Cancer Trials Australia

# Trends in Victorian cancer clinical trials participation 2022–2025

### Acknowledgement of Country

Cancer Trials Australia acknowledges Aboriginal and Torres Strait Islander peoples as Australia's first communities, and as the Traditional Custodians of the lands on which we live and work. Connection to community is central to the life, culture and continuing traditions of First Nations peoples. We pay our respects to all Elders past, present and emerging, and to the communities we have the privilege of working with.


### Acknowledgement of Support

The Annual Victorian Cancer Clinical Trials Census is supported by the Victorian Government, through the Victorian Department of Health.

VICTORIA State Government


### Acknowledgement of Predecessor

We acknowledge Cancer Council Victoria's significant leadership in this space, having the foresight to initiate the Cancer Trials Management Scheme in 1988 to document cancer clinical trial participation across Victoria, and managing that program for over 30 years.

### Acknowledgement of use of Artificial Intelligence

CTA incorporated generative artificial intelligence (AI) tools as part of the analytical workflow for this Census. These tools assisted with data interrogation, quality assurance, figure review, visualisation design and narrative development. The use of AI enabled additional validation checks, cross-figure consistency reviews, identification of data reconciliation issues and exploration of emerging insights.

AI-generated outputs were used as analytical support tools only and did not replace human judgement or review. All findings, interpretations, conclusions and final report content were subject to human oversight, with final responsibility for interpretation, conclusions and publication resting with CTA.

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# Foreword

## Welcome to CTA's second Annual Victorian Cancer Clinical Trials Census Report. This Census demonstrates continued growth and evolution of Victoria's cancer clinical trial ecosystem.

In 2025, 2,172 participants were recruited to 435 trials, reported by 20 clinical research units, representing the most comprehensive Census dataset captured to date. Growth was particularly evident in Early Phase and First Time in Human (FTIH) research, with FTIH recruitment increasing by 136% since 2022 and Early Phase studies now accounting for almost half of all recruiting trials. This report also highlights the important contribution of regional and rural Victorians, who represented 39% of participants, while demonstrating the continuing role of metropolitan centres in providing access to specialised trial opportunities. Encouraging improvements were observed in equity-related measures, including a five-fold increase in reported First Nations participation and substantial improvements in demographic data completeness. Collectively, these findings reinforce Victoria's position as a leading destination for cancer clinical research, while highlighting the growing complexity, reach and workload associated with delivering contemporary cancer clinical trials.

We thank the project team for their consistent, high-quality work, specifically Trizia Bajar and Andrew Chong, for data collation and visualisation.

We would like to acknowledge the many years of work undertaken by Cancer Council Victoria that underpins this project; the effort, and foresight, to collect and curate multiple years of study and participant data describing participation in cancer trials across Victoria has been necessary for many agencies to showcase progress and achievement against their own projects and has enabled representation of the work of many thousands of Site and Sponsor staff across our State.

We would also like to acknowledge the progressive vision of the Cancer Trials Australia Board, and of our colleagues in the Cancer Research, Evidence and Intervention team within the Department of Health who remain willing to support ambitious data projects in the belief that the data will assist us all in delivering better treatment options for Victorian cancer patients.

And last but not least, we sincerely thank the research staff that generate all the activity that is reported here; this is a challenging space, with many demands on your time, and many hands held out requesting your data. This ongoing project is really about representing you, your effort, and your dedication to your participants, in the hope that it enables you to expand resources, infrastructure, treatment options and opportunities for all Victorian cancer patients and their families.

**Kurt Lackovic**
Chief Executive Officer
Cancer Trials Australia

**Emily England**
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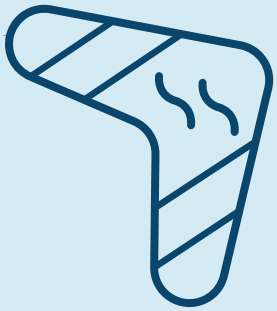
Cancer Trials Australia

# At a Glance

FTIH recruitment increased by

**136%**

between 2022 and 2025



Continued improvement in recording of First Nations participation, increasing

**6 to 30**

per annum over the 4-year reporting period

**39%**

of participants resided in regional or rural Victoria

&

**19%**

of participants were recruited at regional trial sites

2,172

participants recruited in 2025

435

recruiting trials in 2025

Data reported from

twenty

clinical research units across Victoria

49%

of recruiting trials were Early Phase

# Sector Advocacy and Development

## Cancer Trials Australia (CTA) was originally established in 1993 as the Centre for Developmental Cancer Therapeutics (CDCT), to offer clinical trial sites a co-ordinated and dedicated resource team to manage clinical trial administration, including ethics and governance submissions, budget and contract negotiations and financial management of their clinical trial activity.

