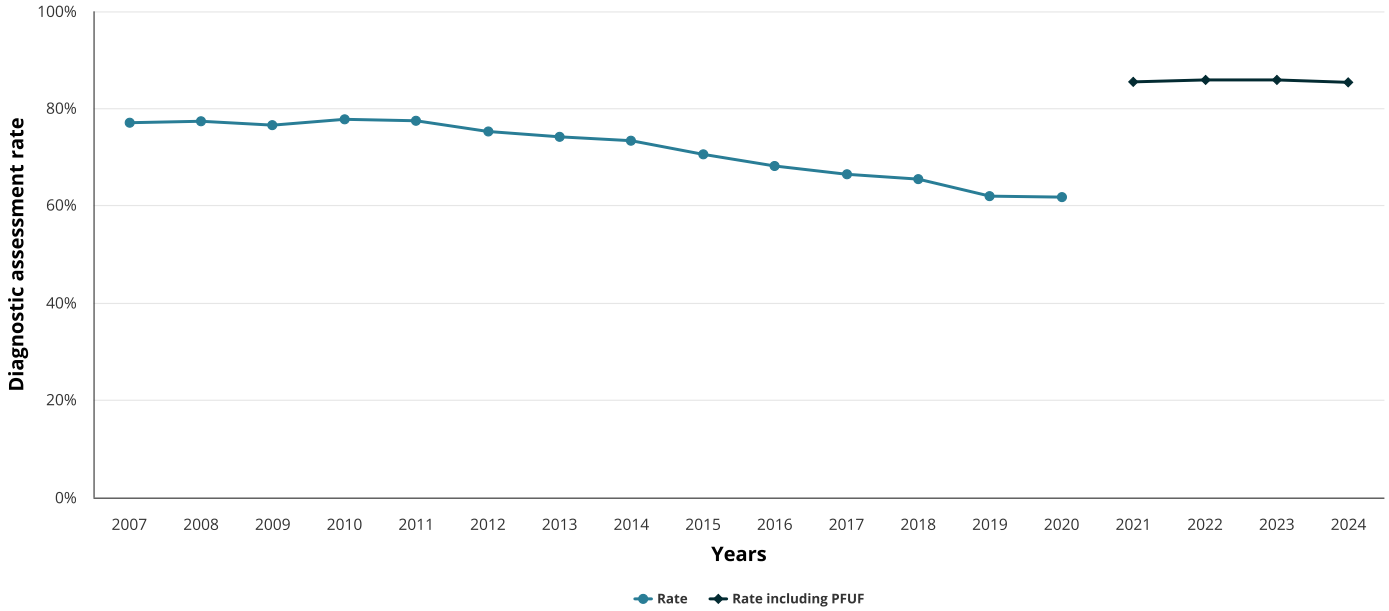
Figure 3.10: Diagnostic assessment rate (colonoscopy) of people aged 50-74, by sex and age group, Australia, 2024



Source: Table A3.10.

Trend: Monitoring reports before 2016 used a different methodology to analyse the diagnostic assessment rate. This means that trend comparisons with rates published in those earlier reports cannot be made. To allow trends to be compared over time, the new indicator specifications have been applied retrospectively to earlier years of program data within this report. However, note that from 2021 colonoscopy form data and MBS claims have been supplemented with Participant follow-up function (PFUF) data, so direct comparisons between 2021 and earlier time periods should not be made. Since 2021, the follow-up diagnostic assessment rate has remained in the 85–86% range (Figure 3.11).

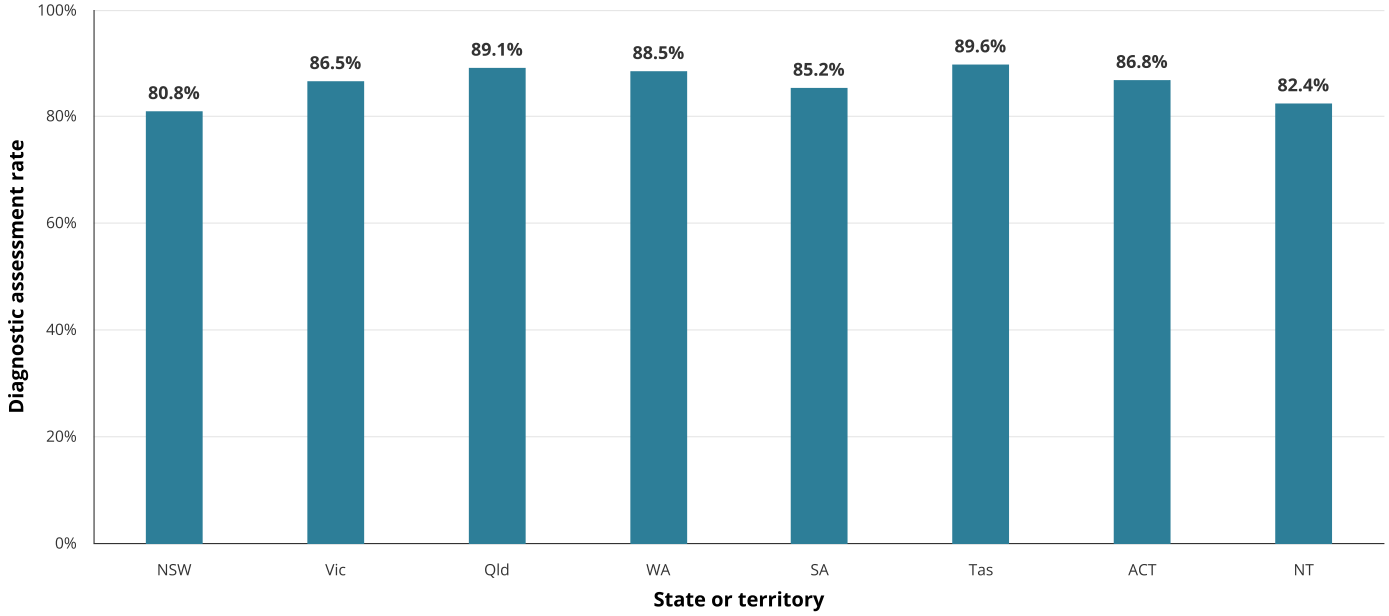
Figure 3.11: Diagnostic assessment rate (colonoscopy) of people aged 50–74, Australia, 2007–2024



Source: Table A3.14.

State or territory: The follow-up diagnostic assessment rate was highest for people living in Tasmania (90%) and lowest for those living in New South Wales (81%) (Figure 3.12). Note that differences in form return and varying pathway practices for diagnostic assessment may affect the results across jurisdictions.

Figure 3.12: Diagnostic assessment rate (colonoscopy) of people aged 50-74, by state and territory, Australia, 2024

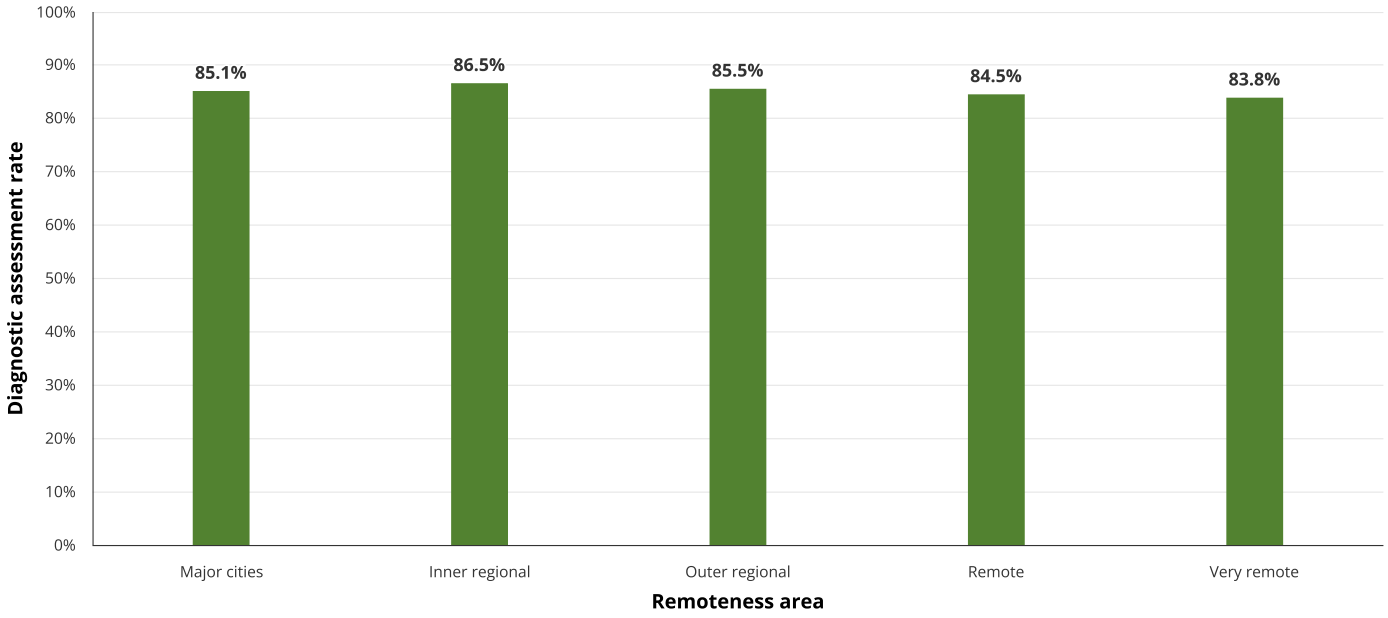


Source: Table A3.12.

Remoteness area: The follow-up diagnostic assessment rate was highest for people living in *Inner regional* areas (87%) and lowest for people living in *Very remote* areas (84%) (Figure 3.13a).

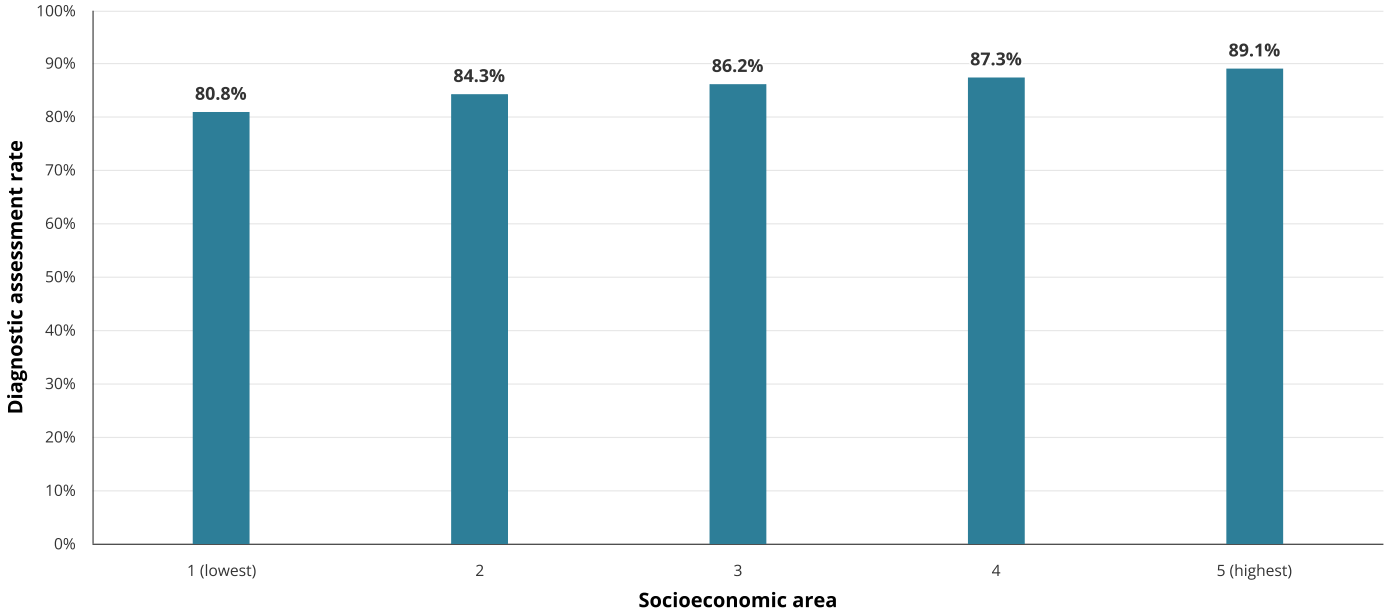
Socioeconomic area: The follow-up diagnostic assessment rate was highest for people living in the highest socioeconomic areas (89%) and lowest for those living in the lowest socioeconomic areas (81%) (Figure 3.13b).

Figure 3.13a: Diagnostic assessment rate (colonoscopy) of people aged 50-74, by remoteness area, Australia, 2024



Source: Table A3.12.

Figure 3.13b: Diagnostic assessment rate (colonoscopy) of people aged 50-74, by socioeconomic area, Australia, 2024



Source: Table A3.12.

Indigenous status: Indigenous Australians had a lower follow-up diagnostic assessment rate than non-Indigenous Australians (79% compared with 86%, respectively) (Table A3.13).

Preferred language spoken at home: People who preferred to speak a language other than English at home had a lower follow-up diagnostic assessment rate than those who spoke English at home (79% compared with 86%, respectively) (Table A3.13).

Disability status: People reporting severe or profound activity limitation had a lower follow-up diagnostic assessment rate than those not reporting such limitation (70% compared with 87%, respectively) (Table A3.13). Note that from 2025 the simplified participant details form no longer asks for self-reported disability status. This disaggregation will be phased out in future reports in favour of future data linkage projects collecting disability status.

PI 4 – Time between positive screen and diagnostic assessment

PI 4 definition

For those who received a positive NBCSP screening test (warranting further assessment) between 1 January 2024 and 31 December 2024, the median time between the positive screen and a follow-up diagnostic assessment within that period or by 31 December 2025.

Rationale: Waiting for a definitive diagnosis after a positive screen can create anxiety. There are various steps, participant decisions, and waiting times that occur along the pathway between a positive screen and a diagnostic assessment. Therefore, this indicator should not be considered a hospital wait time indicator. However, after a positive screen, further diagnostic assessment should occur in a timely fashion as there is a defined risk of bowel cancer in those with a positive screening test – and any harms (such as anxiety) from a positive screen should be minimised.

Data quality: This indicator relies on information being reported to the NCSR (ACSQHC 2020); however, this reporting is not mandated by the NBCSP and is known to be incomplete. Therefore, there is an unknown level of under-reporting for this indicator, and levels of under-reporting may differ across groups (for example, across jurisdictions and across remoteness and socioeconomic areas). Participants with only an MBS claim for colonoscopy services are included (and assumed to have been performed in a private health-care setting), though outcomes from this colonoscopy source are not known. In this report colonoscopy data have been supplemented with Participant follow-up function (PFUF) data for those who had a positive screening test. See Improvements to the known colonoscopy count in Appendix A for further details.

Guide to interpretation: This indicator includes all people with a positive screen in the defined period, not all those invited in the defined period.

Details of the number and proportion of participants for whom time between positive screen and diagnostic assessment was less than or equal to 30, 60, 120, 180, or 360 days, or greater, are included in tables A3.15–A3.17 (Appendix A), together with median time and 90th percentile information in tables A3.18–A3.22.

Those aged 45–49 can now request a screening kit; however, this age group is not reported in this performance indicator.

National median time between positive screen and diagnostic assessment, 2024: 62 days.

The following apply for the 73,745 participants who had a positive screening test in 2024 with a diagnostic assessment recorded:

Australia-wide: The median time between positive screen and assessment was 62 days (Table A3.18).

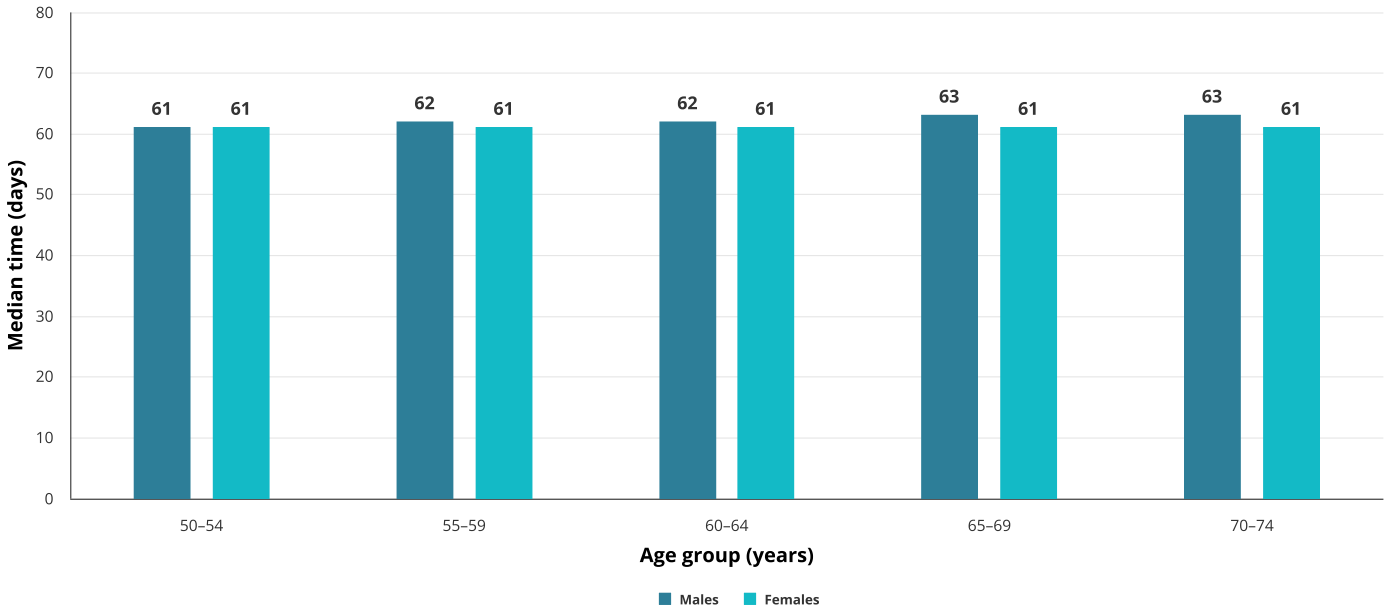
Sex: The median time between a positive screen and diagnostic assessment was 62 days for males and 61 days for females (Figure 3.14).

Age: The median time between a positive screen and diagnostic assessment was from 61 to 62 days across age groups (Figure 3.14).

Health-care provider: The median time between a positive screen and diagnostic assessment for people who went through the private or public health-care systems was 49 and 85 days, respectively (Table A3.19).

Around 14% of diagnostic assessments did not state through which system (public or private) the follow-up assessment was performed. As this indicator relies on information being reported to the NCSR (ACSQHC 2020), and since reporting is not mandated by the NBCSP, differences in wait times by public and private providers should be considered in light of these limitations.

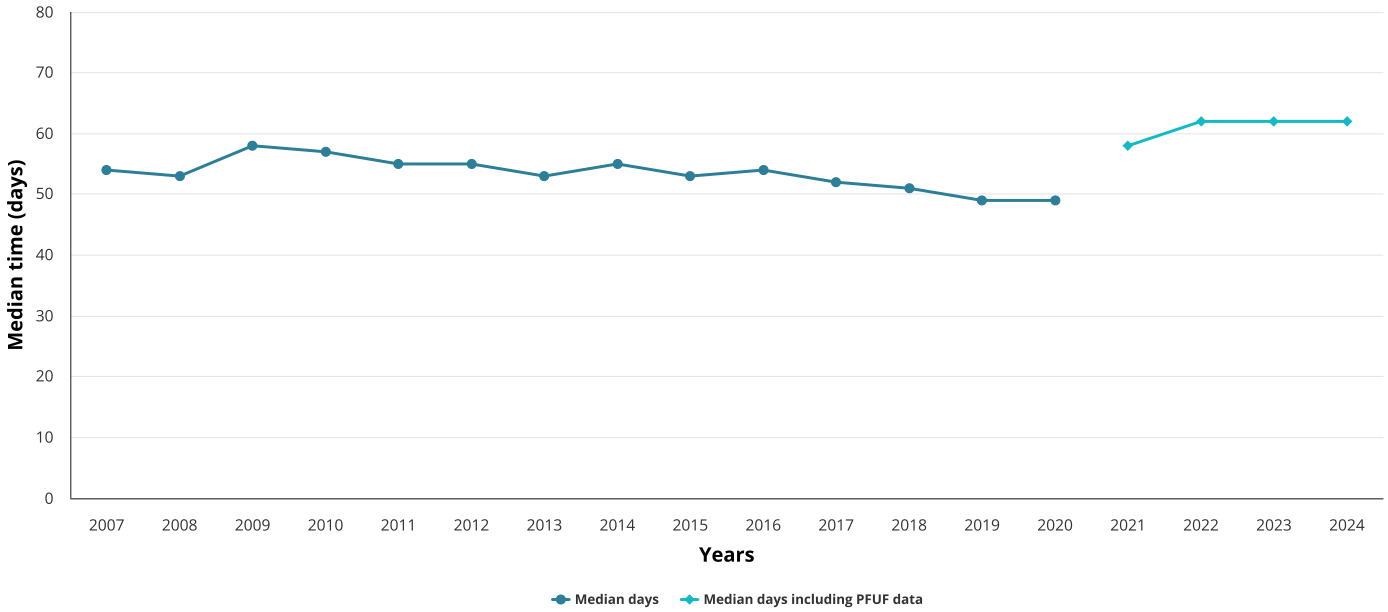
Figure 3.14: Median time (in days) between positive screen and diagnostic assessment of people aged 50-74, by sex and age, Australia, 2024



Source: Table A3.18.

Trend: Monitoring reports before 2016 did not include this analysis, so trend comparisons with data from these earlier reports cannot be made. To allow trends to be compared over time, the new indicator specifications have been applied retrospectively to earlier years of program data within this report. However, note that from 2021 colonoscopy form data and MBS claims have been supplemented with Participant follow-up function (PFUF) data, so direct comparisons between 2021 and earlier time periods should not be made. The median time between a positive screen and diagnostic assessment has been 62 days for the last three years (2022–2024) (Figure 3.15).