In addition to its clinical trial administration services, CTA has been involved in a number of significant sector development initiatives since its inception including; implementing the Mutual Acceptance Program (MAP) across its Members; assisting with the development of a standard clinical trial agreement template for sponsored trials now known as the Medicines Australia Standard Clinical Trial Research Agreement template; the development of a First Time in Human (FTIH) protocol to enable Human Research Ethics Committees (HRECs) to strengthen their capacity to review Early Phase research; developing a pre-screening protocol, to allow patients to be screened at their local hospital for clinical trial participation at another hospital; convening a Phase 1 Fellowship Program to increase capacity for Victorian sites to coordinate FTIH trials; administering a range of projects aimed at increasing clinical trial education and capacity building through Victorian Comprehensive Cancer Centre initiatives and more recently the coordination of the Australian Clinical Trials Education Centre (A-CTEC) to support a dedicated Learning Management System (LMS) hosting a suite of evidence-based, interactive clinical trial education opportunities for Australian clinical trial staff.

This sector development work is undertaken against the background of CTA's day-to-day administrative management of clinical trials for our Member sites, where ethics and governance submissions are coordinated, budgets and contracts negotiated, and financial management of trial activity is undertaken. All of these core activities are underpinned by constantly evolving processes, systems and applications.

To facilitate trial financial management, over many years CTA has supplied a series of electronic applications to sites for recording of clinical trial participants and the activities they undertook as part of their trial experience. This enables CTA to generate invoices to Sponsors to recoup the cost of work undertaken by clinical trial sites. Towards the end of 2020, CTA began significant, strategic investment into our information management systems, specifically to improve the capacity for financial data management and interrogation. This involved a major project to develop and launch a new custom database application, Clinibase, built throughout the 2021 year in partnership with Cardiobase, a Melbourne-based healthcare solutions company. This project was completed in 2022 after transitioning all of CTA's financial management sites to the new application.

Due to the enhanced ability to interrogate the data collected within Clinibase, the application was increasingly recognised as a valuable data resource, describing participant recruitment and activity across the vast majority of Victorian cancer clinical trial sites.

# Data Reporting through Clinibase

Data collection and reporting on annual trends in cancer clinical trials across Victoria was undertaken by Cancer Council Victoria (CCV) from 1988 to 2021, via their Cancer Trials Management Scheme. Supported by the Victorian Government through the Department of Health, for many years this data collection remained the only source of comprehensive, annual, state-wide data on the cancer clinical trial sector.

In late 2022, after CTA's successful transition to Clinibase, the potential for Clinibase to function as the basis for collecting Victorian-wide clinical trials activity was explored; data demands from the sector were becoming increasingly granular and the CCV mechanism of collection and collation was labour intensive, requiring considerable staff time, effort, and commitment.

Clinibase was already in use by the majority of Victoria's clinical trial sites, and the majority of clinical trial activity undertaken across the state was already being captured directly within that application. Importantly, Clinibase offered a user interface where sites could self-maintain ongoing data-entry throughout the year and included a range of in-built reporting and data visualisation tools that could be utilised internally for a sites' own benefit. The opportunity for Clinibase to act as a source for sites to manage multiple data requests, both for internal and external reporting was attractive, as well as CTA's ability to generate cross-site data sets with reduced effort.

One of the main advantages of utilising Clinibase is that participant data is collected throughout the year, and highly validated where sites use Clinibase in their day-to-day operations. This reduces double handling as reports can be produced as needed, directly from the source data. Another benefit is that the data is maintained in a "per participant" format, meaning that granular segmentation can be undertaken, allowing us to pivot the data to gain deeper insights.

After positive discussions with CCV and with support from the Victorian Department of Health, CTA assumed responsibility for state-wide data collection from 1 January 2023, including the 2022 calendar year reporting period, establishing the Annual Victorian Cancer Clinical Trials Census program.

This data ultimately belongs to each clinical trial site; CTA acts as a data custodian to provide this aggregated, anonymised data set for wider sector use. To ensure appropriate permission is gained for this function, Data Sharing Agreements have been executed with all participating sites. This process has taken significant effort, and our thanks go to all site staff who have helped shepherd their Data Sharing Agreement through various legal, cybersecurity and governance approval processes.

It is important to recognise that not all Victorian cancer clinical trial sites are as yet represented within this data set. Participation in the Annual Victorian Cancer Clinical Trials Census and representation in this report is a choice that sites are free to make, and their ability to provide historical data is often dependent on their own internal capacity, prior data collection methodologies, and progress of their Data Sharing Agreement.

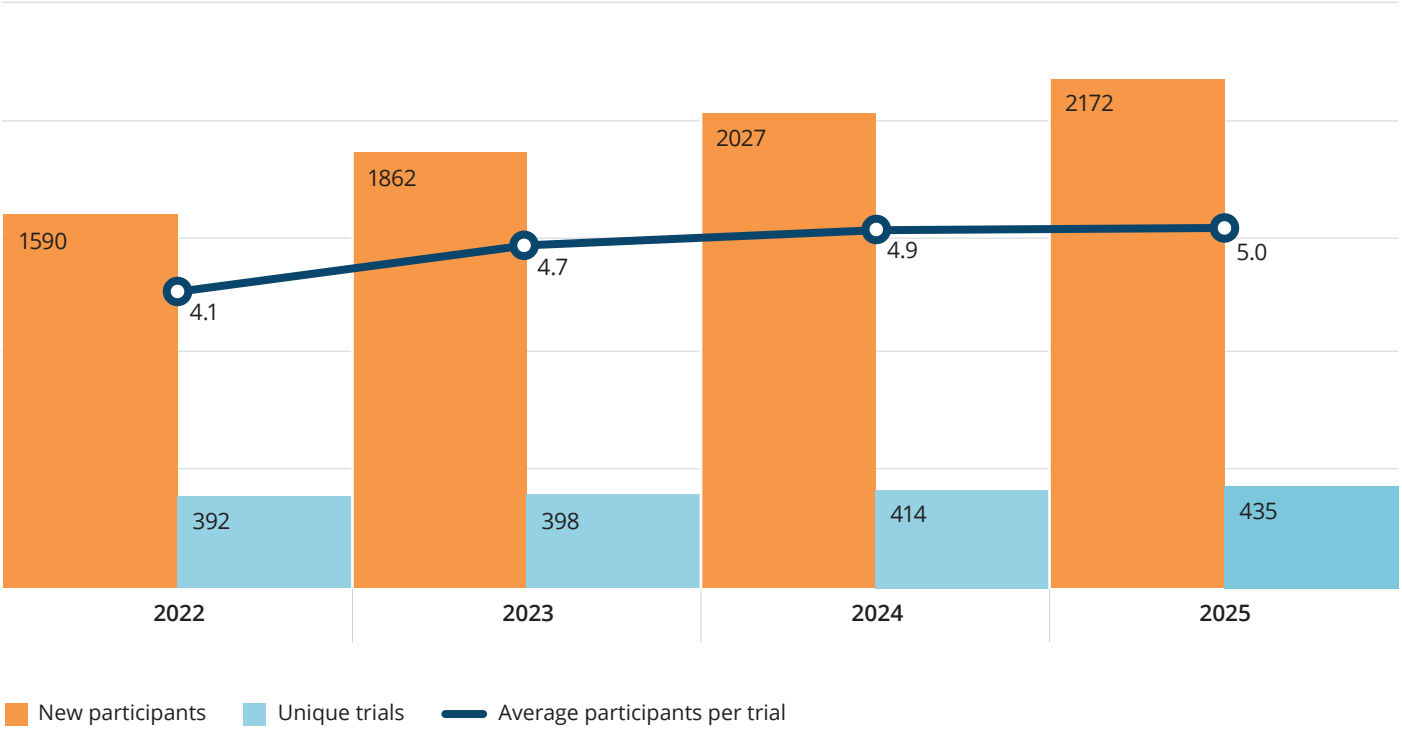
# A Growing Data Set

To date, 20 separate Victorian oncology clinical research groups are represented within the Census dataset, an increase of one compared with the previous reporting period. CTA continues to work collaboratively with the few remaining Victorian cancer clinical trial sites not yet represented within the Census, with the aim of achieving increasingly comprehensive sector-wide reporting.

The addition of a new clinical research group has enabled both contemporary and historical data to be incorporated into the Census. As a result, previously reported 2022–2024 figures have been updated where historical data were available, improving the completeness of the dataset and the accuracy of year-on-year comparisons. This report therefore presents updated 2022–2024 results alongside newly collected 2025 data, representing the most comprehensive view of Victorian cancer clinical trial activity captured by the Census to date across 20 participating Victorian clinical research groups.

# New Participants and Recruiting Trials

**Figure 1:** Number of new participants and unique trials that recruited new participants




We are pleased to report that recruitment continued to increase year-on-year across the full four-year reporting period growing from 1,590 new participants in 2022 to 2,172 in 2025 (Figure 1).