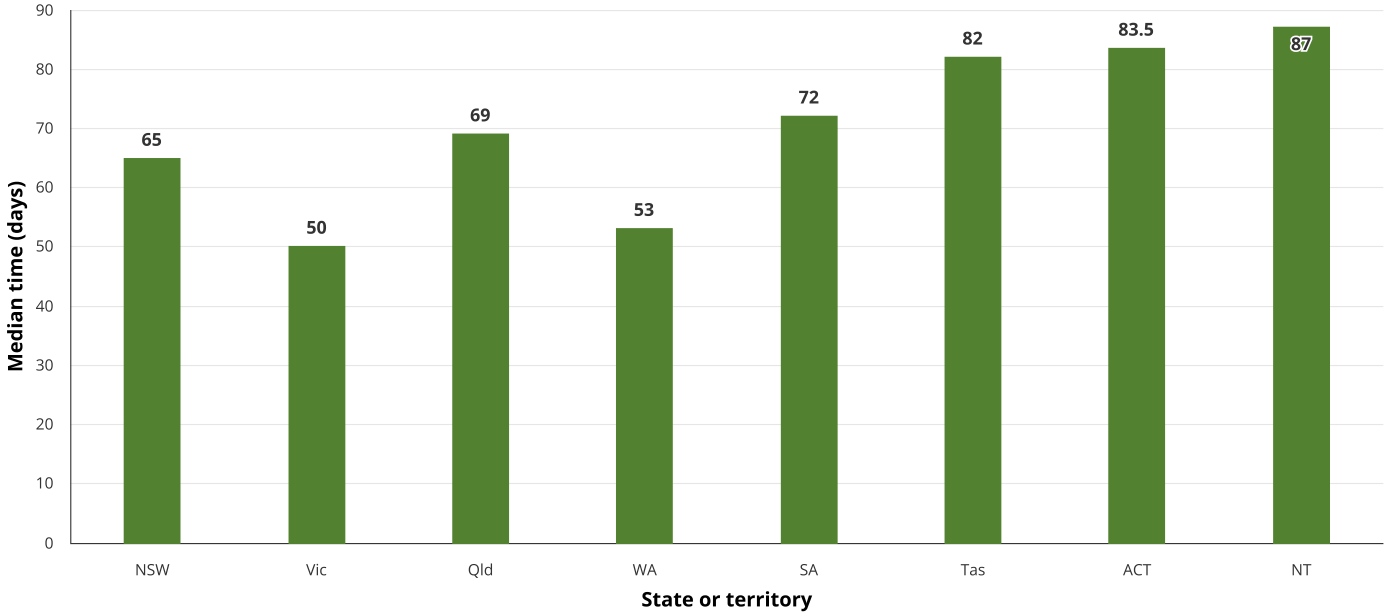
Figure 3.15: Median time (in days) between positive screen and diagnostic assessment of people aged 50-74, Australia, 2007-2024



Source: Table A3.22.

State or territory: The median time between a positive screen and diagnostic assessment was highest for people living in the Northern Territory (87 days) and lowest for those living in Victoria (50 days) (Figure 3.16). Note that differences in form return and varied pathway practices for diagnostic assessment may affect the results across jurisdictions.

Figure 3.16: Median time (in days) between positive screen and diagnostic assessment of people aged 50-74, by state or territory, Australia, 2024

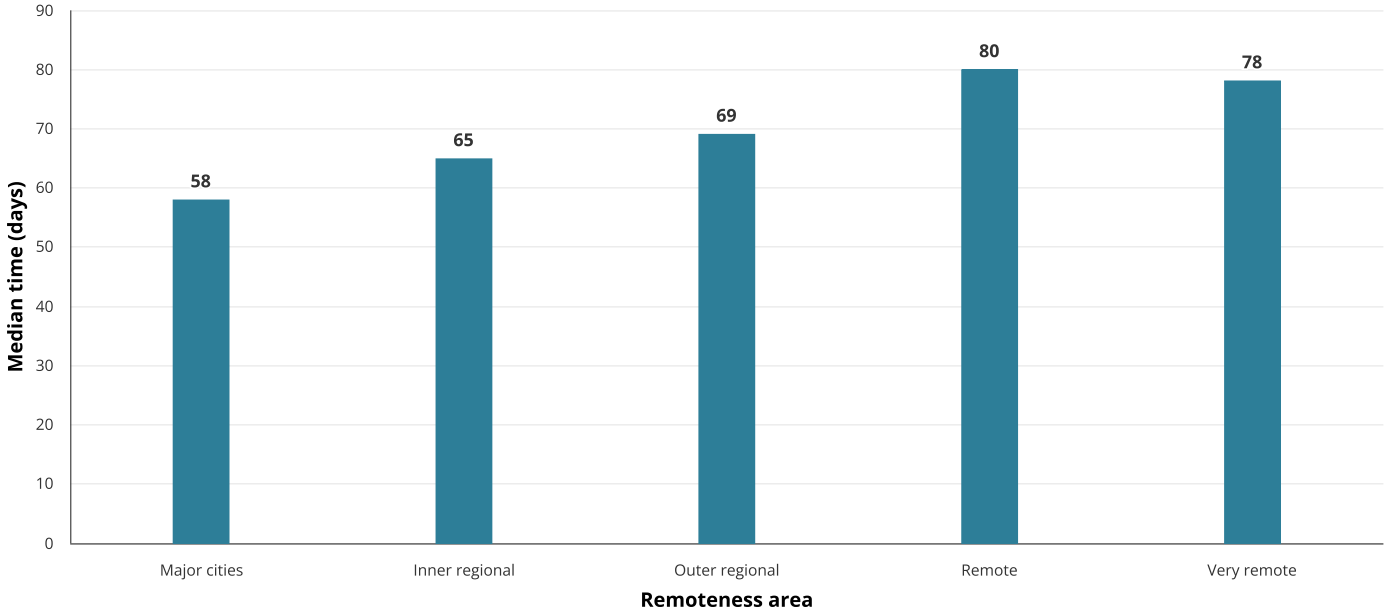


Source: Table A3.20.

Remoteness area: The median time between a positive screen and diagnostic assessment was highest for people living in *Remote areas* (80 days) and lowest for those in *Major cities* (58 days) (Figure 3.17a).

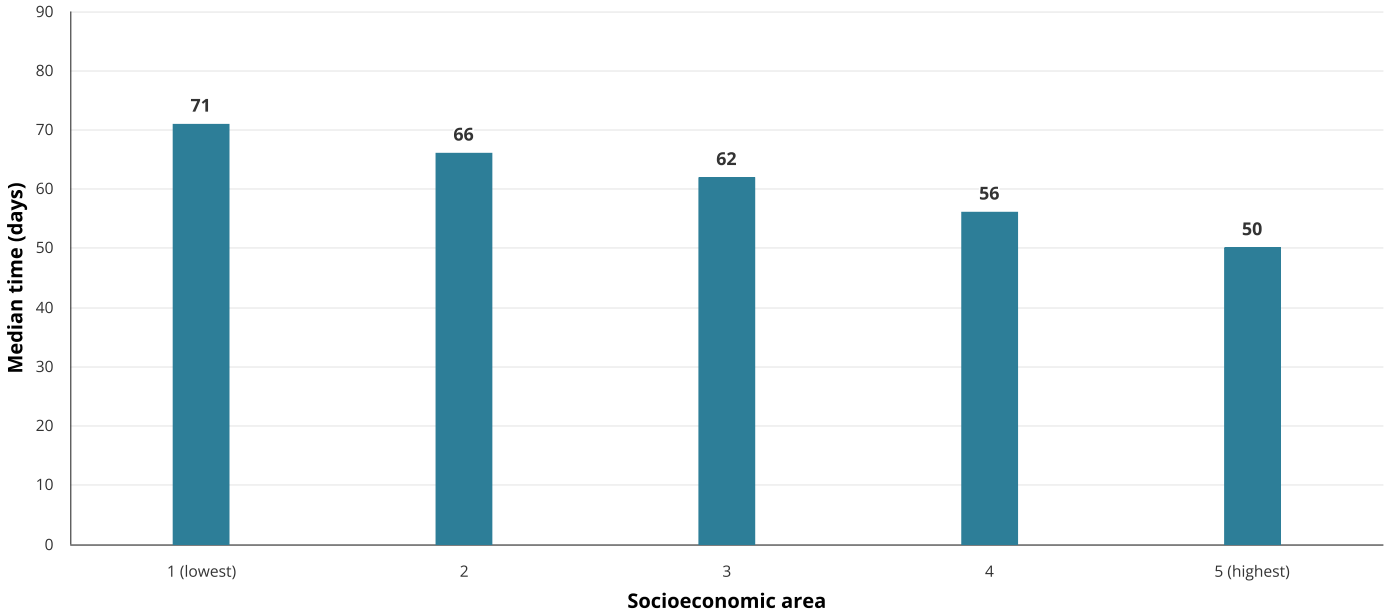
Socioeconomic area: The median time between a positive screen and diagnostic assessment was highest for people living in the lowest socioeconomic areas (71 days) and lowest for those in the highest socioeconomic areas (50 days) (Figure 3.17b).

Figure 3.17a: Median time (in days) between positive screen and diagnostic assessment of people aged 50-74, by remoteness area, Australia, 2024



Source: Table A3.20.

Figure 3.17b: Median time (in days) between positive screen and diagnostic assessment of people aged 50-74, by socioeconomic area, Australia, 2024



Source: Table A3.20.

Indigenous status: There was a longer median time between a positive screen and diagnostic assessment for Indigenous Australians (77 days) than for non-Indigenous Australians (61 days) (Table A3.21).

Preferred language spoken at home: Those who preferred to speak a language other than English at home had a longer median time between a positive screen and diagnostic assessment compared with those who spoke English at home (64 and 61 days, respectively) (Table A3.21).

Disability status: Participants reporting severe or profound activity limitation had a longer median time between a positive screen and diagnostic assessment (82 days) than those not reporting such limitation (60 days) (Table A3.21). Note that from 2025 the simplified participant details form no longer asks for self-reported disability status. This disaggregation will be phased out in future reports in favour of future data linkage projects collecting disability status.

References

ACSQHC (Australian Commission on Safety and Quality in Health Care) (2020) *Colonoscopy Clinical Care Standard*, Australian Commission on Safety and Quality in Health Care, Sydney, accessed 14 May 2025.

Standing Committee on Screening (2018) *Population Based Screening Framework*. *Report prepared for the Community Care and Population Health Principal Committee of the Australian Health Ministers' Advisory Council*, Department of Health, Australian Government, accessed 18 April 2023.

Diagnosis

In this section

The diagnosis data available were not considered complete enough to allow formal reporting for the following performance indicators:

- PI 5a – Adenoma detection rate
- PI 5b – Positive predictive value of diagnostic assessment for detecting adenoma
- PI 8 – Cancer clinico-pathological stage distribution

The following performance indicators are reported, but have not had results updated in this report from those included in the previous monitoring report:

- PI 6a – Bowel cancer detection rate
- PI 6b – Positive predictive value (PPV) of diagnostic assessment for detecting bowel cancer
- PI 7 – Interval cancer rate

These will be updated in future monitoring reports.

See *Analysis of bowel cancer outcomes for the National Bowel Cancer Screening Program 2018* (AIHW 2018) for the most recent stage distribution data.

See Bowel abnormality detection using available assessment and histopathology data at the end of this section for a summary of bowel abnormality detection using data available.

PI 6a – Bowel cancer detection rate

PI 6a definition

The proportion of people who screened through the NBCSP between 1 January 2019 and 31 December 2019 and were diagnosed with a screen-detected bowel (colorectal) cancer within that period or by 31 December 2020.

Rationale: The cancer detection rate is a key indicator of program effectiveness, especially when comparing this rate to the known bowel cancer incidence rate in the target population. Monitoring the cancer detection rate by various stratifications may also reveal emerging positive or negative trends that need to be investigated and rectified if necessary.

Data quality: All iFOBT kits returned are recorded in the NCSR. These are matched with national cancer incidence data, which is considered complete due to cancer being a notifiable disease.

Guide to interpretation: Results for this indicator have not been updated in this report and match those reported in the previous monitoring report.

The matching process across data sets involved creating record pairs by matching records from the NCSR with records from the Australian Cancer Database. Due to the nature of probabilistic linkage, there may be some minor but unavoidable inaccuracy in the linkage process, and this should be considered when interpreting the results.

This indicator counts all valid iFOBT tests analysed in the defined period, not tests analysed from those invited in the defined period.

The rollout of biennial screening was completed in 2019, with years before that having a smaller set of target invitation ages (Table 1.2). As the detection rate differs by age at screen, results across earlier program years may vary due to differences in participant age distribution. Future data, from 2019 onwards, should be less affected.

Detection rate data by Indigenous Australians, by preferred language spoken at home, and by disability status are not currently available.

National bowel cancer detection rate, 2019: 20.3 cancers diagnosed per 10,000 people who returned a valid screening test.

The following apply to the 1,321,993 people who returned a valid iFOBT kit from 1 January 2019 to 31 December 2019:

Australia-wide: A total of 2,683 screen-detected bowel cancers were diagnosed in people who participated in the NBCSP, giving an overall Australia-wide bowel cancer detection rate of 20.3 cancers diagnosed per 10,000 people screened (Table A3.23).

Sex: Males had a higher cancer detection rate than females (24.6 cancers per 10,000 screened compared with 16.5 per 10,000 screened (Table A3.23).

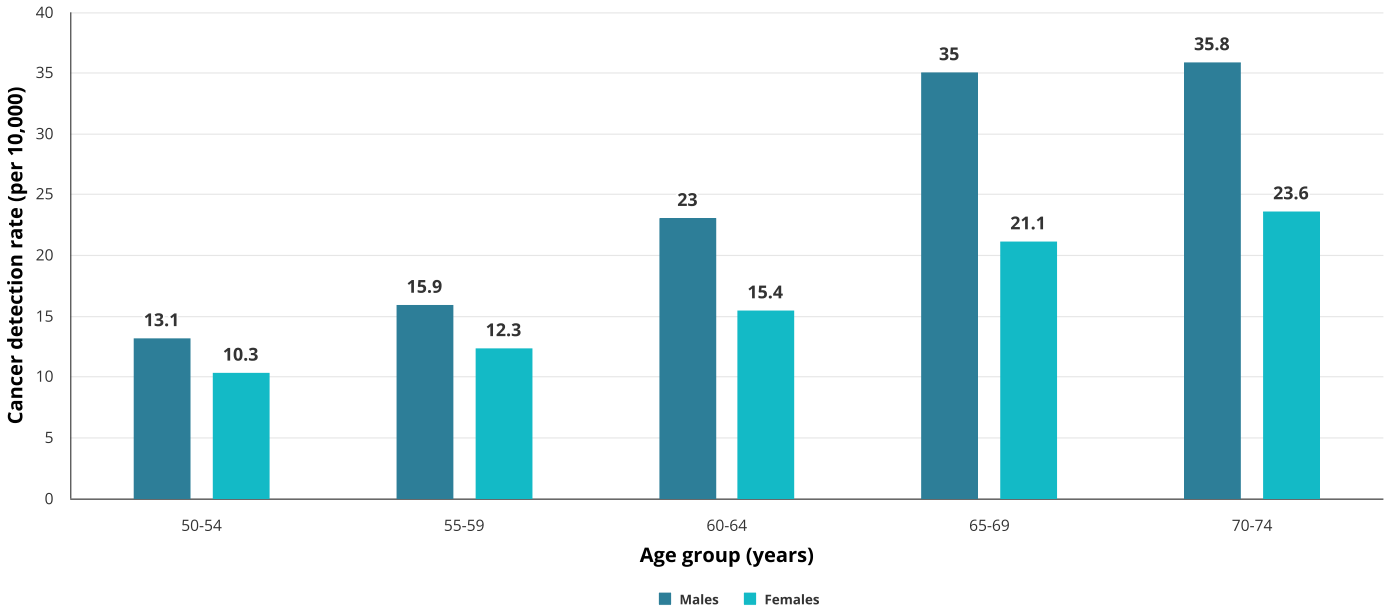
Age: The cancer detection rate increased with each age group, from 11.6 cancers per 10,000 screened for people aged 50–54 at screening to 29.5 per 10,000 for people aged 70–74 (Figure 3.18a).

Screening round: The cancer detection rate was highest for people returning their first screening test (28.8 cancers per 10,000 screened) (Figure 3.18b). This varied by age at first screen, from 14.1 per 10,000 screened for people aged 50–54 to 61.1 per 10,000 screened for people aged 70–74 (Table A3.24b).

Regarding rescreeners:

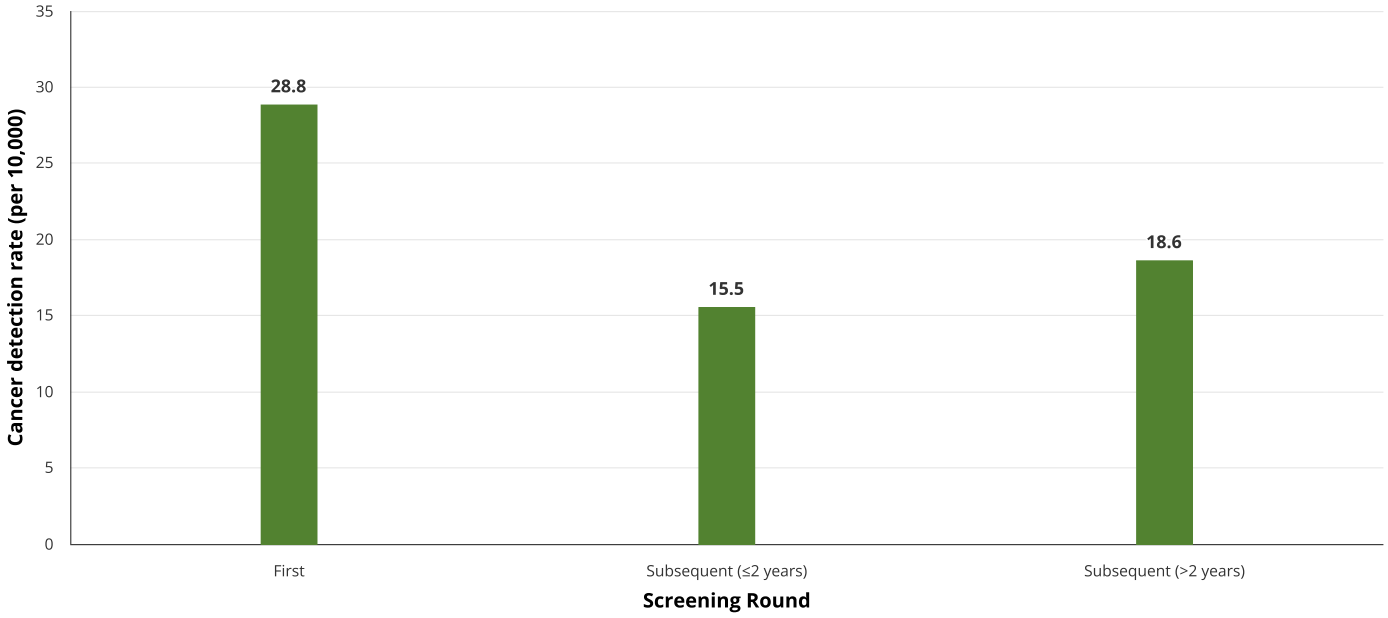
- those rescreening at their next biennial invitation had a cancer detection rate of 15.5 cancers detected per 10,000 screened, and
- those whose previous screening test was more than 2.5 years ago had a cancer detection rate of 18.6 cancers detected per 10,000 screened.

Figure 3.18a: Bowel cancer detection rate of people aged 50–74, by sex and age, Australia, 2019



Source: Table A3.23.

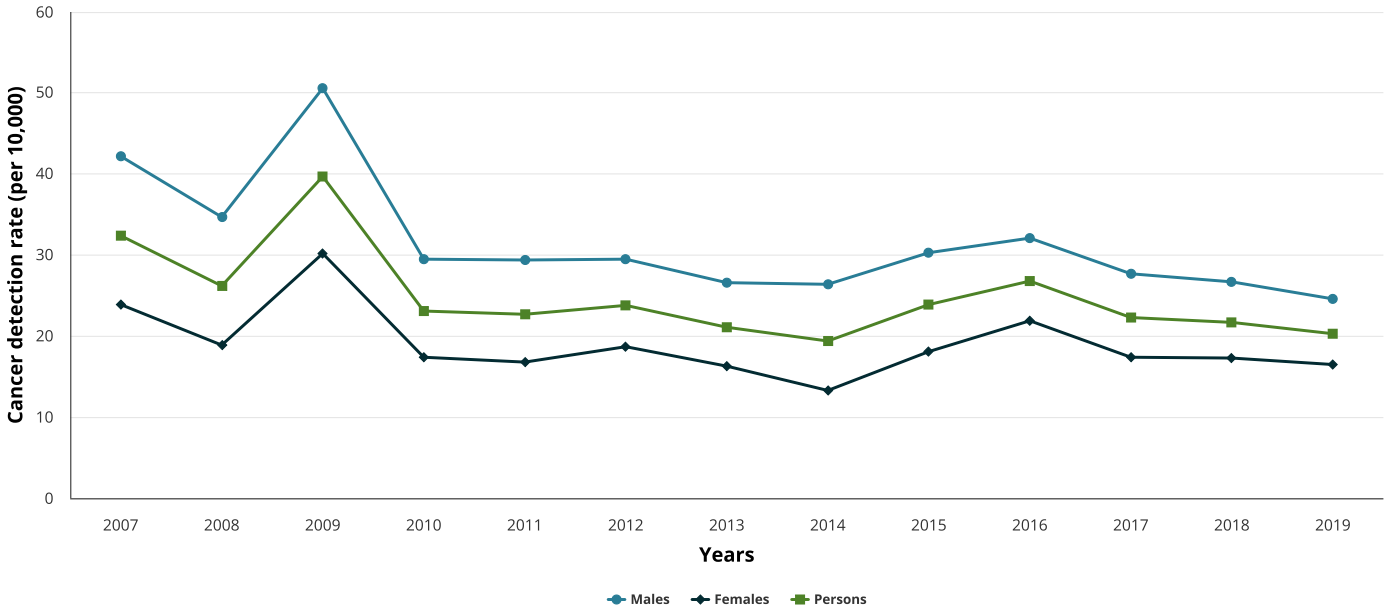
Figure 3.18b: Bowel cancer detection rate of people aged 50–74, by screening round, Australia, 2019



Source: Table A3.24a.