Across the full 4-year span, the number of unique recruiting clinical trials increased from 392 to 435. While this represents steady growth in trial activity, participant recruitment increased at a faster rate than the number of unique recruiting trials, with average participant recruitment rising from 4.1 participants per recruiting trial in 2022 to 5.0 in 2025, a level which has remained steady over the past 2 years.

While this infers increased efficiency in recruitment to trials, this is heavily influenced by many factors including trial portfolio balance and maturity of open trials, maximum trial size/competitive recruitment, disease area, site participation, and sponsor type.

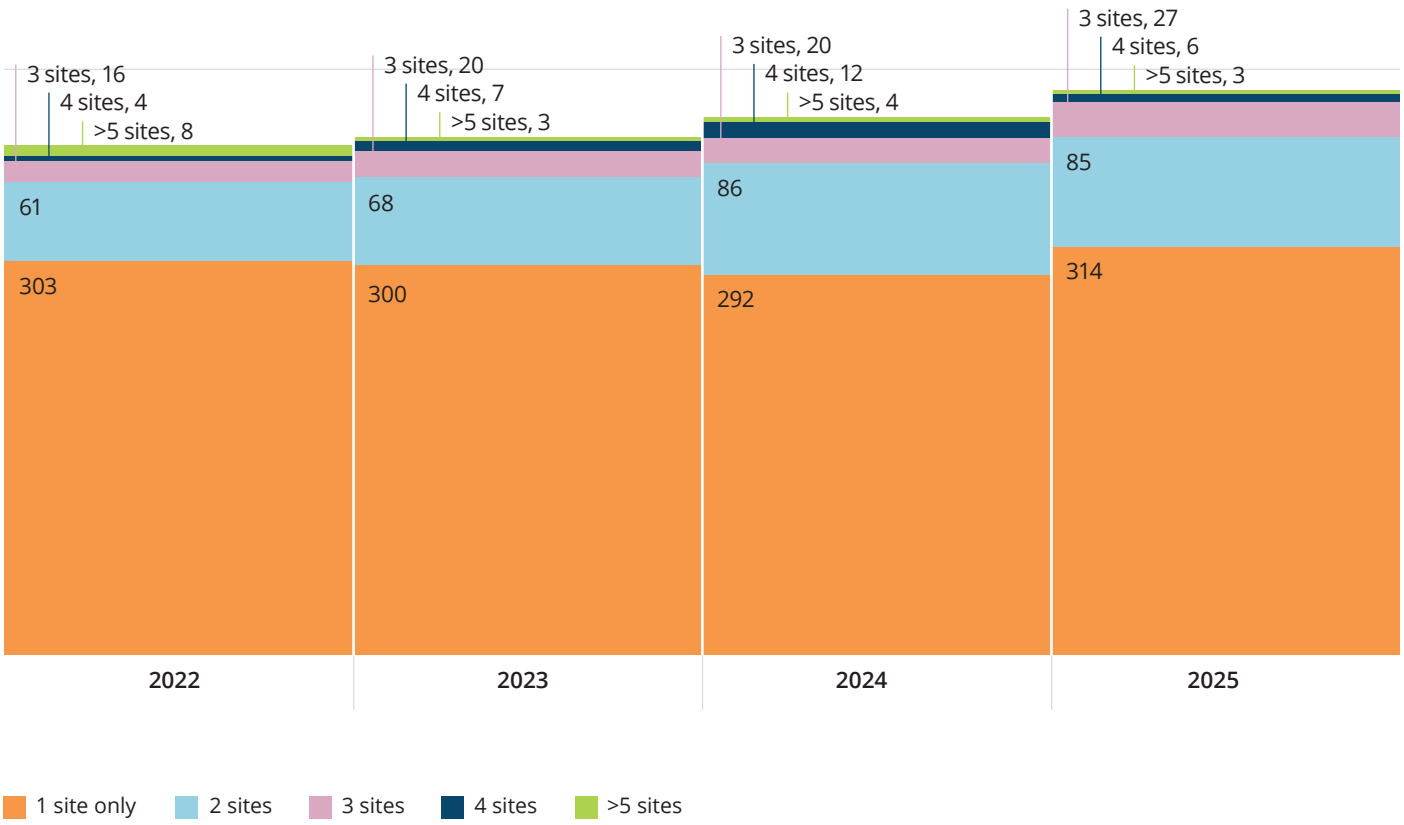
The term "unique trial" represents a single clinical trial protocol, not including duplicate counts of trials being conducted across multiple Victorian clinical trial sites.