Trend: Since 2010, the cancer detection rate has fluctuated between 19 and 27 cancers diagnosed per 10,000 screened. For 2007 and 2008, the target ages invited were mainly 55- and 65-year-olds, leading to higher rates. For 2009, there was a change in the kit that meant only strongly positive screens were likely to be detected as positive; negative results were sent a replacement kit (Figure 3.19).

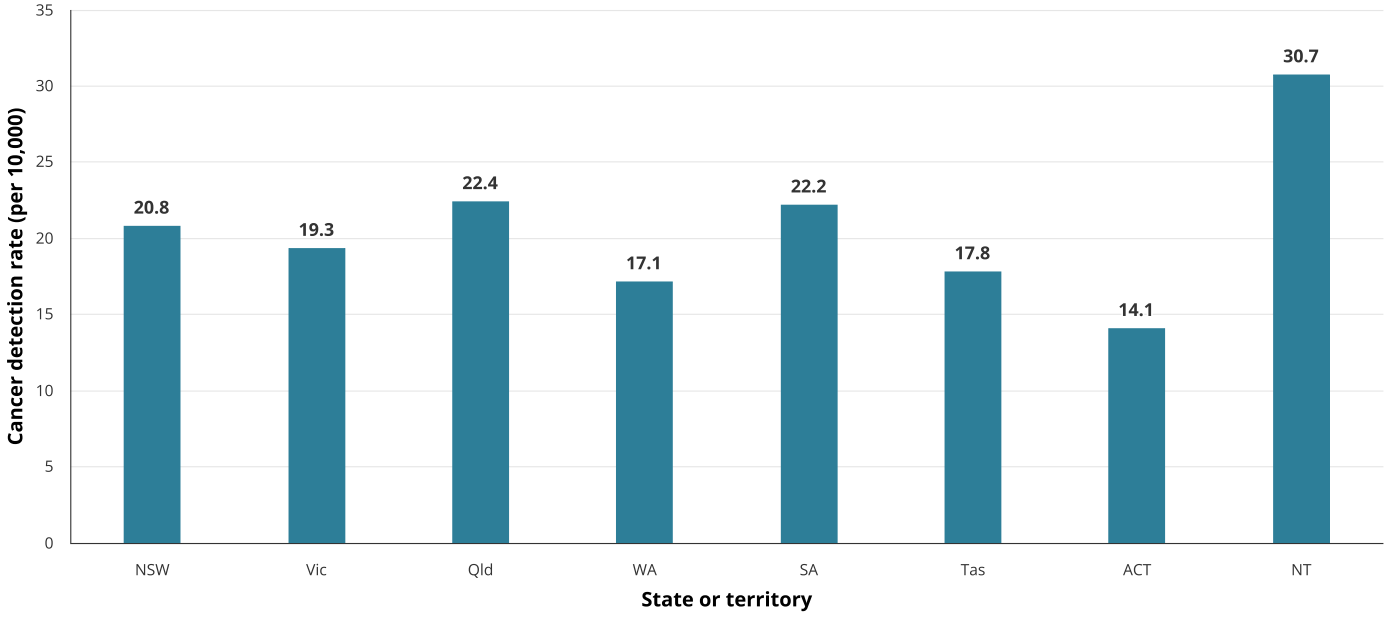
Figure 3.19: Bowel cancer detection rate of people aged 50–75+, by sex, Australia, 2007 to 2019



Source: Table A3.26.

State or territory: The cancer detection rate was highest for people living in the Northern Territory (30.7 cancers detected per 10,000 screened) and lowest for people living in the Australian Capital Territory (14.1 cancers detected per 10,000 screened) (Figure 3.20).

Figure 3.20: Bowel cancer detection rate of people aged 50–75+, by state or territory, Australia, 2019



Source: Table A3.25.

PI 6b – Positive predictive value (PPV) of diagnostic assessment for detecting bowel cancer

PI6b definition

The percentage of people who returned a positive screening test and underwent diagnostic assessment between 1 January 2019 and 31 December 2019 and were diagnosed with a screen-detected bowel (colorectal) cancer within that period or by 31 December 2020.

Rationale: This indicator calculates the positive predictive value (PPV) of diagnostic assessment for detecting cancers; it is a measure of the quality and effectiveness of diagnostic assessment. Monitoring the PPV by various stratifications may also reveal emerging positive or negative trends that need to be investigated and rectified if necessary.

Data quality: All positive iFOBT results are recorded in the NCSR; however, not all diagnostic assessments are. This may lead to PPV results that are slightly higher than in reality. These are matched with national cancer incidence data, which is considered complete due to cancer being a notifiable disease.

Guide to interpretation: Results for this indicator have not been updated in this report and match those reported in the previous monitoring report.

The matching process across data sets involved creating record pairs by matching records from the NCSR with records from the Australian Cancer Database. Due to the nature of probabilistic linkage, there may be some minor but unavoidable inaccuracy in the linkage process, and this should be considered when interpreting the results.

This indicator counts all diagnostic assessments in the defined period, not tests analysed from those invited in the defined period; therefore, the cohort for this indicator is different from that in indicator 6a. Further, the denominator is therefore affected by accuracy of diagnostic assessment notifications to the register, which are not mandated by the NBCSP. This should be taken into consideration when analysing this indicator.

The rollout of biennial screening was completed in 2019, with years before that having a smaller set of target invitation ages (Table 1.2). As the PPV differs by age at screen, results across earlier program years may vary due to differences in participant age distribution. Future data, from 2019 onwards, should be less affected.

PPV data by Indigenous Australians, by preferred language spoken at home, and by disability status are not currently available.

National positive predictive value (PPV) of diagnostic assessment for detecting bowel cancer, 2019: 3.8 cancers per 100 diagnostic assessments after a positive screen.

The following apply to the 64,510 people who underwent a diagnostic assessment after a positive screen from 1 January 2019 to 31 December 2019:

Australia-wide: A total of 2,463 screen-detected bowel cancers were diagnosed in people who underwent a diagnostic assessment after a positive screen, giving an overall Australia-wide positive predictive value (PPV) of 3.8% (Table A3.27).

Sex: Males had a higher PPV than females (4.1% compared with 3.4% (Table A3.27)).

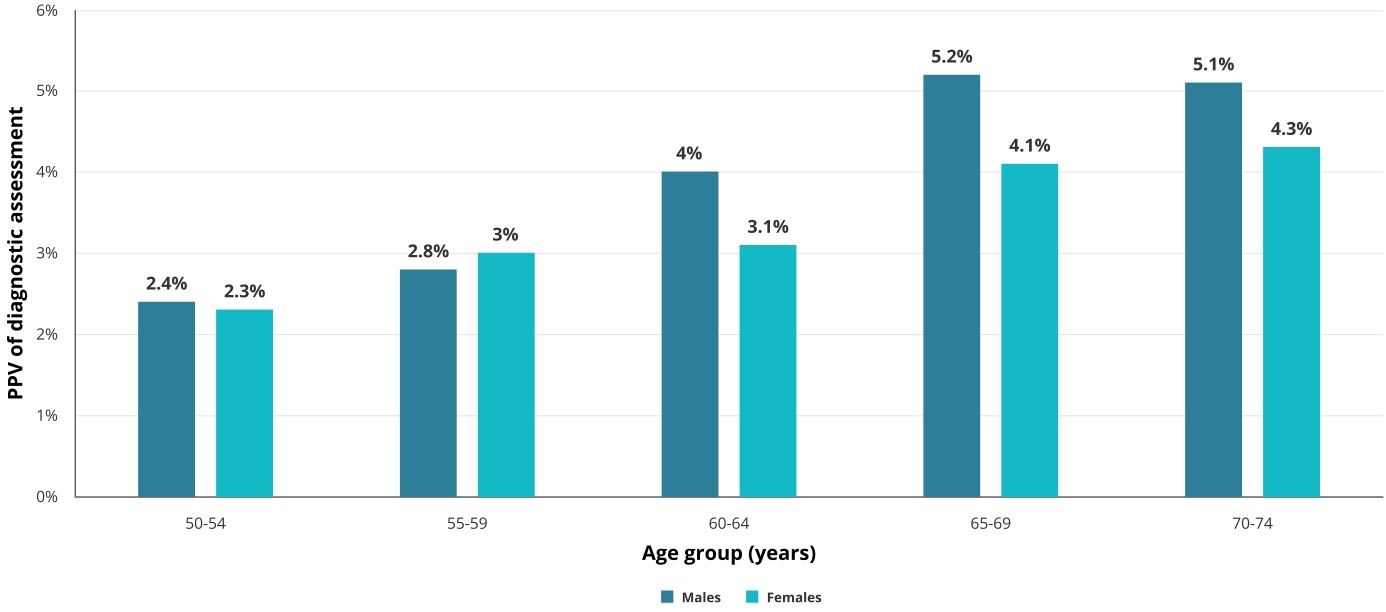
Age: The PPV increased with each age group, from 2.4% for people aged 50–54 to 4.8% for people aged 70–74 (Figure 3.21a).

Screening round: The PPV was highest for people with a positive screen result from their first screening test (5.0%) (Figure 3.21b). This varied by age at first screen, from 2.7% for people aged 50–54 to 7.8% for people aged 70–74 (Table A3.28b).

For those with a positive screen result in a subsequent screening round:

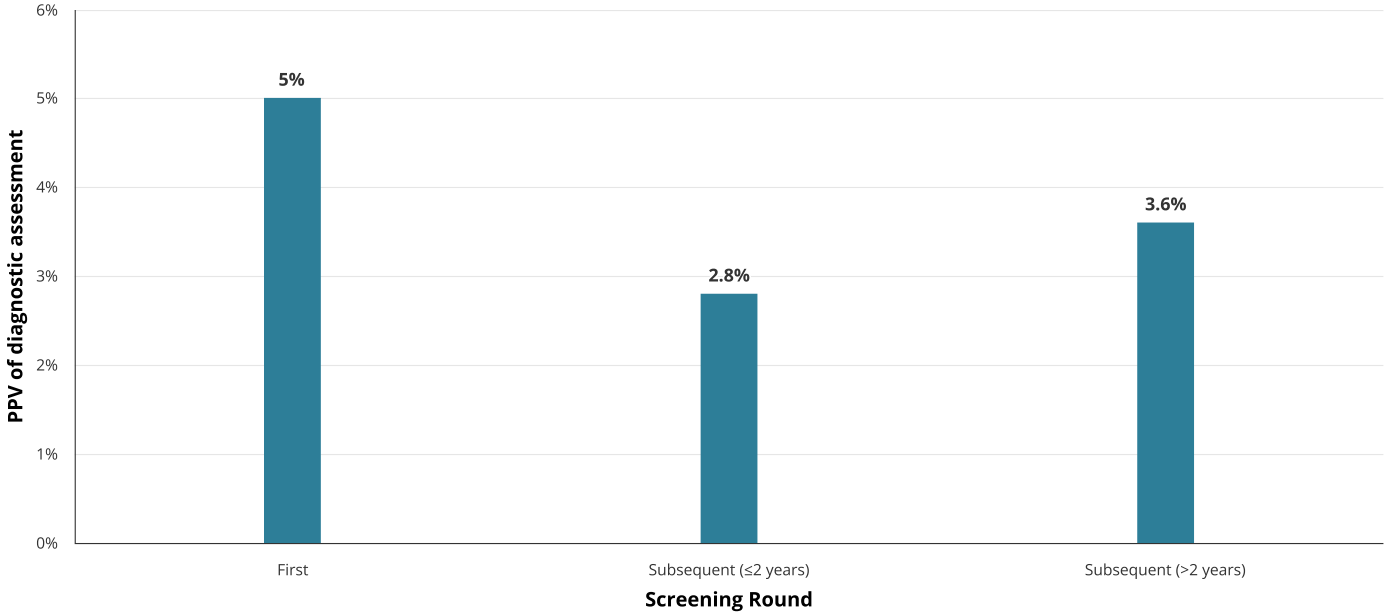
- those rescreening at their next biennial invitation had a PPV of 2.8%, and
- those whose previous screening test was more than 2.5 years ago had a PPV of 3.6%.

Figure 3.21a: PPV of diagnostic assessment for detecting bowel cancer for people aged 50–74, by sex and age, Australia, 2019



Source: Table A3.27

Figure 3.21b: PPV of diagnostic assessment for detecting bowel cancer for people aged 50–74, by screening round, Australia, 2019

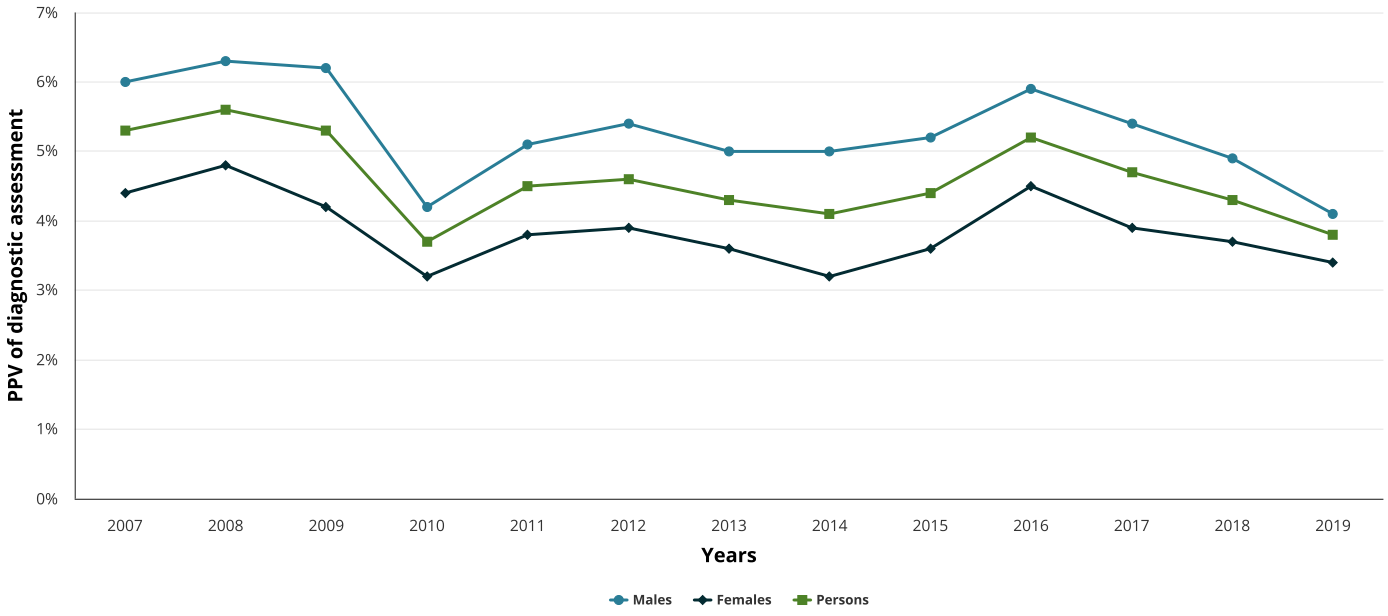


Source: Table A3.28a.

Trend: Since 2010, the PPV has fluctuated between 3.7% and 5.2%. (Figure 3.22). The rollout of biennial screening was completed in 2019, with years before that having a smaller set of target invitation ages (Table 1.2). As the PPV differs by age at screen, results across earlier program years may vary due to differences in participant age distribution. Future data, from 2019 onwards, should be less affected.

As noted under Guide to interpretation, the PPV is affected by the completeness of diagnostic assessment notifications to the NCSR, which are not mandated by the NBCSP.

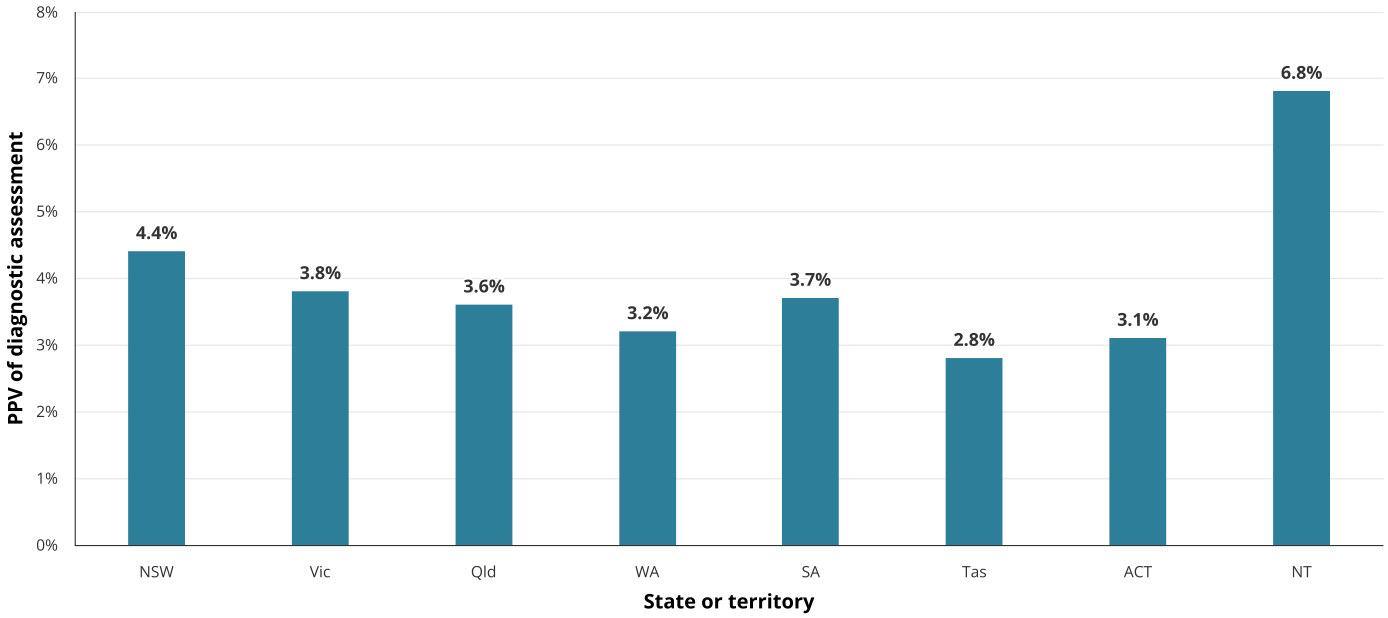
Figure 3.22: PPV of diagnostic assessment for detecting bowel cancer for people aged 50–74, by sex, Australia, 2007 to 2019



Source: Table A3.30.

State or territory: The PPV was highest for people living in the Northern Territory (6.8%) and lowest for people living in Tasmania (2.8%) (Figure 3.23).

Figure 3.23: PPV of diagnostic assessment for detecting bowel cancer for people aged 50–74, by state or territory, Australia, 2019



Source: Table A3.29.

PI 7 – Interval cancer rate

PI 7 definition

The proportion of people who returned a negative or inconclusive screening test between 1 January 2018 and 31 December 2018 and were diagnosed with bowel (colorectal) cancer within 24 months of their screening test.

Rationale: A low interval cancer rate in a population-based screening program is desirable. However, interval cancers are inevitable. A high interval cancer rate reduces the potential for the program to achieve reductions in morbidity and mortality from bowel cancer. Monitoring interval cancer rates is also important to assess the diagnostic assessment component of the screening pathway.

Monitoring the interval cancer rate by various stratifications may also reveal emerging positive or negative trends that need to be investigated and rectified if necessary.

Data quality: All iFOBT results are recorded in the NCSR. These are matched with national cancer incidence data, which is considered complete due to cancer being a notifiable disease.

Guide to interpretation: Results for this indicator have not been updated in this report and match those reported in the previous monitoring report.

The matching process across data sets involved creating record pairs by matching records from the NCSR with records from the Australian Cancer Database. Due to the nature of probabilistic linkage, there may be some minor but unavoidable inaccuracy in the linkage process, and this should be considered when interpreting the results.

This indicator includes all iFOBT tests analysed as negative in the defined period, not negative tests from those invited in the defined period.

The rollout of biennial screening was completed in 2019, with years before that having a smaller set of target invitation ages (Table 1.2). As the interval cancer rate differs by age at screen, results across earlier program years may vary due to differences in participant age distribution. Future data, from 2019 onwards, should be less affected.

Interval cancer rate data by Indigenous Australians, by preferred language spoken at home, and by disability status are not currently available.

National interval cancer rate, 2018: 6.3 cancers diagnosed per 10,000 people who returned a negative or inconclusive screening test.

The following apply to the 1,118,192 people who returned an iFOBT kit from 1 January 2018 to 31 December 2018 that was negative or inconclusive:

Australia-wide: A total of 701 interval cancers were diagnosed, giving an overall Australia-wide interval cancer rate of 6.3 cancers diagnosed within 2 years per 10,000 people with a negative or inconclusive iFOBT (Table A3.31).

Sex: Males had a higher interval cancer rate than females (6.7 per 10,000 negative/inconclusive iFOBTs compared with 5.9 per 10,000 negative/inconclusive iFOBTs) (Table A3.31).

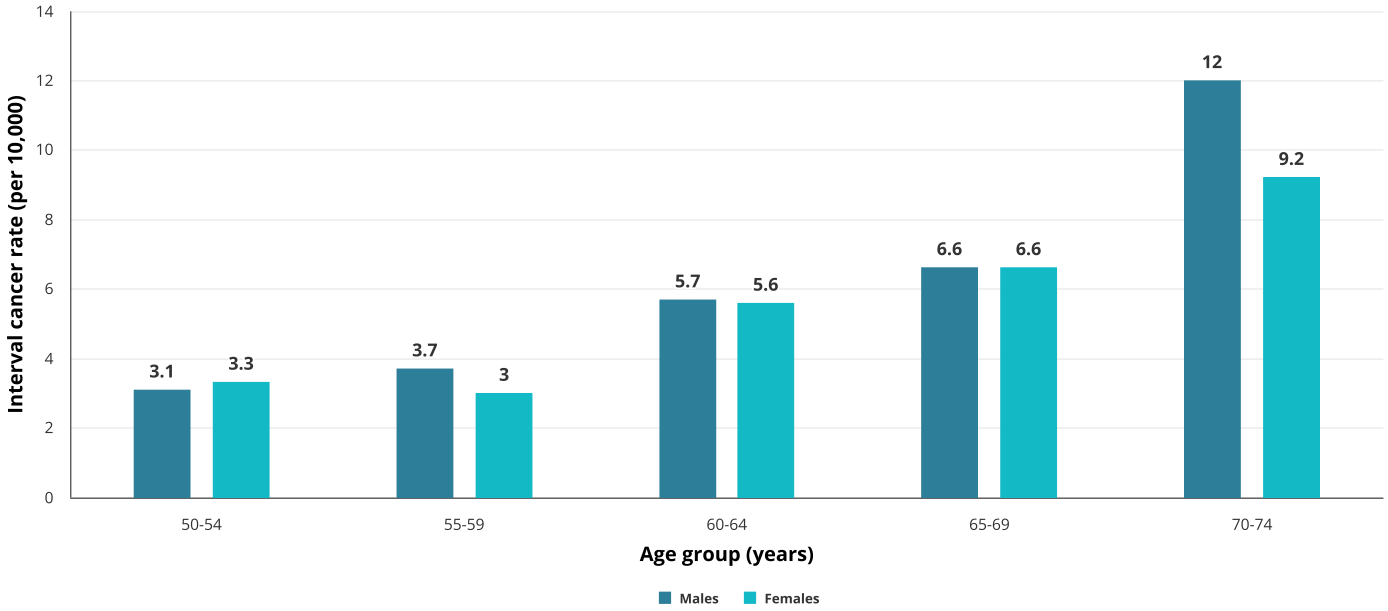
Age: The interval cancer rate generally increased with increasing age groups, from 3.2 per 10,000 negative/inconclusive iFOBTs for people aged 50–54 to 10.5 per 10,000 for people aged 70–74 (Figure 3.24a).

Screening round: The interval cancer rate for those returning their first iFOBT was 5.8 cancers detected per 10,000 negative/inconclusive iFOBTs (Figure 3.24b).

For those diagnosed with an interval cancer after a subsequent screening round:

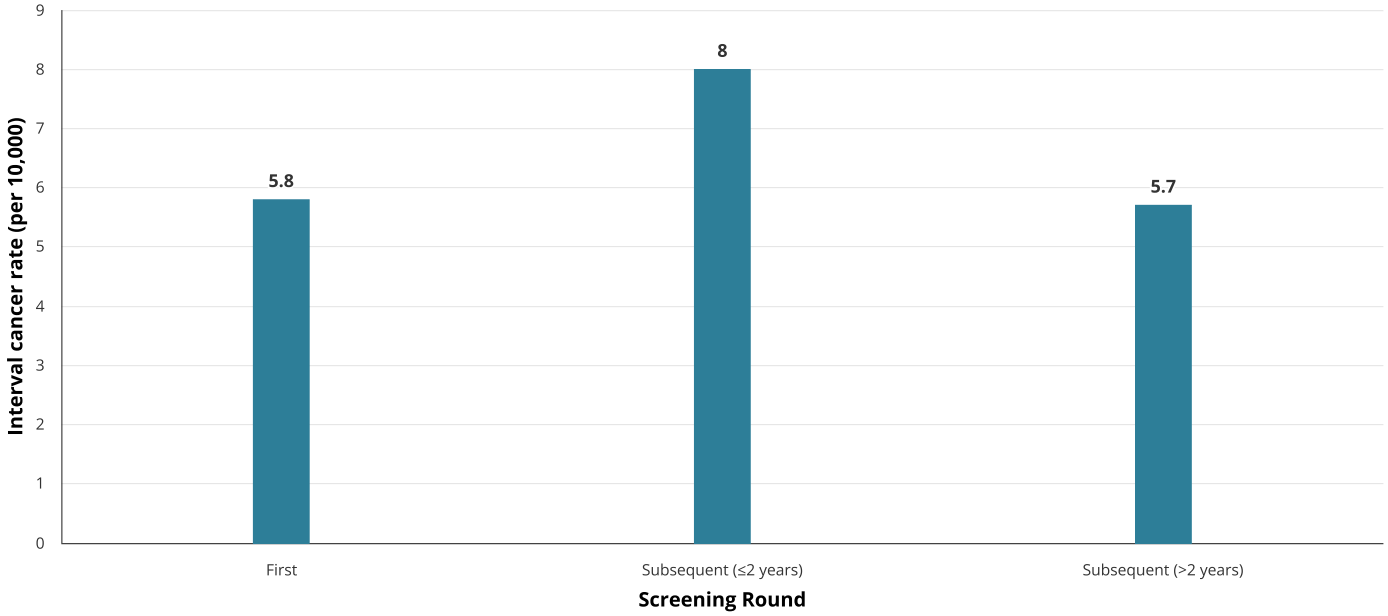
- the interval cancer rate was highest for people rescreening at a biennial screening interval (8.0 per 10,000 negative/inconclusive iFOBTs). This was mainly due to the biennial screening rollout (by 2018, Table 1.2) only having invitees older than 60 (who have higher rates of interval cancers than those aged 50–59) being eligible for a rescreening invitation within 2 years of their previous iFOBT (Table A3.32b).
- those whose previous screening test was more than 2.5 years ago, had an interval cancer rate of 5.7 interval cancers detected per 10,000 negative/inconclusive iFOBT.

Figure 3.24a: Interval cancer rate of people aged 50–74, by sex and age, Australia, 2018



Source: Table A3.31.

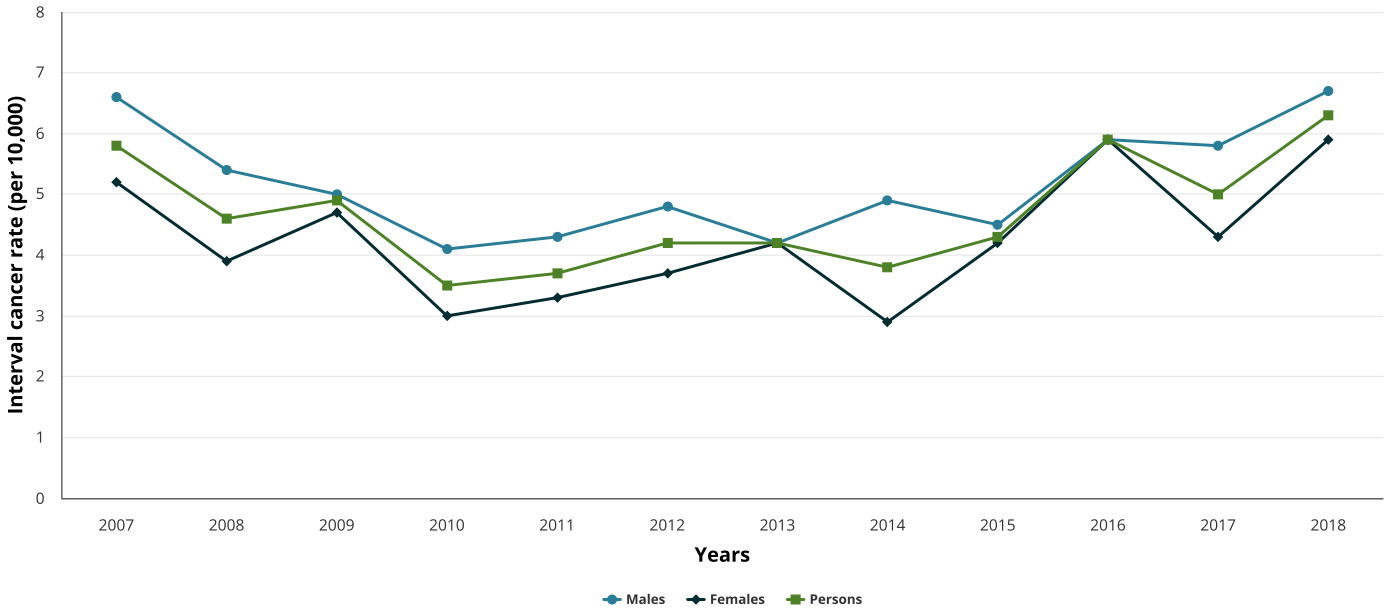
Figure 3.24b: Interval cancer rate of people aged 50–74, by screening round, Australia, 2018



Source: Table A3.32a.

Trend: The interval cancer rate has increased between 2010 and 2018 from 3.5 to 6.3 interval cancers detected per 10,000 negative/inconclusive iFOBTs (Figure 3.25). The rollout of biennial screening was completed in 2019, with years before that having a smaller set of target invitation ages (Table 1.2). As the interval cancer rate differs by age at screen, results across earlier program years may vary due to differences in participant age distribution. For example, reporting on interval cancers in those aged 70–74 (the age group with the highest rates of interval cancers (Figure 3.24)) has only been possible since 2015 due to the biennial rollout. Future data, from 2019 onwards, should be less affected.

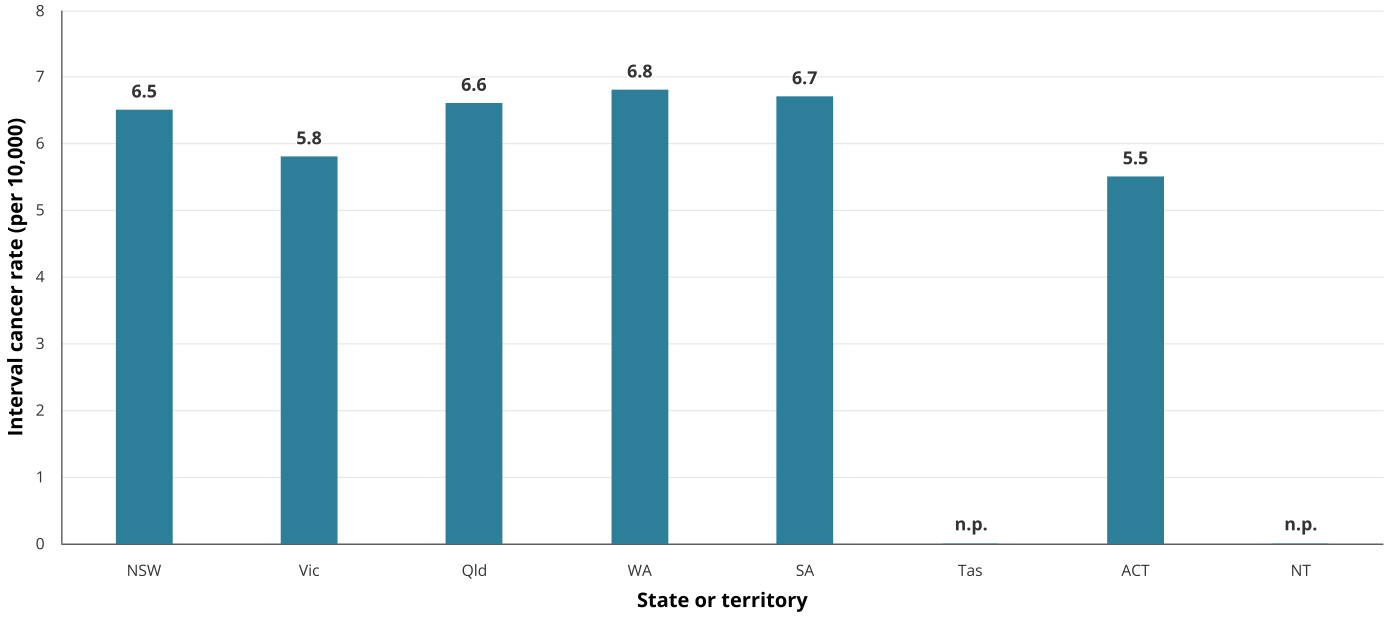
Figure 3.25: Interval cancer rate of people aged 50–74, by sex, Australia, 2007 to 2018



Source: Table A3.34.

State or territory: The interval cancer rate was highest for people living in Western Australia (6.8 per 10,000 negative/inconclusive iFOBTs) and lowest for people living in the Australian Capital Territory (5.5 per 10,000 negative/inconclusive iFOBTs) (Figure 3.26). Interval cancer rates for the Northern Territory and Tasmania have been suppressed in Figure 3.26 due to low counts.

Figure 3.26: Interval cancer rate of people aged 50–74, by state or territory, Australia, 2018



Source: Table A3.33.

Bowel abnormality detection results for 2024

Diagnosis data for 2024 were not considered complete enough to allow for all formal performance indicator reporting of NBCSP diagnostic outcomes in Performance of the screening program, hence those indicators use the latest available, though earlier, reporting periods with more complete data. As an alternative, a summary of bowel abnormality detection results for those assessed in 2024 are presented here for information, using available outcome data from colonoscopy and histopathology forms. In this report colonoscopy form data and MBS claims have been supplemented with Participant follow-up function (PFUF) data for those who had a positive screening test, increasing the number of known colonoscopies. However, colonoscopies sourced from PFUF reports or MBS claims have no accompanying outcome data so are excluded here.

Bowel abnormality detection using available assessment and histopathology data

Of the 62,981 participants who had a diagnostic assessment in 2024, 19,244 had outcome data. Of these:

- 195 (1.0%) had a bowel cancer detected and confirmed by histopathology
- 470 (2.4%) had a suspected bowel cancer at assessment that was still awaiting histopathological diagnosis
- 5,911 (30.7%) had an adenoma diagnosed by histopathology
- 7,018 (36.5%) had no adenoma or cancer recorded (includes those with no issue noted, or other diagnoses)
- 5,650 (29.4%) were still awaiting histopathology outcomes for a polyp biopsy sample (not suspected of being bowel cancer) to be reported to the NCSR (Table A3.35).

Rates of bowel cancer and adenoma detection differed by state or territory (Table A3.36). However, differences across states and territories may be affected by differences in return rates of histopathology forms and should be interpreted with caution.

Performance indicators 6a, 6b and 7 in 'Performance of the screening program, Diagnosis' use notifiable cancer incidence data for 2007–2020, and performance indicator 6b shows that 3.8% of those with a positive screen and diagnostic assessment in 2019 were diagnosed with bowel cancer. Therefore, due to incomplete colonoscopy and histopathology form return, the 1.0% diagnosed with bowel cancer in 2024 is likely underreported. However, including the 2.4% suspected of having bowel cancer in 2024 improves likely cancer detection accuracy.

References

AIHW (2018) *Analysis of bowel cancer outcomes for the National Bowel Cancer Screening Program 2018*, AIHW, Australian Government, accessed 09 May 2022.

Outcomes

In this section

PI 9 – Adverse events – hospital admission

PI 9 definition

The rate at which people who had a diagnostic assessment between 1 January 2024 and 31 December 2024 were admitted to hospital within 30 days of their assessment.

Rationale: As with any invasive procedure, there is the risk of an adverse event occurring with a colonoscopy. 'Maximising benefit and minimising harm' is an important tenet of population screening. Accordingly, it is important to report known harms from screening when monitoring the program's performance.

Data quality: Complete data for this indicator requires linkage with hospital data, which is being investigated, but is not currently performed. The NCSR should receive information on adverse events for participants who had an assessment (ACSQHC 2020), but provision of these data is not mandated by the NBCSP. However, these data will be used until a more complete data source becomes available. Therefore, there is currently an unknown level of under-reporting for this indicator.

In this report, colonoscopy form and MBS claim data have been supplemented with Participant follow-up function (PFUF) data for those who had a positive screening test, increasing the number of known colonoscopies. See Improvements to the known colonoscopy count in Appendix A for further details.

Guide to interpretation: This indicator includes all people who underwent a diagnostic assessment in the defined period, not all those invited in the defined period. Therefore, assessment counts here may differ to other indicators. As per the adverse event form, unplanned hospital admissions after a colonoscopy are recorded only if they occurred within 30 days of the procedure.

Those aged 45–49 can now request a screening kit; however, this age group is not reported in this performance indicator.

National hospital admission rate, 2024: 0.5 per 10,000 assessments.

The following apply to the 62,981 people who had a diagnostic assessment in 2024:

Australia-wide: Three people were admitted to hospital within 30 days of assessment, giving an overall Australia-wide hospital admission rate after assessment of 0.5 per 10,000 assessments (Table A3.37). Reporting of adverse events after an NBCSP colonoscopy is required (ACSQHC 2020) but not mandated by the NBCSP - this rate may be underestimated.

Due to concerns about the level of data completeness, no other disaggregations are presented for this indicator.

PI 10 – Incidence of bowel cancer

PI 10 definition

The (estimated) incidence rate for bowel cancer per 100,000 estimated resident population aged 50–74 between 1 January 2025 and 31 December 2025.

Rationale: Incidence data provide contextual information about the number of new cases of bowel cancer in the population, which can inform NBCSP planning.

Data quality: Each Australian state and territory has legislation requiring mandatory reporting of cancer (excluding basal cell and squamous cell carcinomas of the skin).

The 2021 Australian Cancer Database used in this report contains data on cancers diagnosed up to and including the year 2021.

Guide to interpretation: The latest estimated incidence results (for 2025) are given where possible. However, estimated 2025 incidence numbers are not available for analysis by state or territory, by remoteness and socioeconomic areas, or by Indigenous status. Hence, for these stratifications, the latest actual data to 2021 (the latest year of complete data for all states and territories) are used.

Those aged 45–49 can now request a screening kit; however, this age group is not reported in this performance indicator (except in appendix table A3.38).

National bowel cancer incidence rate, 2025: 91 new cases per 100,000 people aged 50–74.

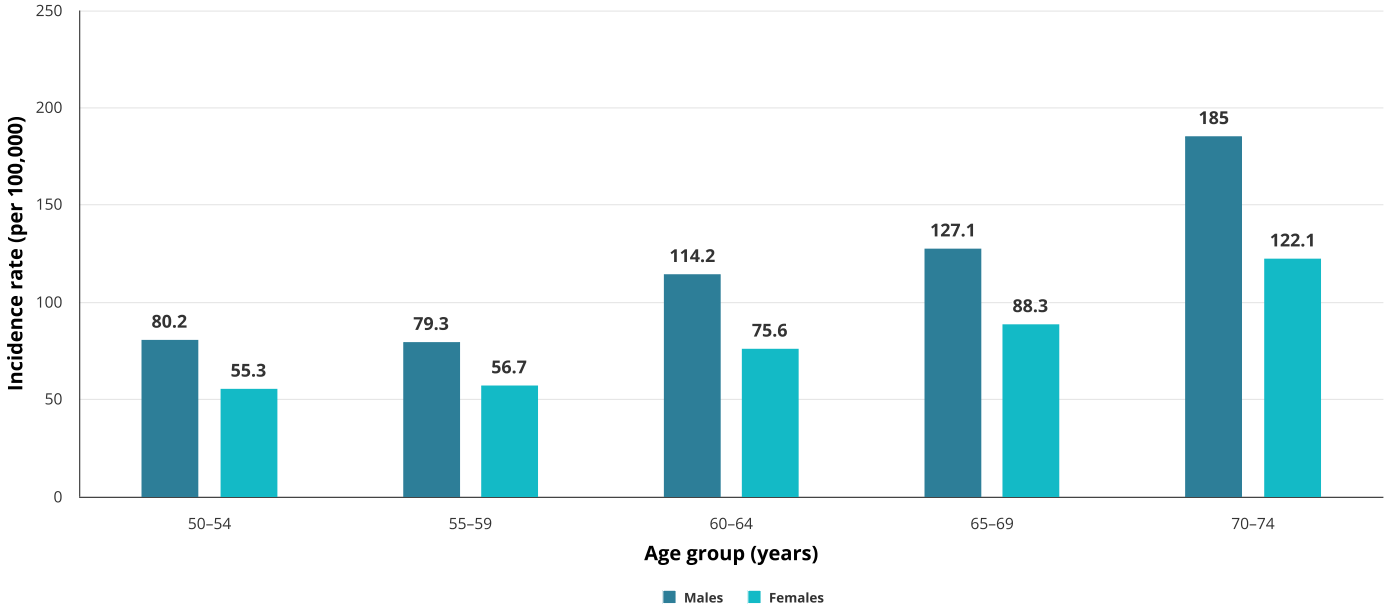
The following estimates were calculated for 2025:

Australia-wide: A total of 6,941 people aged 50–74 were diagnosed with bowel cancer, giving an age-standardised rate of 91 new cases per 100,000 people (Table A3.38).

Sex: Of people aged 50–74, men were more likely to be diagnosed with bowel cancer than women (113 new cases per 100,000 males compared with 77 new cases per 100,000 females). When age standardised, rates for males and females were 109 and 74 new cases, respectively, per 100,000 (Table A3.38).

Age: Bowel cancer incidence rates were higher for older age groups. For people in the target age group, the bowel cancer incidence rate increased with increasing age, from 68 new cases per 100,000 people aged 50–54 to 152 new cases per 100,000 people aged 70–74 (Figure 3.27). In comparison, for those aged 45–49, the bowel cancer incidence rate was 39 new cases per 100,000 people.