The term "recruiting trial" represents a unique trial that recruited participants during any time in any single reporting year, regardless of the year the trial opened.

Please note that these definitions depart slightly from the prior Cancer Council Victoria definitions as, for clinical trial sites using Clinibase in their standard workflow for study start-up, CTA is also able to report data on unique trials that did not recruit during any single reporting year (refer to Figure 3).

# Trial Availability

**Figure 2:** Number of sites opening each unique recruiting trial




Single-site trials remained the dominant model throughout the reporting period across our Victorian Census sites, accounting for approximately 70-77% of recruiting trials each year (Figure 2). However, the proportion of unique trials open at two or more Victorian Census sites increased from 23% in 2022 to 28% in 2025, peaking at 30% in 2024.

The number of multi-site recruiting trials increased from 89 in 2022 to 121 in 2025, representing growth of 36% across the reporting period. This growth was primarily driven by an increase in trials recruiting across two or three sites.

It is important to note that these analyses will undercount true multi-site availability; these trials may be open at non-Census sites, including some sites in Victoria or interstate.

## **Figure 3:** Number of unique trials Open to Accrual during any one year that did or did not recruit participants

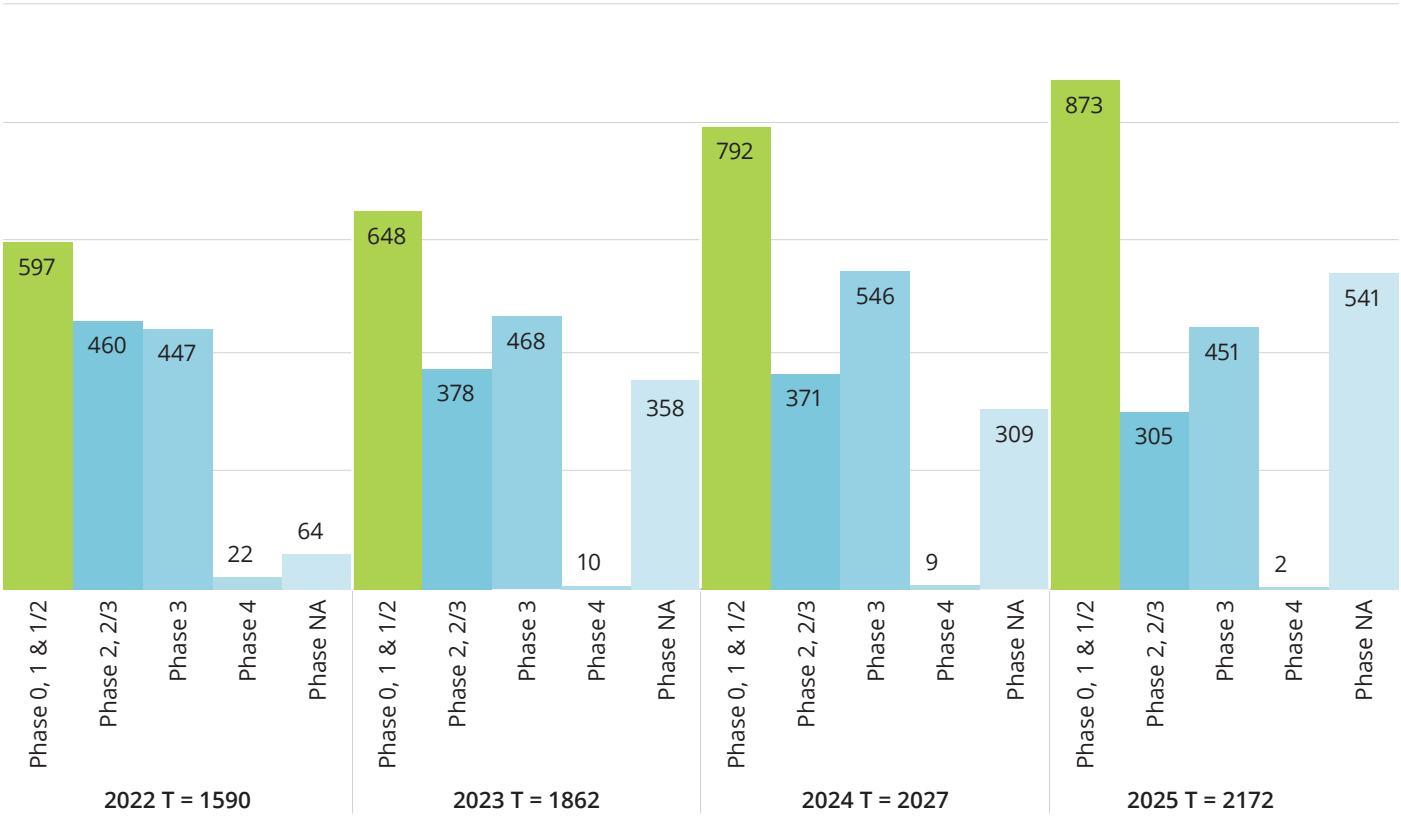
Analysis of trials that were available ie "Open to Accrual" but did not recruit a participant in a given year is not traditionally undertaken; recruitment is usually the starting point for data collection. This under-represents trial availability and obscures site workload that is not captured by recruitment metrics alone, particularly for trials with highly specific eligibility criteria and small eligible populations. Clinibase provides a unique view of trial availability, as a subset of sites use the system from Site Initiation, allowing analysis before the first participant is recruited.