Figure 3.27: Incidence rate of bowel cancer for people aged 50-74, by sex and age group, Australia, 2025

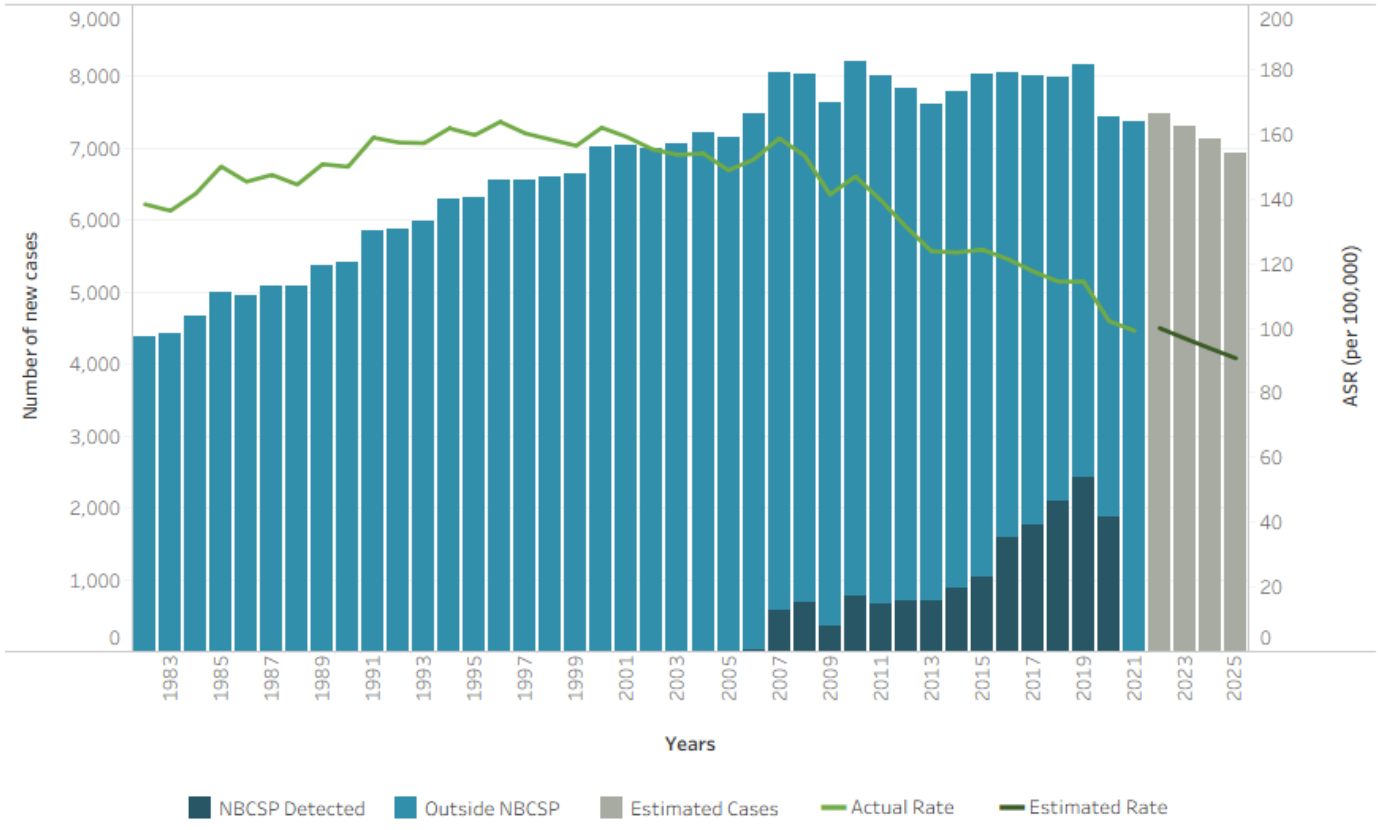


Source: Table A3.38.

Trend: Among people aged 50–74, the number of new bowel cancer cases per year rose from 4,386 in 1982 to a peak of 8,217 in 2010. The number of new cases per year has declined since then to an estimated 6,941 in 2025. The age-standardised rate for new cases (per 100,000 people aged 50–74) rose from 138 in 1982 to a peak of 164 in 1996 (Figure 3.28). Since then, the rate has fallen, and the ASR is estimated as 91 new cases per 100,000 in 2025. The ASRs for bowel cancer are expected to continue to decline.

Note that bowel cancers diagnosed after a positive NBCSP screen are shown separately in Figure 3.28 (only for the years 2006–2020) and have increased from 2006 as the rollout of the eligible NBCSP target ages were added (completed in 2020).

Figure 3.28: Trend in new cases of bowel cancer, people aged 50–74, Australia, 1982–2025



Source: Table A3.41.

Notes:

1. Estimated incidence data for 2022–2025 are based on 2012–2021 incidence data and may differ to actual incidence data due to current and ongoing program or practice changes, or COVID-19 pandemic effects.

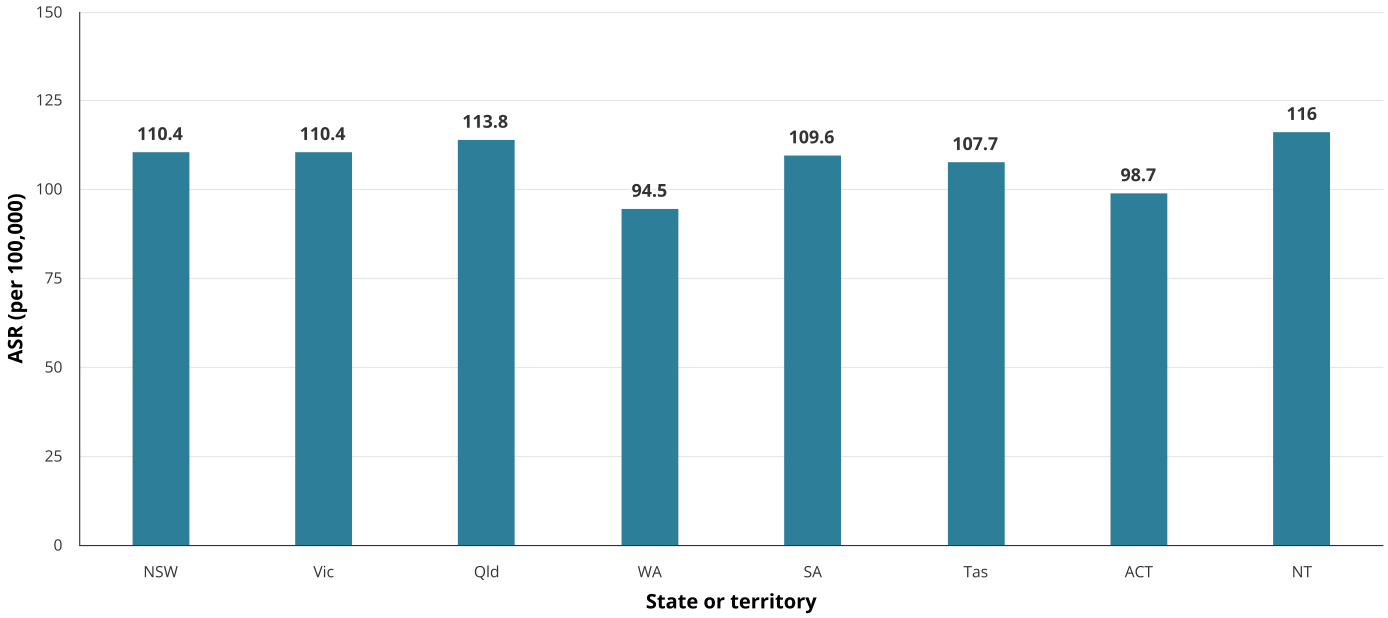
2. The ACD currently contains data on all cases of cancer diagnosed from 1982 to 2021 for all states and territories.

3. Rates were age standardised to the Australian population as at 30 June 2001 and expressed per 100,000 people.

4. Bowel cancer is defined by ICD-10 codes C18–C20 (including C18.1 – Appendix).

State or territory: In the period 2017–2021, the rate of new cases of bowel cancer per 100,000 people aged 50–74 was highest in Queensland (120 new cases of bowel cancer per 100,000 people) and lowest in Western Australia (98 new cases per 100,000 people) (Table A3.39). The age-standardised rates by state or territory followed a similar pattern to the crude rates, though the Northern Territory had the highest age-standardised rate (116 new cases of bowel cancer per 100,000 people) (Figure 3.29).

Figure 3.29: Incidence rate of bowel cancer for people aged 50-74, by state or territory, Australia, 2017-2021



Source: Table A3.39.

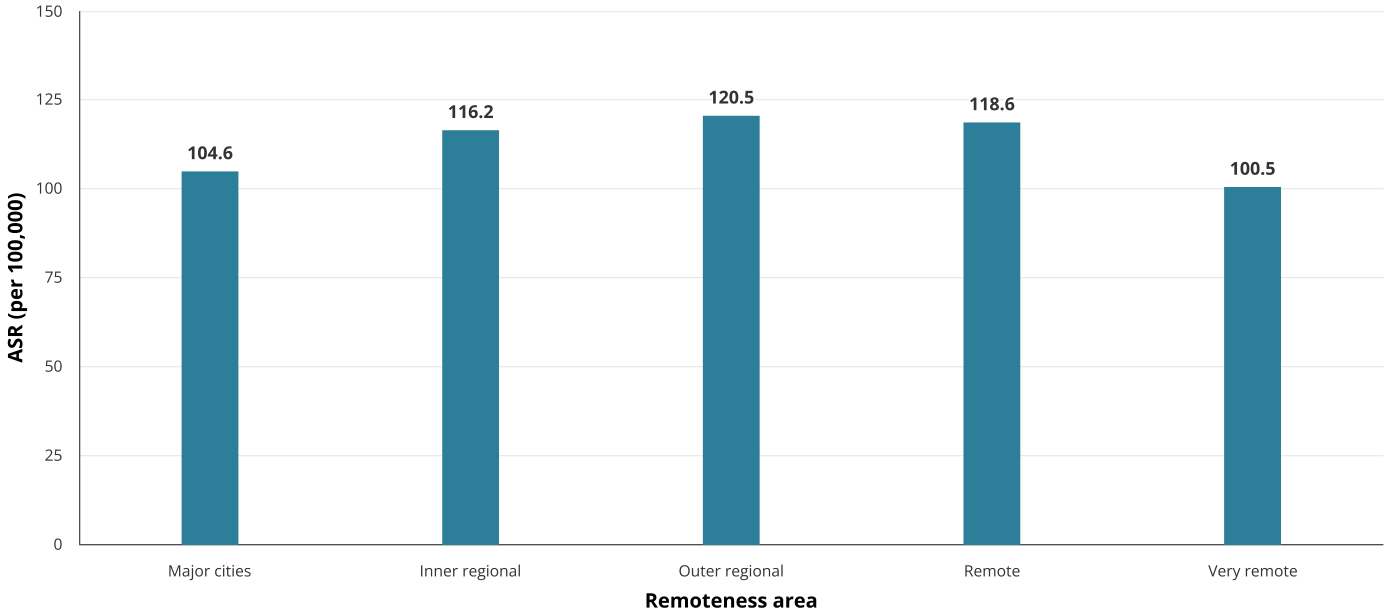
Remoteness area: In the period 2017–2021, incidence of bowel cancer per 100,000 people aged 50–74 differed by remoteness area. Age-standardised rates (ASR) are shown in Figure 3.30a and below.

The ASR for new cases of bowel cancer per 100,000 people aged 50–74 was highest for those living in *Outer regional* areas (121 new cases of bowel cancer per 100,000 people) and lowest for people living in *Very remote* areas (101 new cases per 100,000 people) (Figure 3.30a).

Socioeconomic area: In the period 2017–2021, incidence of bowel cancer per 100,000 people aged 50–74 differed by socioeconomic area. Age-standardised rates are shown in Figure 3.30b and below.

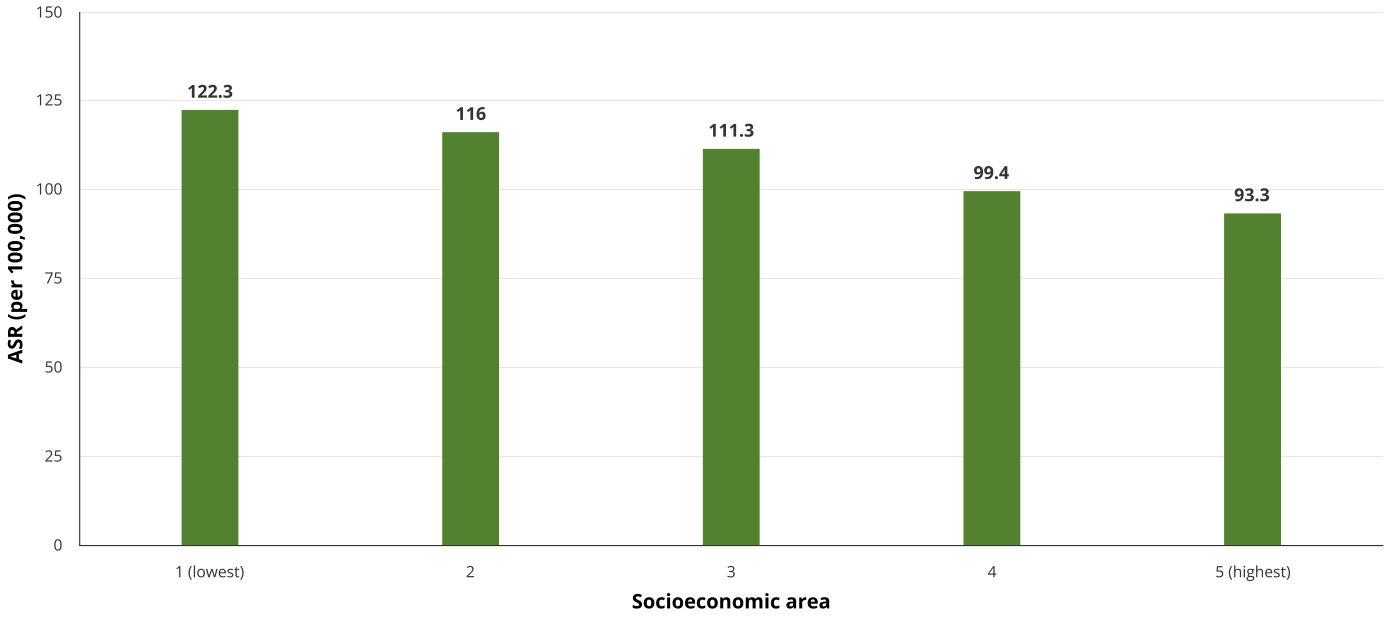
The ASR for new cases of bowel cancer per 100,000 people aged 50–74 was highest for those living in the lowest (most disadvantaged) socioeconomic areas (122 new cases of bowel cancer per 100,000 people) and lowest for people living in the highest socioeconomic areas (93 new cases per 100,000 people) (Figure 3.30b).

Figure 3.30a: Incidence rate of bowel cancer for people aged 50-74, by remoteness area, Australia, 2017-2021



Source: Table A3.39.

Figure 3.30b: Incidence rate of bowel cancer for people aged 50-74, by socioeconomic area, Australia, 2017-2021



Source: Table A3.39.

Aboriginal and/or Torres Strait Islander people: Reliable national data on the diagnosis of cancer for Indigenous Australians are not available. All state and territory cancer registries collect information on Indigenous status; however, in some jurisdictions, the quality of the data is insufficient for analysis. Information in the Australian Cancer Database (ACD) on Indigenous status is considered to be of sufficient completeness for reporting for New South Wales, Victoria, Queensland, Western Australia, the Australian Capital Territory, and the Northern Territory.

While the majority (91%) of Indigenous Australians live in these 6 jurisdictions, the degree to which data for these jurisdictions are representative of data for all Indigenous Australians is unknown (ABS 2021). For the 6 jurisdictions analysed, 3.6% (1,258 records) of the relevant ACD records had unknown Indigenous status for bowel cancer diagnoses for people aged 50–74 in 2016–2020 (Table A3.40).

The incidence counts and rates for Indigenous and non-Indigenous Australians presented are under-estimated due to the relatively large proportion of people whose Indigenous status is not stated, or not available. Also, it is likely that some Indigenous Australians are misclassified as non-Indigenous Australians. Therefore, the estimates presented in this report should be interpreted with caution. In addition, age-standardised incidence rates should be used to compare the incidence of bowel cancer for Indigenous and non-Indigenous Australians to account for the different age structures of Indigenous and non-Indigenous populations. See Box 3.1 for information on Indigenous rates calculated using Indigenous population estimates from the 2021 Census.

Box 3.1: Indigenous Australians – incidence and mortality: populations and rates

To derive bowel cancer incidence and mortality rates for Indigenous Australians, this report used Indigenous population estimates and projections based on the 2021 Census. Previous monitoring reports used those based on the 2016 Census or earlier.

Due to a large non-demographic increase in Census counts of Aboriginal and Torres Strait Islander people between 2016 and 2021, the rates for Aboriginal and Torres Strait Islander people in this report are generally lower than, and are not comparable to, those in previous reports.

For further information, see Understanding change in counts of Aboriginal and Torres Strait Islander people and Guide to using historical estimates for comparative analysis and reporting

Based on the data from the 6 jurisdictions analysed, Indigenous Australians aged 50–74 had a crude incidence rate of bowel cancer of 107 per 100,000. Following adjustment for differences in the age structure between the two population groups, Indigenous Australians had a higher incidence rate than non-Indigenous Australians in 2017–2021 (115 and 105 cases, respectively, per 100,000 people) (Figure 3.31).

Figure 3.31: Incidence rate of bowel cancer, by Indigenous status, 50-74, NSW, Vic, Qld, WA, ACT, and NT, 2017-2021

Source: Table A3.40

PI 11 – Mortality from bowel cancer

PI 11 definition

The (estimated) mortality rate for bowel cancer per 100,000 estimated resident population aged 50–74 between 1 January 2025 and 31 December 2025.

Rationale: Mortality data provide contextual information about trends in the level of bowel cancer mortality in the population, which can inform NBCSP planning.

Data quality: Cause of Death Unit Record File data are provided to the AIHW by the jurisdictional registrars of Births, Deaths and Marriages and the National Coronial Information System (managed by the Victorian Department of Justice) and include causes of death coded by the ABS. It is suspected that bowel cancer deaths are under reported due to issues with death certificate coding (see Appendix A).

Monitoring reports for the NBCSP from 2019 onwards use ICD-10 codes C18–C20, and C26.0 when reporting deaths from bowel cancer using the NMD. This differs from the approach used for versions of the report before 2019 and will result in a greater number of deaths being attributed to bowel cancer (see Box 2.1).

Guide to interpretation: The latest estimated mortality results (for 2025) are given where possible. However, analysis by state or territory, by remoteness and socioeconomic areas, and Indigenous status use the latest actual mortality data (which were to 2023 at the time this report was prepared).

Those aged 45–49 can now request a screening kit; however, this age group is not reported in this performance indicator (except in appendix table A3.42).

National bowel cancer mortality rate, 2025: 23 deaths per 100,000 people aged 50–74.

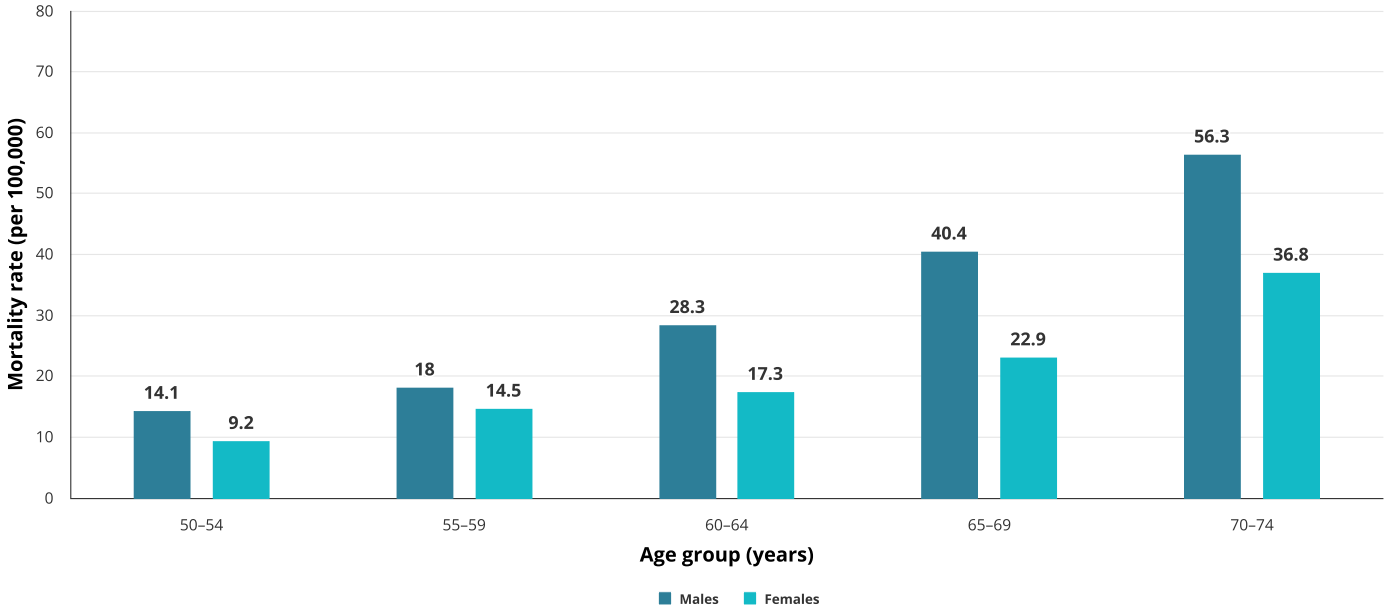
The following estimates were calculated for 2025:

Australia-wide: A total of 1,779 people aged 50–74 died from bowel cancer, giving an age-standardised rate of 23 deaths per 100,000 people (Table A3.42).

Sex: Males aged 50–74 were more likely to die from bowel cancer than females (30 deaths per 100,000 males compared with 19 deaths per 100,000 females) (Figure 3.32). When age standardised, rates for males and females were 28 and 18 deaths, respectively, per 100,000 (Table A3.42).

Age: The bowel cancer mortality rate was higher for older age groups (Table A3.42). For people in the target age range, the estimated bowel cancer mortality rate per 100,000 people rose from 12 deaths for those aged 50–54 to 46 deaths for those aged 70–74 (Figure 3.32). In comparison, for those aged 45–49, the estimated bowel cancer mortality rate was 8 deaths per 100,000 people.

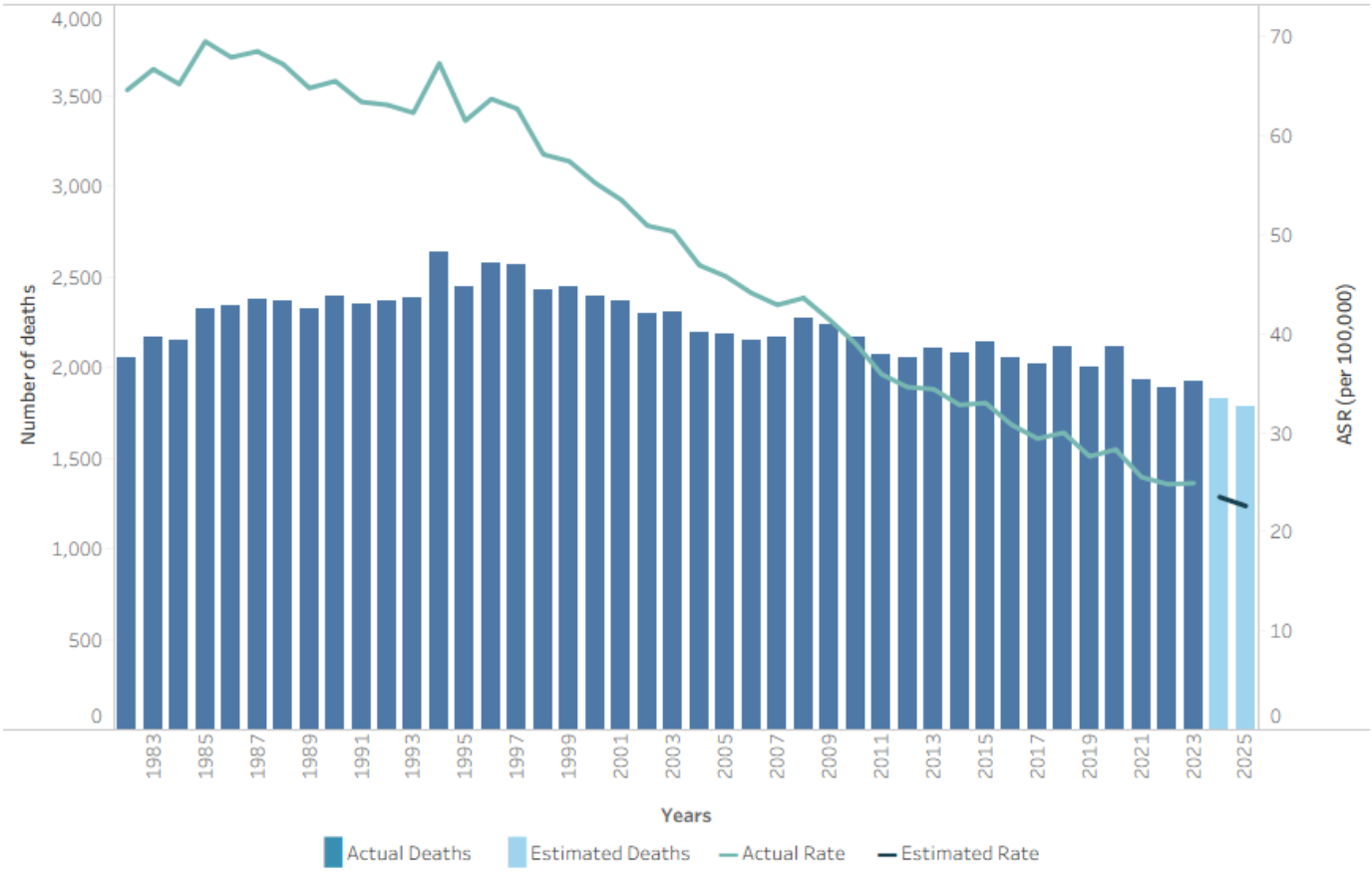
Figure 3.32: Mortality rate from bowel cancer for people aged 50-74, by sex and age, Australia 2025



Source: Table A3.42.

Trend: Since 1985, the age-standardised mortality rate from bowel cancer per 100,000 people aged 50–74 has fallen from 70 to an estimated 23 deaths per 100,000 in 2025 (Figure 3.33). The number of deaths from bowel cancer peaked at 2,635 cases in 1994 and decreased to an estimated 1,779 in 2025. The overall effect of the increasing and ageing Australian population is that, while the age-standardised mortality rate has steadily fallen over time, the actual number of deaths has remained stable or slowly declined.

Figure 3.33: Trend in deaths from bowel cancer, people aged 50–74, Australia, 1982–2025



Source: Table A3.45.

Notes:

1. Estimated mortality data for 2024–2025 are based on 2014–2023 mortality data and may differ to actual mortality data due to current and ongoing program or practice changes, or COVID-19 pandemic effects. See Appendix A for further information.

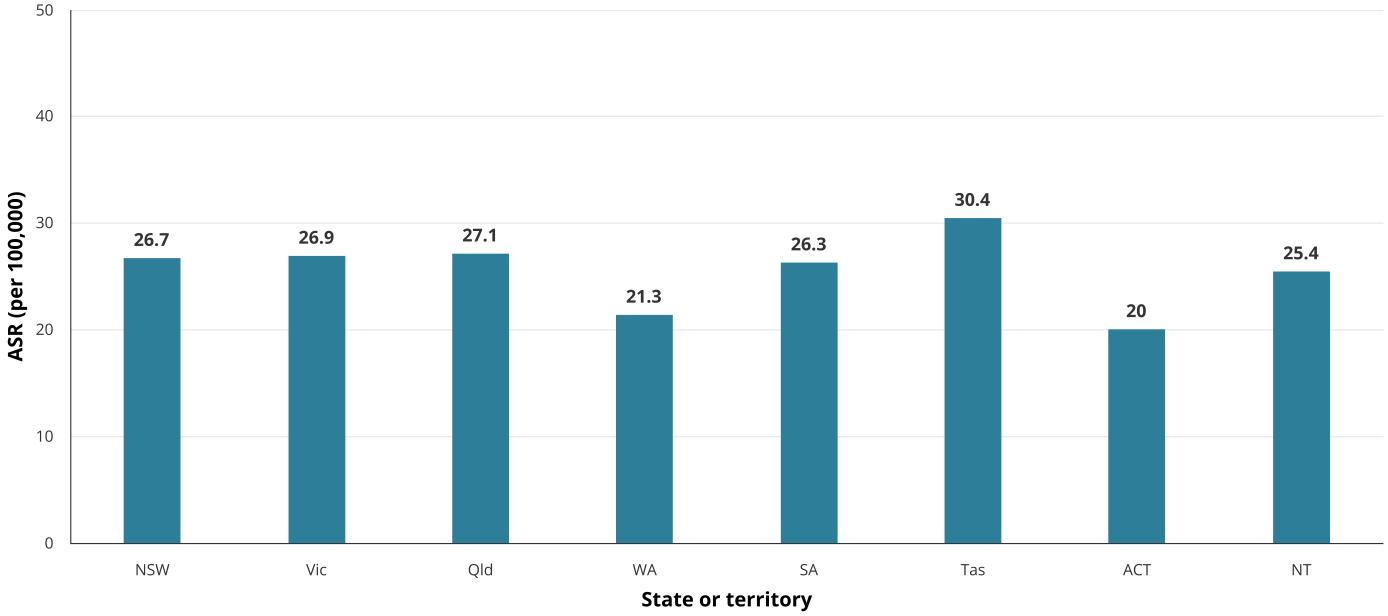
2. Deaths registered in 2021 and earlier are based on the final version of cause of death data; deaths registered in 2022 are based on the revised version; and deaths registered in 2023 are based on preliminary versions. Revised and preliminary versions are subject to further revision by the ABS.

3. Rates were age standardised to the Australian population as at 30 June 2001 and expressed per 100,000 people.

The NBCSP started in 2006 and, from 2020, rollout of biennial screening for all eligible Australians in the current target age group (50–74) was in effect. Once biennial invitations have been in place for a number of years, and actual mortality data are available for 2024 onwards, it will be easier to quantify the program's impact on bowel cancer mortality. However, studies conducted by the AIHW of people diagnosed with bowel cancer in 2006–2008 showed that NBCSP invitees (particularly those who participated) diagnosed with bowel cancer had less risk of dying from the disease and were more likely to have less advanced cancers when diagnosed than non-invitees. These findings provide evidence that the NBCSP is contributing to reducing morbidity and mortality from bowel cancer in Australia (AIHW 2014, 2018a, 2018b).

State or territory: In 2019–2023, the mortality rate per 100,000 people aged 50–74 was highest in Tasmania (33 deaths from bowel cancer) and lowest in the Australian Capital Territory (21 deaths) (Table A3.43). The age-standardised rates by state or territory followed a generally similar pattern to the crude rates (Figure 3.34).

Figure 3.34: Mortality rate from bowel cancer for people aged 50-74, by state or territory, Australia, 2019-2023



Source: Table A3.43.

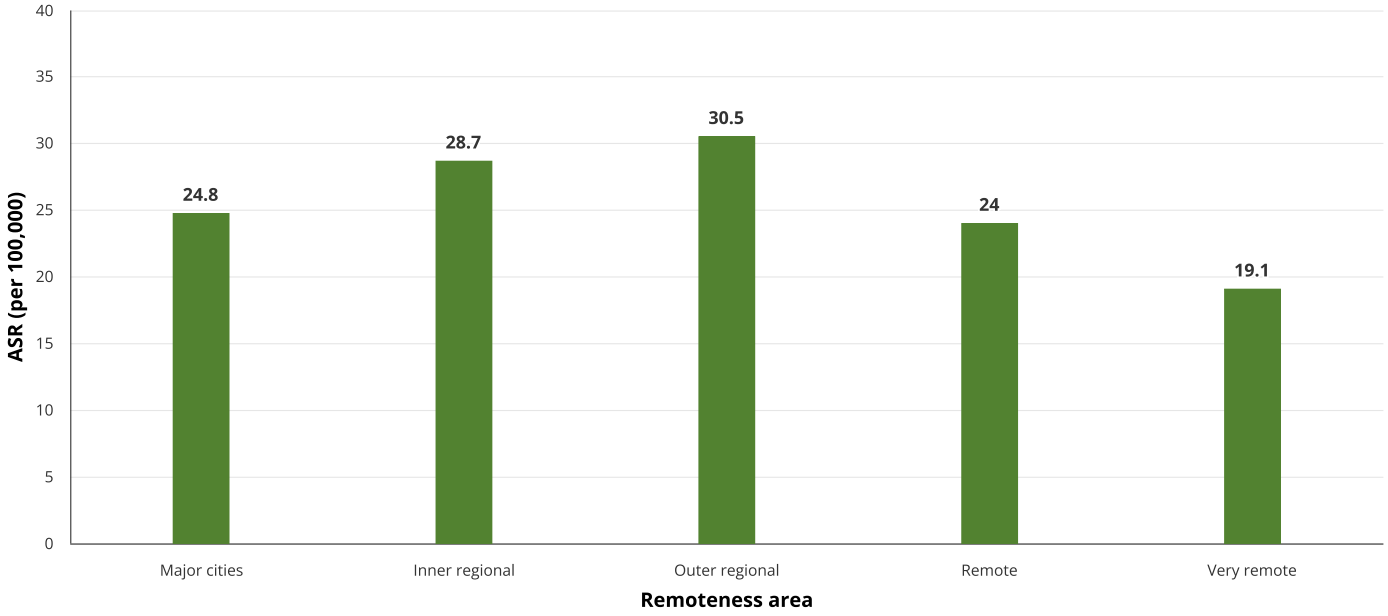
Remoteness area: In the period 2019–2023, mortality from bowel cancer per 100,000 people aged 50–74 differed by remoteness area. Age-standardised rates are shown in Figure 3.35a and below.

The ASR per 100,000 people aged 50–74 was highest for those living in *Outer regional* areas (31 deaths from bowel cancer) and lowest for those living in *Very remote* areas (19 deaths) (Figure 3.35a).

Socioeconomic area: In the period 2019–2023, mortality from bowel cancer per 100,000 people aged 50–74 differed by socioeconomic area. Age-standardised rates are shown in Figure 3.35b and below.

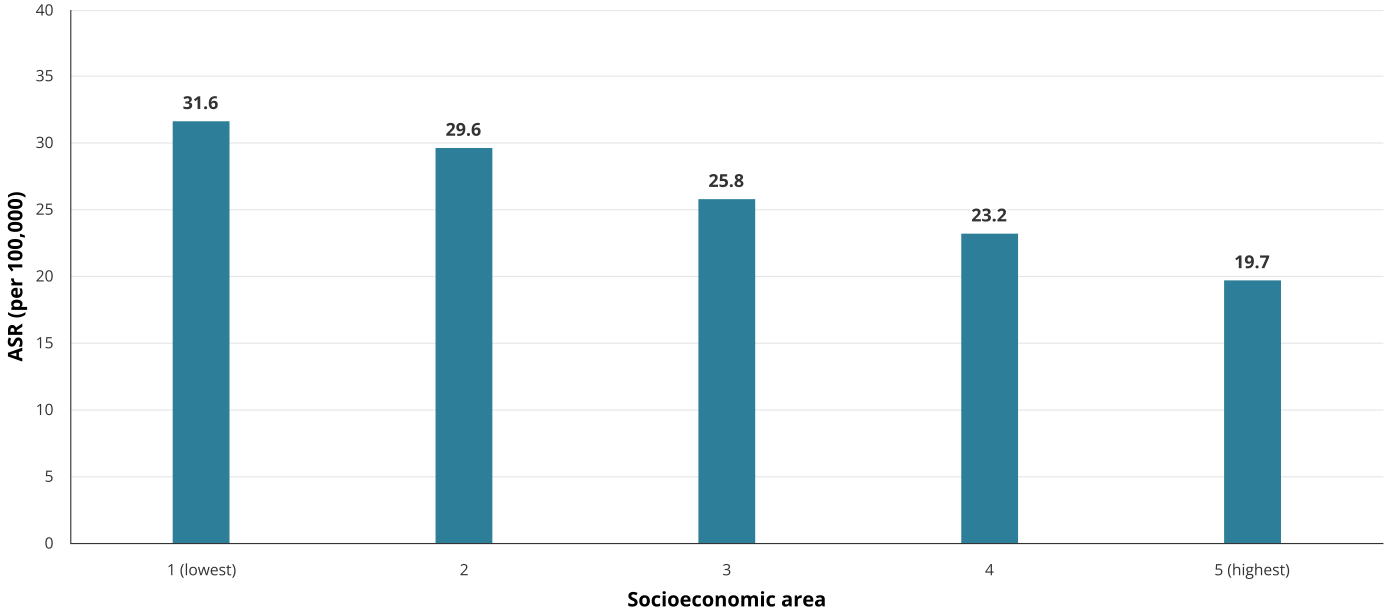
The ASR per 100,000 people aged 50–74 was highest for those living in the lowest socioeconomic areas (32 deaths from bowel cancer) and lowest for those living in the highest socioeconomic areas (20 deaths) (Figure 3.35b).

Figure 3.35a: Mortality rate from bowel cancer for people aged 50–74, by remoteness area, Australia, 2019–2023



Source: Table 3.43.

Figure 3.35b: Mortality rate from bowel cancer for people aged 50–74, by socioeconomic area, Australia, 2019–2023



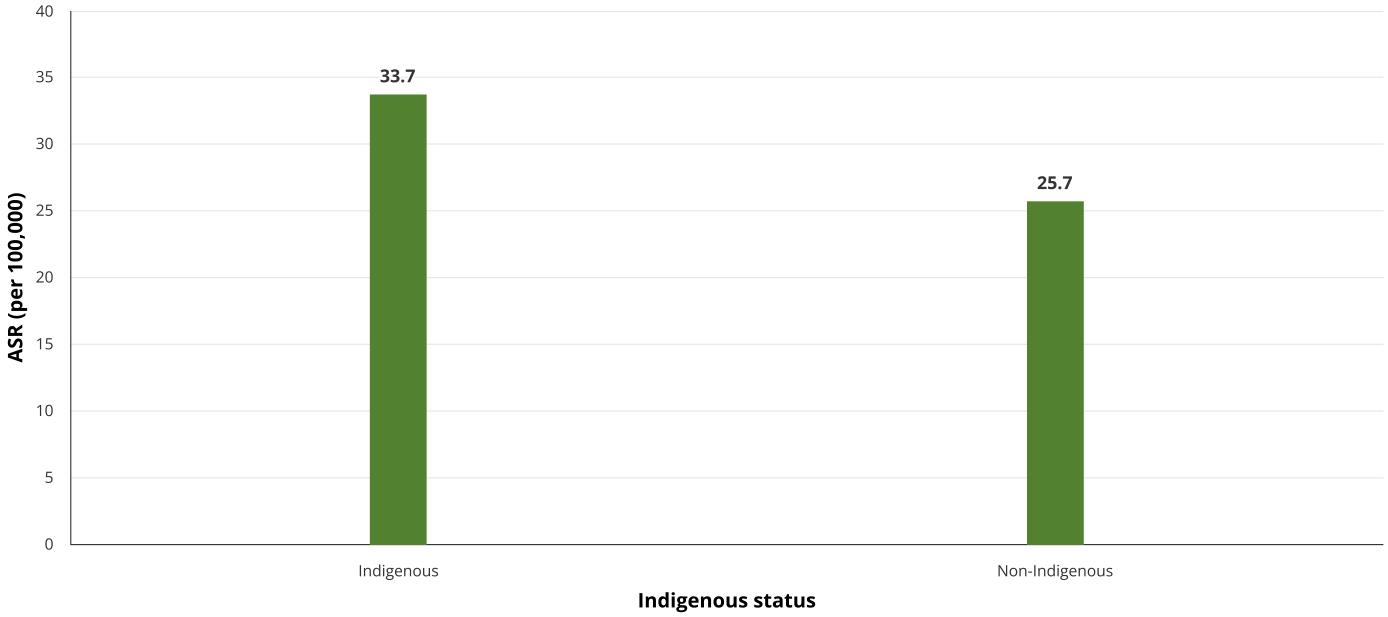
Source: Table A3.43.

Aboriginal and/or Torres Strait Islander people: Age-standardised mortality rates should be used to compare the mortality rate from bowel cancer between Indigenous and non-Indigenous Australians to account for the different age structures between the 2 populations. Only mortality data from New South Wales, Queensland, Western Australia, South Australia, and the Northern Territory are considered adequate for reporting by Indigenous status for the period of analyses. Other jurisdictions have a small number of Indigenous deaths, and identification of these in their death registration systems is relatively poor, making the data less reliable. Note that these jurisdictions differ from those used to calculate incidence for Indigenous and non-Indigenous Australians (see Box 3.1).

For the period 2019–2023, 242 Indigenous Australians aged 50–74 died from bowel cancer in Australia, with 212 of these deaths registered in New South Wales, Queensland, Western Australia, South Australia, and the Northern Territory.

In these jurisdictions for the period 2019–2023, Indigenous Australians aged 50–74 had a crude mortality rate of 31 deaths per 100,000. Following adjustment for differences in age structure between the two population groups, mortality from bowel cancer was higher for Indigenous Australians compared with non-Indigenous Australians (ASRs per 100,000 people of 34 and 26 deaths, respectively, from bowel cancer) (Figure 3.36).

Figure 3.36: Mortality rate from bowel cancer, 50-74 years, by Indigenous status, NSW, Qld, WA, SA, and NT, 2019–2023



Source: Table A3.44.

References

ACSQHC (Australian Commission on Safety and Quality in Health Care) (2020) *Colonoscopy Clinical Care Standard*, Australian Commission on Safety and Quality in Health Care, Sydney, accessed 14 May 2025.

ABS (2021) *Census of Population and Housing - Counts of Aboriginal and Torres Strait Islander Australians*, ABS, Australian Government, accessed 31 March 2026.

AIHW (2014) *Analysis of bowel cancer outcomes for the National Bowel Cancer Screening Program*, AIHW, Australian Government, accessed 09 May 2022.

AIHW (2018a) *Analysis of bowel cancer outcomes for the National Bowel Cancer Screening Program 2018*, AIHW, Australian Government, accessed 09 May 2022.

AIHW (2018b) *Analysis of cancer outcomes and screening behaviour for national cancer screening programs in Australia*, AIHW, Australian Government, accessed 09 May 2022.

Australian Government
Australian Institute of Health and Welfare

Equity in the NBCSP

Low socioeconomic areas

Equity in the National Bowel Cancer Screening Program – Low socioeconomic areas

The National Bowel Cancer Screening Program (NBCSP) is monitored in relation to equity of access to relevant services for different population groups, including by geographical location, socioeconomic area, Indigenous status, preferred language spoken at home, and disability status. Routine monitoring of rates by various stratifications may reveal emerging trends for further investigation.

This chapter provides a summary of performance indicators for 5 population subgroups. Note that there is large overlap of the Indigenous population with 2 of the other population subgroups presented here, due to higher proportions of Indigenous Australian participants living in the lowest socioeconomic areas and in *Very remote* areas.

Low socioeconomic areas

This section compares performance indicator results between the highest and lowest socioeconomic areas only. However, as noted in Performance of the screening program, across all performance indicators, there is a general gradient of increasingly poorer outcomes across the five socioeconomic groupings as socioeconomic disadvantage increases.

Australians living in the lowest (most disadvantaged) socioeconomic areas had a lower participation rate than those living in the highest socioeconomic areas. Further, those that screened in the lowest socioeconomic areas experienced a higher screening positivity rate than those living in the highest socioeconomic areas, yet had a lower follow-up diagnostic assessment rate and a longer median time between a positive screen and an assessment.

Australians living in the lowest socioeconomic areas had higher age-standardised bowel cancer incidence and mortality rates than those living in the highest socioeconomic areas (Table 4.1).

Table 4.1: Summary of performance indicators for lowest and highest socioeconomic areas

Indicator	Summary of performance indicators for the lowest socioeconomic areas compared with the highest[(a)]	Lowest socioeconomic areas	Highest socioeconomic areas
PI 1 - Participation rate	Lower participation rate	36.3%	46.9%
PI 2 - Screening positivity rate	Higher screening positivity rate	6.9%	4.7%
PI 3 - Diagnostic assessment rate	Lower diagnostic assessment follow-up rate	80.8%	89.1%
PI 4 - Time between positive screen and diagnostic assessment	Longer median time	71 days	50 days
PI 9 - Adverse events –hospital admission	Comparison not published	n.p.	n.p.
PI 10 - Incidence of bowel cancer	Higher age-standardised incidence rate	122 per 100,000	93 per 100,000
PI 11 - Mortality from bowel cancer	Higher age-standardised mortality rate	32 per 100,000	20 per 100,000

a. Lowest socioeconomic areas have the greatest socioeconomic disadvantage.

Notes:

1. The participation indicator PI 1 is reported against the period 2023–2024 with follow-up to June 2025. The screening indicator PI 2 is reported against the period 2024. The assessment indicators PIs 3 and 4 are reported against the period 2024 with follow-up to 31 December 2025. Incidence (PI 10) is reported for 2017–2021. Mortality (PI 11) is reported for 2019–2023.
2. Indicators PI 3–9 rely on information being reported to the NCSR (ACSQHC 2020). As this NBCSP form return is not mandated by the NBCSP, there may be incomplete form return and incomplete data. However, Participant follow-up function (PFUF) data are now used to supplement missing colonoscopy form data and MBS claims.
3. PI 5a (adenoma detection rate), PI 5b (PPV of diagnostic assessment for detecting adenoma), PI 6a (bowel cancer detection rate), PI 6b (PPV of diagnostic assessment for detecting bowel cancer), PI 7 (interval cancer rate), and PI 8 (cancer clinico-pathological stage distribution) are not reported due to data incompleteness or unavailability.