Figure 3 shows that most Open to Accrual trials successfully recruited participants. In 2025, 435 of 488 open trials (89%) recruited participants, compared with 392 of 420 open trials (93%) in 2022. While the number of trials with no recruitment increased from 28 in 2022 to 53 in 2025, these trials represented a relatively small proportion of the overall portfolio, increasing from 7% to 11%. Maintaining a broad trial portfolio inevitably includes some studies with no recruitment in a given year, especially rare cancer trials that may remain open for extended periods so eligible participants can access them when identified.

Trials yet to recruit a participant represent substantial, under-recognised work by Victorian clinical trial sites, which maintain study availability despite limited direct financial reimbursement, as clinical trial payments are predominantly associated with participant visits. The reasons for no recruitment cannot be determined from these data alone and may include late-year start-up, rare tumour types, limited eligible participants, multi-site recruitment patterns, delayed closure, or other operational factors. Figure 3 also does not show recruitment duration or targets, so these findings should be interpreted alongside the broader growth in recruiting trials and participants reported elsewhere.

# Early Phase Trials

**Figure 4:** Participant recruitment by Phase and year

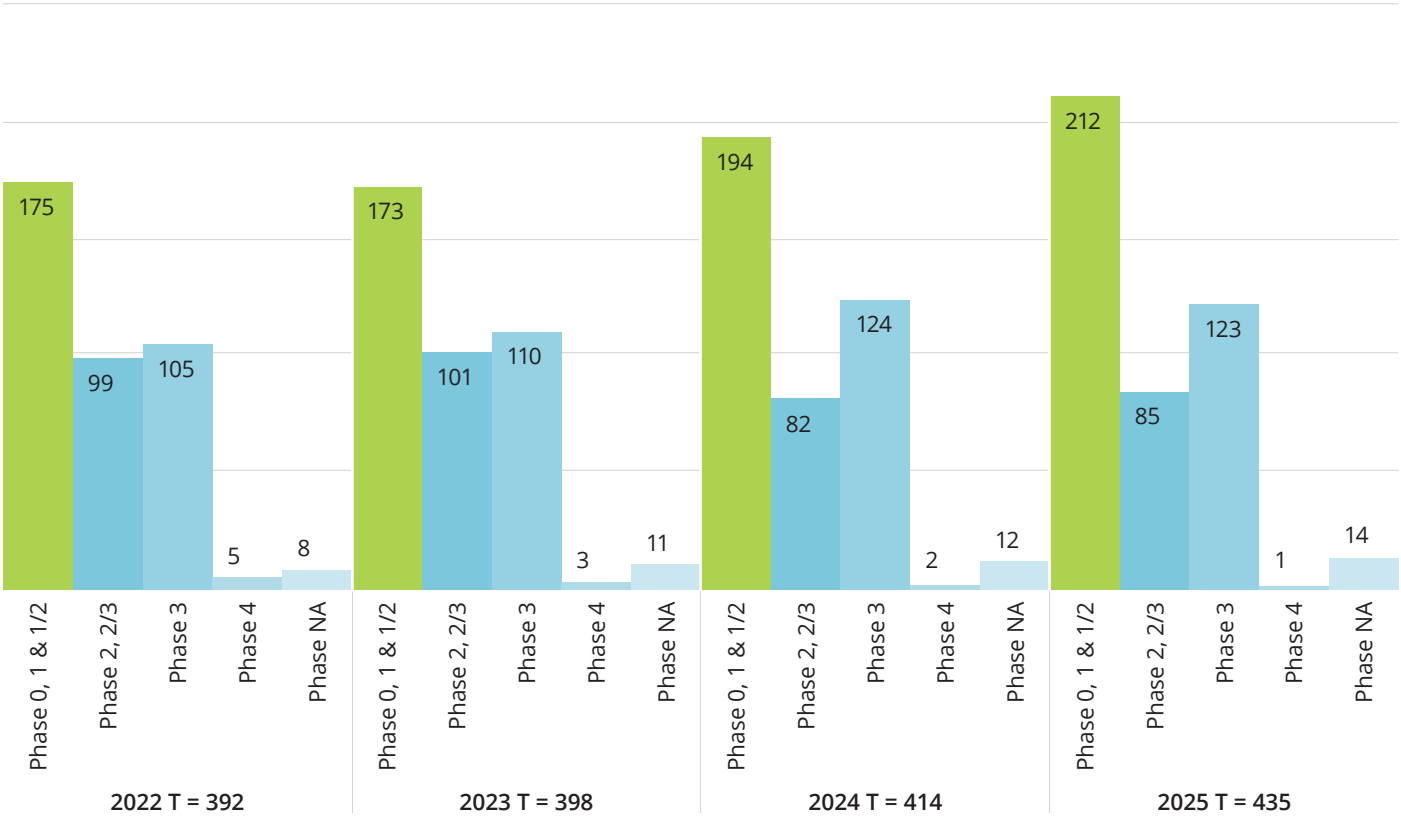



Over the past 12 years, Australia has developed a reputation as a destination of choice for the conduct of commercially sponsored clinical research, in particular Early Phase clinical trials. In fact, growth in clinical trials across Australia between 2015-2022 sits second only to China.[1] Furthermore, on a per capita basis, Australia now attracts more commercially sponsored clinical trials than any other country.[2]

The growth in Australian clinical trials across this period is predominantly due to growth in Phase 1 trials (9.5% per annum), with some growth seen in Phase 2 trials, and no growth or declines observed in later Phase trials.[2] Key reasons for growth in Early Phase trials across Australia include the speed with which trials can be initiated, lower clinical research costs including access to a Research and Development Tax Incentive, and the quality of data produced, which is accepted globally. In addition, the strength of engagement with clinician-researchers, knowledgeable clinical trial staff, experienced Australian clinical trial networks, as well as world-class universities and medical research institutes also underpin this. These reasons ensure Australia now ranks #3 in the world for total number of commercially sponsored Phase 1 trials initiated per annum, behind the much larger USA and China.[3]