Sources: AIHW ACD 2021; AIHW NMD; AIHW analysis of NCSR as at 31 December 2024 (NCSR RDE 6/02/2026).

References

ACSQHC (Australian Commission on Safety and Quality in Health Care) (2020) *Colonoscopy Clinical Care Standard*, Australian Commission on Safety and Quality in Health Care, Sydney, accessed 14 May 2025.

Very remote areas

This section compares performance indicator results between *Major cities* and v*ery remote* areas only. However, as noted in Performance of the screening program, both *Remote* and v*ery remote* areas had poorer participation and higher positivity rates than all other areas.

Australians living in *Very remote* areas had a lower participation rate than those living in *Major cities*. They also experienced a higher screening positivity rate than Australians living in *Major cities* yet had a slightly lower follow-up diagnostic assessment rate and a longer median time between a positive screen and an assessment.

Australians living in *Very remote* areas had a lower age-standardised bowel cancer incidence rate and a lower age-standardised mortality rate compared with those living in *Major cities* (Table 4.2).

Table 4.2: Summary of performance indicators for *Very remote* and *Major cities* areas

Indicator	Summary of performance indicators for *Very remote* areas compared with *Major cities*	*Very remote*	*Major cities*
PI 1 - Participation rate	Lower participation rate	26.5%	41.7%
PI 2 - Screening positivity rate	Higher screening positivity rate	8.2%	5.6%
PI 3 - Diagnostic assessment rate	Lower diagnostic assessment follow-up rate	83.8%	85.1%
PI 4 - Time between positive screen and diagnostic assessment	Longer median time	78 days	58 days
PI 9 - Adverse events –hospital admission	Comparison not published	n.p.	n.p.
PI 10 - Incidence of bowel cancer	Lower age-standardised incidence rate	101 per 100,000	105 per 100,000
PI 11 - Mortality from bowel cancer	Lower age-standardised mortality rate	19 per 100,000	25 per 100,000

Notes:

1. The participation indicator PI 1 is reported against the period 2023–2024 with follow-up to June 2025. The screening indicator PI 2 is reported against the period 2024. The assessment indicators PIs 3 and 4 are reported against the period 2024 with follow-up to 31 December 2025. Incidence (PI 10) is reported for 2017–2021. Mortality (PI 11) is reported for 2019–2023.
2. Indicators PI 3–9 rely on information being reported to the NCSR (ACSQHC 2020). As this NBCSP form return is not mandated by the NBCSP, there may be incomplete form return and incomplete data. However, Participant follow-up function (PFUF) data are now used to supplement missing colonoscopy form data and MBS claims.
3. PI 5a (adenoma detection rate), PI 5b (PPV of diagnostic assessment for detecting adenoma), PI 6a (bowel cancer detection rate), PI 6b (PPV of diagnostic assessment for detecting bowel cancer), PI 7 (interval cancer rate), and PI 8 (cancer clinico-pathological stage distribution) are not reported due to data incompleteness or unavailability.

Sources: AIHW ACD 2021; AIHW NMD; AIHW analysis of NCSR as at 31 December 2025 (NCSR RDE 6/02/2026).

References

ACSQHC (Australian Commission on Safety and Quality in Health Care) (2020) *Colonoscopy Clinical Care Standard*, Australian Commission on Safety and Quality in Health Care, Sydney, accessed 14 May 2025.

Aboriginal and/or Torres Strait Islander people

Indigenous Australians had a lower estimated participation rate than non-Indigenous Australians. They also experienced a higher screening positivity rate but have a lower follow-up diagnostic assessment rate and a longer median time between a positive screen and an assessment. Indigenous Australians had higher age-standardised bowel cancer incidence rates and higher mortality rates compared with non-Indigenous Australians (Table 4.3).

Reasons for differences in screening outcomes between Indigenous and non-Indigenous Australians are not known. However, a contributing factor can be that higher proportions of Indigenous Australians live in *Remote* and *very remote* locations and in lower socioeconomic areas, where there is poorer access to relevant services.

Table 4.3: Summary of performance indicators for Indigenous and non-Indigenous Australians

Indicator	Summary of performance indicators for Indigenous Australians compared with non-Indigenous Australians	Indigenous	Non-Indigenous
PI 1 - Participation rate[a]	Lower participation rate	38.4%	42.4%
PI 2 - Screening positivity rate	Higher screening positivity rate	7.9%	5.6%
PI 3 - Diagnostic assessment rate	Lower diagnostic assessment follow-up rate	78.9%	85.7%
PI 4 - Time between positive screen and diagnostic assessment	Longer median time	77 days	61 days
PI 9 - Adverse events –hospital admission	Comparison not published	n.p.	n.p.
PI 10 - Incidence of bowel cancer[b][c]	Higher age-standardised incidence rate	115 per 100,000	105 per 100,000
PI 11 - Mortality from bowel cancer[c][d]	Higher age-standardised mortality rate	34 per 100,000	26 per 100,000

a. Participation rates by Indigenous status were estimated using 2021 Census proportions (see Appendix C for more information).
b. Includes only New South Wales, Victoria, Queensland, Western Australia, the Australian Capital Territory, and the Northern Territory.
c. These rates were calculated using Indigenous populations based on the 2021 Census and should not be compared with rates calculated using populations based on previous Censuses. See Box 3.1 for more information.
d. Includes only New South Wales, Queensland, Western Australia, South Australia and the Northern Territory.

Notes:

1. The participation indicator PI 1 is reported against the period 2023–2024 with follow-up to June 2025. The screening indicator PI 2 is reported against the period 2024. The assessment indicators PIs 3 and 4 are reported against the period 2024 with follow-up to 31 December 2025. Incidence is reported for 2017–2021. Mortality is reported for 2019–2023.
2. Indicators PI 3–9 rely on information being reported to the NCSR (ACSQHC 2020). As this NBCSP form return is not mandated by the NBCSP, there may be incomplete form return and incomplete data. However, Participant follow-up function (PFUF) data are now used to supplement missing colonoscopy form data and MBS claims.
3. PI 5a (adenoma detection rate), PI 5b (PPV of diagnostic assessment for detecting adenoma), PI 6a (bowel cancer detection rate), PI 6b (PPV of diagnostic assessment for detecting bowel cancer), PI 7 (interval cancer rate), and PI 8 (cancer clinico-pathological stage distribution) are not reported due to data incompleteness or unavailability.
4. The incidence counts and rates for Indigenous and non-Indigenous Australians presented are underestimates due to the relatively large proportion of people whose Indigenous status is not stated. Also, it is likely that some Indigenous Australians are misclassified as non-Indigenous Australians. Therefore, the estimates presented should be interpreted with caution.
5. Bowel cancer incidence and mortality rates for Indigenous and non-Indigenous Australians are compared using age-standardised rates to account for the different age structures of these populations.

Sources: Census data; AIHW ACD 2021; AIHW NMD; AIHW analysis of NCSR as at 31 December 2025 (NCSR RDE 6/02/2026).

References

ACSQHC (Australian Commission on Safety and Quality in Health Care) (2020) *Colonoscopy Clinical Care Standard*, Australian Commission on Safety and Quality in Health Care, Sydney, accessed 14 May 2025.

Preferred language spoken at home

Australians who preferred to speak a language other than English at home had a lower participation rate than those who preferred to speak English. They experienced the same screening positivity rate; however, those with a positive screening result had a lower follow-up diagnostic assessment rate and longer median time between a positive screen and an assessment (Table 4.4).

Table 4.4: Summary of performance indicators for English speakers and those who preferred to speak a language other than English (LOTE) at home

Indicator	Summary of performance indicators for those who preferred language other than English at home compared with English speakers	LOTE	English
PI 1 - Participation rate[(a)]	Lower participation rate	24.1–30.8%	44.4–47.3%
PI 2 - Screening positivity rate	Same screening positivity rate	5.6%	5.8%
PI 3 - Diagnostic assessment rate	Lower diagnostic assessment follow-up rate	78.6%	86.4%
PI 4 - Time between positive screen and diagnostic assessment	Longer median time	64 days	61 days
PI 9 - Adverse events –hospital admission	Comparison not published	n.p.	n.p.
PI 10 - Incidence of bowel cancer[(b)]	Comparison not available	n.a.	n.a.
PI 11 - Mortality from bowel cancer[(b)]	Comparison not available	n.a.	n.a.

a. Participation rates by preferred language spoken at home were estimated using 2021 Census proportions (see Table A4.1 and Appendix C for more information).
b. Data for this indicator are not available.

Notes:

1. The participation indicator PI 1 is reported against the period 2023–2024 with follow-up to June 2025. The screening indicator PI 2 is reported against the period 2024. The assessment indicators PIs 3 and 4 are reported against the period 2024 with follow-up to 31 December 2025. Incidence and mortality data are not currently available for reporting by preferred language spoken at home.
2. Indicators PI 3–9 rely on information being reported to the NCSR (ACSQHC 2020). As this NBCSP form return is not mandated by the NBCSP, there may be incomplete form return and incomplete data. However, Participant follow-up function (PFUF) data are now used to supplement missing colonoscopy form data and MBS claims.
3. PI 5a (adenoma detection rate), PI 5b (PPV of diagnostic assessment for detecting adenoma), PI 6a (bowel cancer detection rate), PI 6b (PPV of diagnostic assessment for detecting bowel cancer), PI 7 (interval cancer rate), and PI 8 (cancer clinico-pathological stage distribution) are not reported due to data incompleteness or unavailability.

Sources: Census data; AIHW analysis of NCSR as at 31 December 2025 (NCSR RDE 6/02/2026).

References

ACSQHC (Australian Commission on Safety and Quality in Health Care) (2020) *Colonoscopy Clinical Care Standard*, Australian Commission on Safety and Quality in Health Care, Sydney, accessed 14 May 2025.

Disability status

Australians with severe or profound disability experienced a higher screening positivity rate, yet had a lower follow-up diagnostic assessment rate, and a longer median time between a positive screen and an assessment than those not reporting such limitation (Table 4.5).

Table 4.5: Summary of performance indicators for those with severe or profound activity limitation and those without severe or profound activity limitation

Indicator	Summary of performance indicators for those with severe or profound disability compared with those without severe or profound disability	Severe or profound activity limitation reported	No severe or profound activity limitation reported
PI 1 - Participation rate[(a)]	Comparison not published	n.p.	n.p.
PI 2 - Screening positivity rate	Higher screening positivity rate	10.9%	5.5%
PI 3 - Diagnostic assessment rate	Lower diagnostic assessment follow-up rate	69.9%	87.3%
PI 4 - Time between positive screen and diagnostic assessment	Longer median time	82 days	60 days
PI 9 - Adverse events –hospital admission	Comparison not published	n.p.	n.p.
PI 10 - Incidence of bowel cancer[(b)]	Comparison not available	n.a.	n.a.
PI 11 - Mortality from bowel cancer[(b)]	Comparison not available	n.a.	n.a.

a. Estimates of participation rates by disability status could not be reported in the current report due to changes in completeness of disability status information in the NCSR (see Appendix A and Appendix C for more information).
b. Data for this indicator are not available.

Notes

1. The participation indicator PI 1 is reported against the period 2023–2024 with follow-up to June 2024. The screening indicator PI 2 is reported against the period 2024. The assessment indicators PIs 3 and 4 are reported against the period 2024 with follow-up to 31 December 2025. Incidence and mortality data are not currently available for reporting by disability status.
2. Indicators PI 3–9 rely on information being reported to the NCSR (ACSQHC 2020). As this NBCSP form return is not mandated by the NBCSP, there may be incomplete form return and incomplete data. However, Participant follow-up function (PFUF) data are now used to supplement missing colonoscopy form data and MBS claims.
3. PI 5a (adenoma detection rate), PI 5b (PPV of diagnostic assessment for detecting adenoma), PI 6a (bowel cancer detection rate), PI 6b (PPV of diagnostic assessment for detecting bowel cancer), PI 7 (interval cancer rate), and PI 8 (cancer clinico-pathological stage distribution) are not reported due to data incompleteness or unavailability.

Sources: AIHW analysis of NCSR as at 31 December 2025 (NCSR RDE 6/02/2026).

References

ACSQHC (Australian Commission on Safety and Quality in Health Care) (2020) *Colonoscopy Clinical Care Standard*, Australian Commission on Safety and Quality in Health Care, Sydney, accessed 14 May 2025.

Technical notes

Table: Abbreviations

Term	Description
ABDS	Australian Burden of Disease Study
ABS	Australian Bureau of Statistics
ACD	Australian Cancer Database
ACT	Australian Capital Territory
AIHW	Australian Institute of Health and Welfare
ASGS	Australian Statistical Geography Standard
ASR	age-standardised rate
DALY	disability-adjusted life year
ICD	International Classification of Diseases and Related Health Problems
ICD-O	International Classification of Diseases for Oncology
iFOBT	immunochemical faecal occult blood test
IRSD	Index of Relative Socio-economic Disadvantage
LOTE	language other than English
MBS	Medicare benefits schedule
NBCSP	National Bowel Cancer Screening Program
NCSR	National Cancer Screening Register
NMD	National Mortality Database
NSW	New South Wales
NT	Northern Territory
PFUF	Participant follow-up function
PHCP	primary health-care practitioner (general practitioner or other primary health-care provider)
PI	performance indicator
PPV	positive predictive value
Qld	Queensland
RDE	raw data extract
SA	South Australia
Tas	Tasmania
TNM	Tumour, Nodes and Metastasis
Vic	Victoria
WA	Western Australia
YLD	years lived with disability
YLL	years of life lost

Table: Symbols

Symbol	Description
—	nil or rounded to zero
. .	not applicable
>	greater than

≤	less than or equal to
n.a.	not available
n.p.	not publishable because of small numbers, confidentiality or other concerns about the quality of the data
N	number

Other technical notes

See Appendices.

Glossary

Note: Terms in bold within definitions are defined elsewhere in the glossary.

Aboriginal and/or Torres Strait Islander: A person of Aboriginal and/or Torres Strait Islander descent who identifies as an Aboriginal and/or Torres Strait Islander. See also **Indigenous**.

adenocarcinoma: A cancer that began in a glandular epithelial cell (see **epithelium**).

adenoma (adenomatous polyp): A **benign** tumour that arises from epithelial cells (see **epithelium**). All adenomas have **malignant** potential. Adenomas in the rectum or colon have a higher chance of developing into **cancer** (see **adenocarcinoma**) than adenomas in most other organs. An adenoma can be classified from highest risk (advanced) to lowest risk (diminutive).

age-specific rate: The number of cases occurring in each specified age group by the corresponding population in the same age group, expressed as 'per 100,000 people'.

age-standardised rate (ASR): A rate derived by removing the influence of age when comparing populations with different age structures. This is usually necessary as the rates of many diseases vary strongly (usually increasing) with age. The age structures of the different populations are converted to the same 'standard' structure, which allows disease rates to be compared.

asymptomatic: Describes being without symptoms.

benign: Describes non-cancerous tumours that may grow larger but do not spread to other parts of the body. Not **malignant**.

bowel (colorectal) cancer: A cancer definition that comprises both cancer of the colon and cancer of the rectum.

cancer death: A death where the underlying cause of death is indicated as cancer. People with cancer who die of other causes are not counted in the mortality statistics in this publication.

cancer (malignant neoplasm): A large range of diseases whose common feature is that some of the body's cells become defective and begin to multiply out of control. These cells can invade and damage the area around them and can also spread to other parts of the body through the circulatory and lymphatic systems to cause further damage.

colonoscopy: A diagnostic assessment procedure to examine the bowel using a special scope (colonoscope), usually carried out in a hospital or day clinic.

conditional relative survival: The probability of surviving a given number of years, provided that an individual has already survived a specified amount of time after diagnosis (usually 5 or 10 years). Compare with **relative survival**.

crude rate: The number of events over a specified period (for example, a year) divided by the total population. The crude rate (for participation, attendance and follow-up) is the proportion of people who have proceeded to a key point on the screening pathway (at the date of the data extraction) out of those eligible to proceed to that point.

The crude proportions will generally underestimate the true proportions of the population that participated in the National Bowel Cancer Screening Program. This is because, at any point in time, there are members of the population who are eligible to proceed to the next point on the screening pathway but who have not yet had time to do so. Similarly, there is a time lag between when a person with a positive **iFOBT result** is referred for a **colonoscopy** and when they can have the procedure.

defer: Describes the action of an invitee who would like to participate in the National Bowel Cancer Screening Program but is unable to do so at this time. Such invitees will be contacted once the nominated deferral period has elapsed. Compare with **opt out**.

disability-adjusted life year (DALY): A year of healthy life lost, either through premature death or equivalently through living with disability due to illness or injury. It is the basic unit used in burden of disease and injury estimates.

eligible population: People who can request a screening kit from the register but are not automatically sent a kit. This includes people aged 45–49 who are registered on a green Medicare card or a Department of Veterans' Affairs gold card. See also **target population**.

epithelium: The tissue lining the outer layer of the body, the digestive tract and other hollow organs and structures.

false negative: A screening test result that incorrectly indicates a person does not have a marker for the condition being tested when they do have the condition. Not all screening tests are completely accurate, so false negative results cannot be discounted. Further, with an **iFOBT**, if a **polyp**, **adenoma**, or **cancer** is not bleeding at the time of the test, it may be missed by the screening test.

false positive: A screening test result that incorrectly indicates that a person has the marker being tested when they do not have the condition. As iFOBTs detect blood in stool (which may be caused by a number of conditions), a false positive finding for bowel cancer may still detect other non-bowel cancer conditions, or precancerous **polyps** or **adenomas**.

histopathology: The microscopic study of the structure and composition of tissues and associated disease.

immunochemical faecal occult blood test (iFOBT): immunochemical faecal occult blood test – a self-administered test to detect blood in bowel motions, but not bowel cancer itself. The iFOBT is analysed by a pathology laboratory, and results forwarded to the participant and **primary health care practitioner** (if nominated). The 2-sample screening kits can have an overall adequacy rating of:

- Expired: the kit was returned after the expiry date of the sample tubes
- Unsatisfactory: the kit was received greater than 28 days from the first sample date

- Not received: the kit was returned without the sample tubes
- Spoiled / Damaged: both sample tubes in the returned kit were spoiled or damaged

These first 4 adequacy ratings are given an overall result of *No result*. The final potential adequacy rating is:

Correctly completed: the sample tubes were not judged in the above categories overall.

Overall results of the correctly completed kits are then categorised into:

- *Positive*: at least one sample was positive (≥ 20 µg Haemoglobin per gram faeces) for occult blood, regardless of the other sample
- *Negative*: both samples were negative for occult blood
- *Inconclusive*: one sample was negative, and the other sample was Spoiled/Damaged or Not received, or both samples were negative. but the kit was received at the lab greater than 14 days since the first sample was taken.

Positive and negative overall results are used in positivity calculations. No result and Inconclusive results are resent a replacement kit by the pathology laboratory.

incidence: The number of new cases (of an illness or event, and so on) occurring during a given period, usually 1 year. Compare with **prevalence**.

Indigenous: A person of Aboriginal and/or Torres Strait Islander descent who identifies as Aboriginal and/or Torres Strait Islander. See also **Aboriginal and/or Torres Strait Islander**.

interval cancer: A bowel cancer that is diagnosed after completion of a negative screening episode and before the next screening examination or within 24 months of a negative screening episode, whichever comes first.

invitee: A person invited to participate in the National Bowel Cancer Screening Program.

lymph node: A mass of lymphatic tissue, often bean-shaped, that produces adaptive immune system cells and through which lymphatic fluid filters. These nodes are located throughout the body.

malignant: Describes **tumours** with the capacity to spread to surrounding tissue or to other sites in the body.

metastasis: The process by which cancerous cells are transferred (or spread) from one part of the body to another; for example, via the lymphatic system or the bloodstream.

morbidity: Ill health in an individual, or the level of ill health in a population or group.

mortality: The number of deaths occurring during a given period.

new cancer case: A person who has a new cancer diagnosed for the first time. One person may have more than one cancer and therefore may be counted more than once in incidence statistics if it is decided that the additional cancers are not of the same origin. This decision is based on a series of principles, set out in more detail in a publication by Jensen et al. (1991).

non-valid address: A non-valid address may be a result of the NCSR not recognising a current postal address, or a return to sender flag is currently recorded against the invitee and their given address.

opt out: Describes what invitees do who advise that they do not wish to participate in the National Bowel Cancer Screening Program, now or in the future. Invitees who opt out will not be contacted again. Invitees may elect to opt back in at a later date.

participant: A person who has agreed to participate in the National Bowel Cancer Screening Program by returning a completed iFOBT kit and participant details form.

polyp: A small growth of colon tissue that protrudes into the colonic or rectal lumen. Polyps are usually asymptomatic, but sometimes cause visible rectal bleeding and, rarely, other symptoms. Most polyps are **benign**. Adenomatous polyps are more likely to become **malignant** than other types of polyps.

polypectomy: The removal of a **polyp** or **adenoma**.

positive predictive value: Proportion of people with a positive **iFOBT** screen who have **adenomas** or cancer detected at **colonoscopy** and confirmed by **histopathology**.

prevalence: The total number of people alive at a specific date who have been diagnosed with a particular disease (such as cancer) within a defined period.

primary health-care practitioner (PHCP): A general practitioner or other primary health-care provider. This may include remote health clinics or specialists providing general practitioner services.

prognosis: The likely outcome of an illness.

radiation therapy: The treatment of disease with any type of radiation, most commonly with ionising radiation, such as X-rays, beta rays and gamma rays.

relative survival: A measure of the average survival experience of a population of people diagnosed with cancer, relative to the 'average' Australian of the same sex and age, at a specified interval after diagnosis (usually 5 or 10 years). A 5-year relative survival figure of 100% means that the cancer has no impact on the person's chance of still being alive 5 years after diagnosis, whereas a figure of 50% means that the cancer has halved that chance.

screening: Repeated testing, at regular intervals, of asymptomatic people to detect a medical condition at an earlier stage than would otherwise be the case. Screening tests are not diagnostic (for example, see **false positive**, **false negative**, and **positive predictive value**); therefore, people who receive a positive screening result require further assessment and diagnosis to determine whether they have the disease or risk marker being screened for.

skipping a round: As of November 2019, people who are potentially eligible for the National Bowel Cancer Screening Program but who have had a recent **colonoscopy** (within the last 2 years) are notified that they will skip a round of the immunochemical faecal occult blood test (**iFOBT**), rather than being invited to participate.

stage: The extent of a cancer in the body. Staging is usually based on the size of the **tumour**, whether lymph nodes contain cancer, and whether the cancer has spread from the original site to other parts of the body (undergone **metastasis**).

symptom: Any evidence of disease apparent to the patient. For the purposes of this report, symptoms can include visible rectal bleeding, change in bowel habit, bowel obstruction or anaemia.

target population: People who are actively targeted by the National Bowel Cancer Screening Program. This includes people aged 50–74 registered on a green Medicare card or a Department of Veterans' Affairs gold card. See also **eligible population**.

tumour: An abnormal growth of tissue. Can be **benign** (not a **cancer**) or **malignant** (**cancer**).

underlying cause of death: The disease or injury that initiated the train of events leading directly to death, or the circumstances of the accident or violence that produced the fatal injury.

valid results: iFOBT results that are classified as either positive or negative. Inconclusive results are excluded.

Years lived with disability (YLD): A measure of the years of what could have been a healthy life but were instead spent in states of less than full health. YLD represent non-fatal burden.

Years of life lost (YLL): Years of life lost due to premature death, defined as dying before the global ideal life span at the age of death. YLL represent fatal burden.

References

Jensen OM, Parkin DM, MacLennan R, Muir CS and Skeet RG (eds) (1991) *Cancer registration: principles and methods*, IARC Scientific Publication no. 95, IARC, Lyon, France.

Appendices

Appendix A: Data sources

In this section

To provide a comprehensive picture of national cancer statistics in this report, a range of data sources were used, including AIHW and external data sources. These data sources are described in this appendix.

Australian Burden of Disease Study

The Australian Burden of Disease Study (ABDS) 2024 (AIHW 2024) used burden of disease analysis to measure the impact of 220 diseases and injuries on the health of the Australian population. The study provides a detailed picture of the burden of disease in the population in 2003, 2011, 2015, 2018, and 2024 (with 2024 being projected estimates). It includes estimates of total, fatal, and non-fatal burden for the total Australian population. It also includes national estimates of the contribution made by selected risk factors on the disease burden in Australia.

The ABDS 2018 includes the latest subnational burden of disease estimates, (by state or territory, remoteness area and socioeconomic area).

The ABDS uses and adapts the methods of global studies to produce estimates that are more relevant to the Australian health policy context.

Results from the study provide an important resource for health policy formulation, health service planning, and population health monitoring. The results provide a foundation for further assessments; for example, in relation to health interventions that aim to prevent or treat diabetes and its complications, and disease expenditure.

Full details on the various methods, data sources, and standard inputs used in the ABDS are available in *Australian Burden of Disease Study 2018: methods and supplementary material* (AIHW 2021).

Australian Cancer Database

All forms of cancer, except basal and squamous cell carcinomas of the skin, are notifiable diseases in each Australian state and territory. Legislation in each jurisdiction requires hospitals, pathology laboratories, and various other institutions to report all cases of cancer to their central cancer registry. An agreed subset of the data collected by these registries is supplied annually to the AIHW, where it is compiled into the Australian Cancer Database (ACD). The ACD used in this report currently contains data on all cases of cancer diagnosed from 1982 to 2021 for all states and territories.

Cancer reporting and registration is a dynamic process, and records in the state and territory cancer registries may be modified if new information is received. As a result, the number of cancer cases reported by the AIHW for any particular year may change slightly over time and may not always align with state and territory reporting for that same year.

The 2022–2025 estimated cancer cases for incidence were derived using a combination of ABS estimated resident populations and Centre for Population projections, as described in the technical notes of *Cancer data in Australia* (AIHW 2025).

The latest Data Quality Statement for the ACD can be found on the AIHW METEOR website.

National Bowel Cancer Screening Program

This report uses National Cancer Screening Register (NCSR) data (raw data extract as at 6 February 2026) to present statistics on the progression of eligible participants along the screening pathway for those invited into the National Bowel Cancer Screening Program (NBCSP). It covers measures of participation, iFOBT results, and follow-up investigations and outcomes. However, while data for follow-up investigations should be returned to the NCSR (ACSQHC 2020), this is not mandated by the NBCSP so data are incomplete. Analyses are presented by age, sex, state or territory, remoteness and socioeconomic areas, Indigenous status, preferred language spoken at home, and disability status.

From mid-November 2019, the NBCSP Register data were transitioned from the Department of Human Services to the NCSR. Following the transition, the NCSR is now the sole source of NBCSP data in Australia.

Determining Indigenous status in the NCSR

This report uses both the Person and PersonHistory table in the NCSR to determine a person's self-identified Indigenous status. Firstly, the most recently reported Indigenous status from Person is used. For those where this value is not stated, any historical Indigenous status values available in the PersonHistory table are used, with a preference to Indigenous over non-Indigenous Australians status if multiple values have been selected in the past.

Reporting of estimated participation by disability status

Due to changes in data completeness by self-reported disability status in NBCSP records prior to migration to the NCSR (in November 2019), estimated participation by disability status cannot be reported in this report.

Improvements to the valid NBCSP invitations count

For data from 2020 onwards, improvements have been made to exclude a number of incorrectly recorded invitations within the NCSR. This includes identifying and excluding prospective invitees without a valid mailing address. A non-valid address may be a result of the NCSR not recognising a current postal address, or a return to sender flag has previously been recorded against the invitee and their given address.

Improvements to the known colonoscopy count

Due to incomplete colonoscopy form return for those having a follow-up diagnostic assessment after a positive screen, this report now supplements colonoscopy form data and MBS claims with Participant follow-up function (PFUF) data. This means data for PIs 3, 4 and 9 from 2021 onwards cannot be compared with previous years.

The PFUF is a system whereby participants who have had a positive screen are contacted by PFUF officers in their jurisdiction if a follow-up diagnostic assessment has not been recorded in the NCSR within a certain period. Any PFUF confirmation of a colonoscopy having occurred is then used in this report to supplement colonoscopy form data and MBS claims (though note that MBS claims prior to 2021 are incomplete in the NCSR). While this can be used to improve the *number* of colonoscopies known to have taken place for program participants, it does not improve colonoscopy *outcome* data (that is, the diagnostic findings from these additional colonoscopies are not known).

From 2021 onwards, Bowel abnormality detection results using available assessment and histopathology data only includes colonoscopies known from colonoscopy or histopathology forms, as only colonoscopies from these sources record outcomes. Therefore, these outcome data cannot be compared with previous years.

The Data Quality Statement for the NBCSP can be found on the AIHW METEOR website.

National Death Index

The National Death Index is a database, housed at the AIHW, which contains records of all deaths occurring in Australia since 1980. The data are obtained from the registrars of Births, Deaths and Marriages in each state and territory. The National Death Index is designed to facilitate the conduct of epidemiological studies and its use is strictly confined to medical research.

Cancer incidence records from the ACD were linked to the National Death Index and used to calculate the survival and prevalence data presented in this report.

See the Data Quality Statement for the National Death Index for further information.

National Mortality Database

The AIHW National Mortality Database (NMD) contains information supplied by the registrars of Births, Deaths and Marriages and the National Coronial Information System – and coded by the ABS – for deaths from 1964 to 2023. Registration of deaths is the responsibility of the Registry of Births, Deaths and Marriages in each state and territory. These data are then collated and coded by the ABS and maintained at the AIHW in the NMD.

In the NMD, both the year in which the death occurred and the year in which it was registered are provided. For the purposes of this report, actual mortality data are shown based on the year the death was registered.

In this report, deaths registered in 2021 and earlier are based on the final version of cause of death data; deaths registered in 2022 are based on the revised version; and deaths registered in 2023 are based on preliminary versions. Revised and preliminary versions are subject to further revision by the ABS.

The 2024–2025 estimates for mortality were based on deaths from the 2014–2023 NMD and were derived using a combination of ABS estimated resident populations and Centre for Population projections, as described in the technical notes of *Cancer data in Australia* (AIHW 2025).

The data quality statements underpinning the AIHW NMD can be found on the following ABS web pages:

- ABS quality declaration summary for Deaths, Australia
- ABS quality declaration summary for Causes of death, Australia

For more information on the AIHW NMD, see the National Mortality Database.

Lastly, the ABS has noted that there is a high likelihood that many deaths coded to ICD-10 code 'C26.0 Malignant neoplasms of the intestinal tract, unspecified' are deaths from colon, sigmoid, rectum, and anus cancers (ABS 2016). Therefore, deaths coded as C26.0 have been included in bowel cancer deaths throughout this report (and in monitoring reports from 2019 onwards).

Population data

Throughout this report, population data were used to derive bowel cancer incidence and mortality rates. The population data were sourced from the ABS using the most up-to-date estimates available at the time of analysis.

To derive its estimates of the resident populations, the ABS uses the 5-yearly Australian Census of Population and Housing data and adjusts them as follows:

- all respondents in the Census are placed in their state or territory, statistical area, and postcode of usual residence; overseas visitors are excluded
- an adjustment is made for people missed in the Census
- Australians temporarily overseas on Census night are added to the usual residence Census count.

Estimated resident populations are then updated each year from the Australian Census data, using indicators of population change, such as births, deaths, and net migration.
More information is available from the ABS website.

The projected incidence and mortality rates cited for 2025 in this report will sometimes differ from the rates that would occur if the Centre for Population data were used to calculate rates.

For the Indigenous Australian incidence and mortality comparisons in this report, the most recently released ABS Indigenous estimated resident populations (based on the 2021 Census of Population and Housing) were used.

References

ABS (2016) *Causes of death, Australia, 2015: complexities in the measurement of bowel cancer in Australia*. ABS catalogue number 3303.0, ABS, Australian Government.

ACSQHC (Australian Commission on Safety and Quality in Health Care) (2020) *Colonoscopy Clinical Care Standard*, Australian Commission on Safety and Quality in Health Care, Sydney, accessed 14 May 2025.

AIHW (2021) Australian Burden of Disease Study: methods and supplementary material 2018, AIHW, Australian Government, accessed 09 May 2022.

AIHW (2024) *Australian Burden of Disease Study 2024*, AIHW, Australian Government, accessed 15 May 2025.

AIHW (2025) Cancer data in Australia, AIHW, Australian Government, accessed 13 March 2026.

Appendix B: Classifications

In this section

International Classification of Diseases for Oncology

Cancers were originally classified solely under the International Classification of Diseases and Related Health Problems (ICD) classification system, based on topographic site and behaviour. However, during the creation of the 9th Revision of the ICD in the late 1960s, working parties suggested creating a separate classification for cancers that included improved morphological information. The first edition of the International Classification of Diseases for Oncology (ICD-O) was subsequently released in 1976 and, in this classification, cancers were coded by both morphology (histology type and behaviour) and topography (site).

Since that first edition of the ICD-O, a number of revisions have been made, mainly in the area of lymphomas and leukaemias. The current edition, the 3rd Edition (ICD-O-3), was released in 2000 and is used by most state and territory cancer registries in Australia, as well as by the AIHW in regard to the ACD.

Index of Relative Socio-economic Disadvantage

The Index of Relative Socio-economic Disadvantage (IRSD) is one of 4 Socio-Economic Indexes for Areas developed by the ABS. This index is based on factors such as average household income, education levels, and unemployment rates. It is not a person-based measure, but an area-based measure of socioeconomic disadvantage in which small areas of Australia are classified on a continuum from disadvantaged to affluent. This information is used as a proxy for the socioeconomic disadvantage of people living in those areas and may not be correct for each person in that area.

In this report, the first socioeconomic area corresponds to geographical areas containing the 20% of the population with the greatest socioeconomic disadvantage according to the IRSD, and the fifth area corresponds to the 20% of the population with the least socioeconomic disadvantage. Caution should always be used when analysing the results of data that have been converted using correspondences, with the potential limitations of the data considered.

Socioeconomic areas for screening data

Participants' areas of residence were assigned to socioeconomic areas using the Statistical Area Level 2 of the participant's residential address according to the IRSD for 2021. Socioeconomic groupings (based on IRSD rankings) were calculated with a Statistical Area Level 2 correspondence, using a population-based method at the Australia-wide level. Participants whose Statistical Area Level 2 was not available in the socioeconomic correspondence were included in an 'Unknown' column in the relevant tables.

Socioeconomic areas for incidence and mortality

Socioeconomic disadvantage areas were assigned to cancer cases according to the IRSD for 2021 of the Statistical Area Level 2 of residence at the time of diagnosis, and to deaths according to the 2021 Statistical Area Level 2 of residence at the time of death.

International Statistical Classification of Diseases and Related Health Problems

The ICD is used to classify diseases and other health problems (including symptoms and injuries) in clinical and administrative records. The use of a standard classification system enables the storage and retrieval of diagnostic information for clinical and epidemiological purposes that is comparable between different service providers, across countries and over time.

In 1903, Australia adopted the ICD to classify causes of death and it was fully phased in by 1906. Since 1906, the ICD has been revised 9 times in recognition of new diseases (for example, acquired immunodeficiency syndrome, or AIDS), increased knowledge of diseases, and changing terminology in describing diseases. The version currently in use, the ICD-10 (WHO 1992), was endorsed by the 43rd World Health Assembly in May 1990 and officially came into use in World Health Organization member states from 1994.

International Statistical Classification of Diseases and Related Health Problems, Australian Modification

The Australian modification of the ICD-10, referred to as the ICD-10-AM (NCCH 2010), is based on the ICD-10. The ICD-10 was modified for the Australian setting by the National Centre for Classification in Health, with assistance from clinicians and clinical coders. Despite the modifications, compatibility with the ICD-10 at the higher levels of the classification (that is, up to 4-character codes) has been maintained. The ICD-10-AM has been used to classify diagnoses in hospital records in all states and territories since 1999–2000 (AIHW 2000).

Remoteness Areas

The Remoteness Areas divide Australia for statistical purposes into broad geographical regions that share common characteristics of remoteness. The Remoteness Structure divides each state and territory into several regions on the basis of their relative access to services. There are 6 classes of Remoteness Area in the Remoteness Structure: *Major cities*, *Inner regional*, *Outer regional*, *Remote*, *Very remote*, and *Migratory*. The category *Major cities* includes Australia's capital cities, except for Hobart and Darwin, which are classified as *Inner regional*. Remoteness Areas are based on the Accessibility and Remoteness Index of Australia, produced by the Australian Population and Migration Research Centre at the University of Adelaide.

Remoteness Area for screening data

Participants' residential address Statistical Area Level 2 data were mapped to 2021 Australian Statistical Geography. As some Statistical Area Level 2 areas can span different Remoteness Areas, a weighting for each Remoteness Area was attributed to the Statistical Area Level 2 in such cases. This can result in non-integer counts for remoteness classifications.

Remoteness Area for incidence and mortality

Each unit record in the ACD contains 2021 Statistical Area Level 2. To calculate cancer incidence by Remoteness Area, a correspondence was used to map the 2021 Statistical Area Level 2 to the 2021 Remoteness Area. Cancer mortality rates by Remoteness Area were based on 2021 Remoteness Area classifications.

Tables in this report based on geographical location were rounded to integer values. Where figures were rounded, discrepancies may occur between totals and sums of the component items. Participants whose postcode was not available in the remoteness correspondence were included in an 'Unknown' column in the relevant tables.

References

AIHW (Australian Institute of Health and Welfare) (2000) *Australian hospital statistics 1998–99*, AIHW, Australian Government, accessed 09 May 2022.

NCCH (National Centre for Classification in Health) (2010) *The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification (ICD-10-AM), Australian Classification of Health Interventions (ACHI) and Australian Coding Standards (ACS), 7th edn*, University of Sydney, Sydney.

WHO (World Health Organization) (1992) *International Statistical Classification of Diseases and Related Health Problems, 10th Revision, vol. 1*, WHO, Geneva.

Appendix C: Methodology for calculating participation for population subgroups

In this section

- Estimated participation by Indigenous status
- Estimated participation by language spoken at home
- Estimated participation by disability status

Determining participation rates by Indigenous status, preferred language spoken at home, and disability status requires the number of screening invitations sent out to members of each of these population groups (the denominator) as well as the number of people in each group who returned a completed screening kit (the numerator).

Unfortunately, at present, information on these groups is known only for participants who choose to identify when they return a completed details form along with their iFOBT for analysis (the numerator). That is, identification of these population groups is known only for the 40% of people who participated, not for all invitees. As a result, it is not possible to accurately determine participation rates for these population groups.

An alternative method to estimate the number of invitations sent out to people in these population groups involves using the percentages of those aged 50–74 who reported as such in the 2021 Census.

To do so, percentages based on Census counts (tables C1–C3) have been applied to the number of overall invitations (by age group and sex) to estimate invitation volumes by population groups. These estimated denominator data can then be used with the known population group numerator data gained from the returned participant details forms of those who participated.

Estimated participation by Indigenous status

There are limitations in the data available to estimate Indigenous Australians' participation in the NBCSP, due to differences in the 'not stated' proportions between the 2021–2022 NBCSP participation data and the 2021 Census data (3.8% and 4.5% 'not stated', respectively). An overall participation rate for invitees who self-identified as Indigenous has been estimated (see Equity in the NBCSP), but these limitations should be considered when interpreting these data.

Opportunities to improve the accuracy of calculating Indigenous Australian participation rates will continue to be explored. New information may become available that enables improved estimates to be produced for future reports.

Table C1: Percentage of the population by Indigenous status as identified in the 2021 Census, by sex and age

Sex	Age group (years)	Indigenous (%)	Non-Indigenous (%)	Not stated (%)
Males	50–54	2.40	92.36	5.24
Males	55–59	2.10	92.73	5.17
Males	60–64	1.87	93.28	4.85
Males	65–69	1.53	93.79	4.68
Males	70–74	1.14	94.27	4.59
Males	50–74	1.86	93.20	4.94
Females	50–54	2.59	93.35	4.06
Females	55–59	2.27	93.60	4.12
Females	60–64	1.94	94.12	3.94
Females	65–69	1.59	94.38	4.03
Females	70–74	1.19	94.62	4.19
Females	50–74	1.97	93.96	4.06
Persons	50–54	2.50	92.87	4.64
Persons	55–59	2.19	93.18	4.63
Persons	60–64	1.91	93.71	4.38
Persons	65–69	1.56	94.10	4.34
Persons	70–74	1.17	94.45	4.38
Persons	**50–74**	**1.92**	**93.59**	**4.49**

Source: 2021 Census.

Estimated participation by language spoken at home

Census data for population subgroups broken down by the language they spoke at home include a 'not stated' percentage for those who did not respond to this question (Table C2). This is equal to the 'not stated' option for those who participate and choose not to provide population group information.

For preferred language spoken at home, the NCSR assumes all who do not self-identify a language speak English. As a result, there is no 'not stated' language spoken at home data for participants (numerator) to match the 'not stated' percentage data from the Census (used for the denominator).

To resolve this issue, a participation range method was used for language spoken at home. The rate is provided as a range that covers what the percentage would be if the entire 'not stated' percentage was added to the 'English' column, and what it would be if the entire 'not stated' percentage was added to the 'Language other than English' column (Table 4.4).

Table C2: Percentage of the population by language spoken at home as self-identified in the 2021 Census, by sex and age

Sex	Age group (years)	English (%)	Language other than English (%)	Not stated (%)
Males	50–54	74.89	19.14	5.98
Males	55–59	76.08	18.17	5.75
Males	60–64	78.15	16.50	5.35
Males	65–69	78.95	15.83	5.22
Males	70–74	80.07	14.70	5.23
Males	*50–74*	*77.41*	*17.05*	*5.54*
Females	50–54	74.72	20.85	4.43
Females	55–59	75.83	19.72	4.44
Females	60–64	77.19	18.50	4.31
Females	65–69	77.57	17.95	4.48
Females	70–74	78.96	16.19	4.85
Females	*50–74*	*76.70*	*18.82*	*4.49*
Persons	50–54	74.80	20.01	5.19
Persons	55–59	75.96	18.96	5.08
Persons	60–64	77.66	17.53	4.81
Persons	65–69	78.24	16.93	4.84
Persons	70–74	79.50	15.47	5.03
Persons	**50–74**	**77.04**	**17.96**	**5.00**

Source: 2021 Census.

Estimated participation by disability status

Census data for population subgroups broken down by disability status include a 'not stated' percentage for those who did not respond to this question (Table C3). This should equate to the 'not stated' option for those who participate and choose not to provide population group information.

However, due to changes in completeness of disability status information in the NCSR, estimates of participation rates by disability status could not be reported in the current report (Table 4.5).

Table C3: Percentage of the population by disability status as self-identified in the 2021 Census, by sex and age

Sex	Age group (years)	Has need for assistance with core activities (%)	Does not have need for assistance with core activities (%)	Not stated (%)
Males	50–54	3.60	90.15	6.26
Males	55–59	4.64	89.33	6.03
Males	60–64	6.15	88.23	5.62
Males	65–69	7.94	86.67	5.39
Males	70–74	10.95	83.72	5.33
Males	*50–74*	*6.34*	*87.89*	*5.77*

Females	50–54	4.12	91.18	4.70
Females	55–59	5.20	90.08	4.72
Females	60–64	6.62	88.86	4.52
Females	65–69	8.26	87.12	4.62
Females	70–74	11.45	83.73	4.82
Females	*50–74*	*6.84*	*88.48*	*4.67*
Persons	50–54	3.86	90.67	5.46
Persons	55–59	4.93	89.72	5.36
Persons	60–64	6.39	88.56	5.05
Persons	65–69	8.10	86.90	4.99
Persons	70–74	11.21	83.72	5.07
Persons	**50–74**	**6.60**	**88.20**	**5.20**

Source: 2021 Census.

Notes

Data quality statement

Australian Cancer Database, 2020; Quality Statement

National Bowel Cancer Screening Program screening data 2021–2023; Quality Statement

National Death Index (NDI), Data Quality Statement

Acknowledgements

David Meere, Kayla Ruskin and Sarah Twyman prepared this monitoring report under the direction of Moira Hewitt. The authors thank the Bowel Screening Section at the Department of Health, Disability and Ageing, who provided valuable input.

The National Cancer Screening Register supplied the National Bowel Cancer Screening Program data for this report.

The financial support of the Department of Health, Disability and Ageing is gratefully acknowledged.

Data

Data tables: National Bowel Cancer Screening Program monitoring report 2026 supplementary tables

Data

XLSX 1.2MB

Data tables: National Bowel Cancer Screening Program monitoring report 2026 appendix tables

Data

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