In oncology specifically, a study of trends in Phase 1 oncology trials initiated across Australia between 2012-2022 demonstrated a substantial increase in the number of trials (31.7% per annum), with growth driven predominantly by emerging biopharmaceutical companies from Asia. Most of these studies were initiated in Melbourne and Sydney, with very few including regional sites.[4]

## **Figure 5:** Number of unique recruiting trials by Phase and year




Specific initiatives have also sought to enhance the number of Early Phase trials available in Victoria; CTA has supported development of a First Time in Human (FTIH) protocol to enable Human Research Ethics Committees (HRECs) to strengthen their capacity to review Early Phase research and has convened a Phase 1 Fellowship Program to increase capacity for Victorian sites to coordinate FTIH Trials. CTA also contributed to the Early Phase Clinical Trials Guidance within the Scientific Expert Review Toolkit established by the Victorian State Government in 2019, which supports and supplements quality and safety decision-making in the ethics review process within Victoria. This allows for trials to be approved by ethics committees without the need for IND/FDA approval, allowing Victorian sites to gain expedited access to Early Phase trials.

Early Phase trials are vital to our participants – they deliver novel therapies to patients faster.

In Figures 4 to 7 we have defined Phase 0, Phase 1 and Phase 1/2 as "Early Phase" trials and compared these to later Phase trials. Not Applicable (NA) is used to describe trials without defined Phases, including for example neo-adjuvant and expanded access trials.

Participant recruitment continued to be concentrated within early-phase clinical trials, with recruitment to Phase 0, Phase 1 and Phase 1/2 studies increasing from 597 participants in 2022 to 873 participants in 2025 (Figure 4). These studies represented the largest recruitment category throughout the reporting period and accounted for approximately 40% of all participants recruited in 2025.

Recruitment to Phase 2 studies declined across the reporting period, from 460 participants in 2022 to 305 participants in 2025, while Phase 3 recruitment remained comparatively stable overall despite year-to-year variation.

When analysing Figure 5, the data indicate that the Victorian cancer clinical trial portfolio continues to maintain a strong Early Phase focus, with almost half of all recruiting trials in 2025 classified as Phase 0, Phase 1 or Phase 1/2 studies. These trials representing the largest recruiting trial category in every year across the reporting period increasing from 45% in 2022 to 49% in 2025.

# Early Phase Trials (continued)

**Figure 6:** Proportion of participant recruitment to FTIH trials as a sub-set of Phase 0, 1 and 1/2 trials

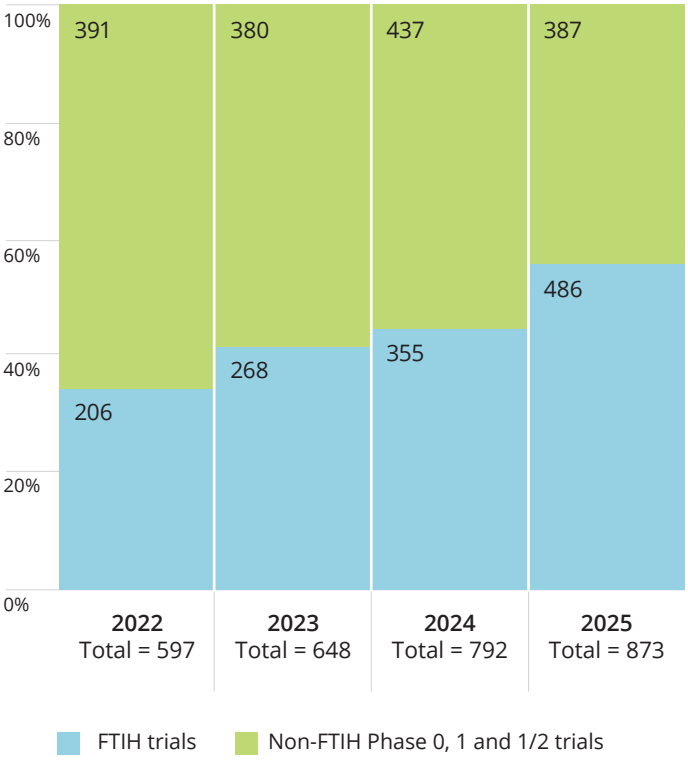
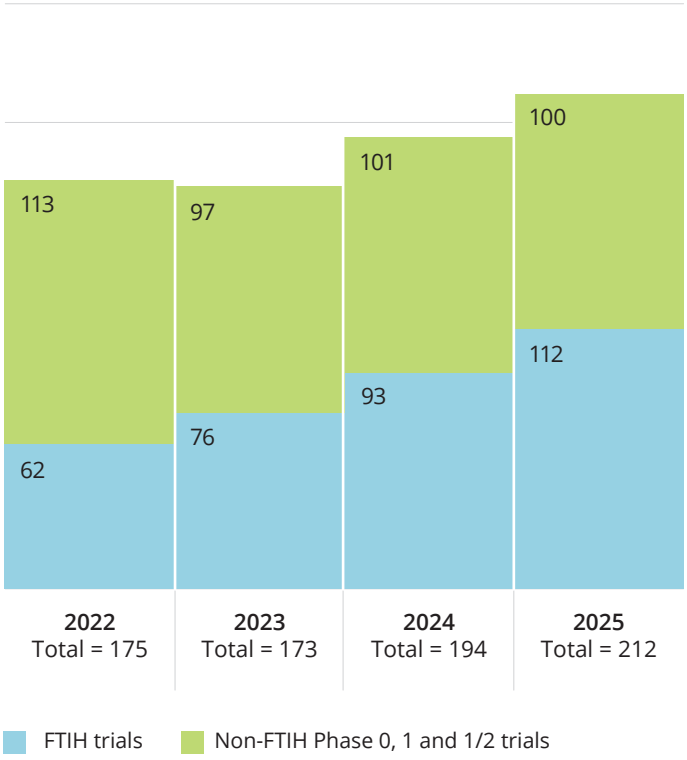



**Figure 7:** Proportion of unique recruiting FTIH trials as a sub-set of Phase 0, 1 and 1/2 trials




While the relative proportion of Early Phase trials within the Victorian cancer clinical trial portfolio remained broadly consistent, the profile of this Phase group in terms of trial type and participant recruitment continued to shift towards First Time in Human (FTIH) studies (Figures 6 and 7).

Participant recruitment to FTIH trials increased from 206 participants in 2022 to 486 participants in 2025, representing an increase of 136% across the reporting period. Over the same period, the proportion of Early Phase participants recruited to FTIH studies increased from 35% to 56%.

The number of unique recruiting FTIH trials increased from 62 to 112 over the same period representing an increase in the proportion of 35% in 2022, to 53% in 2025.

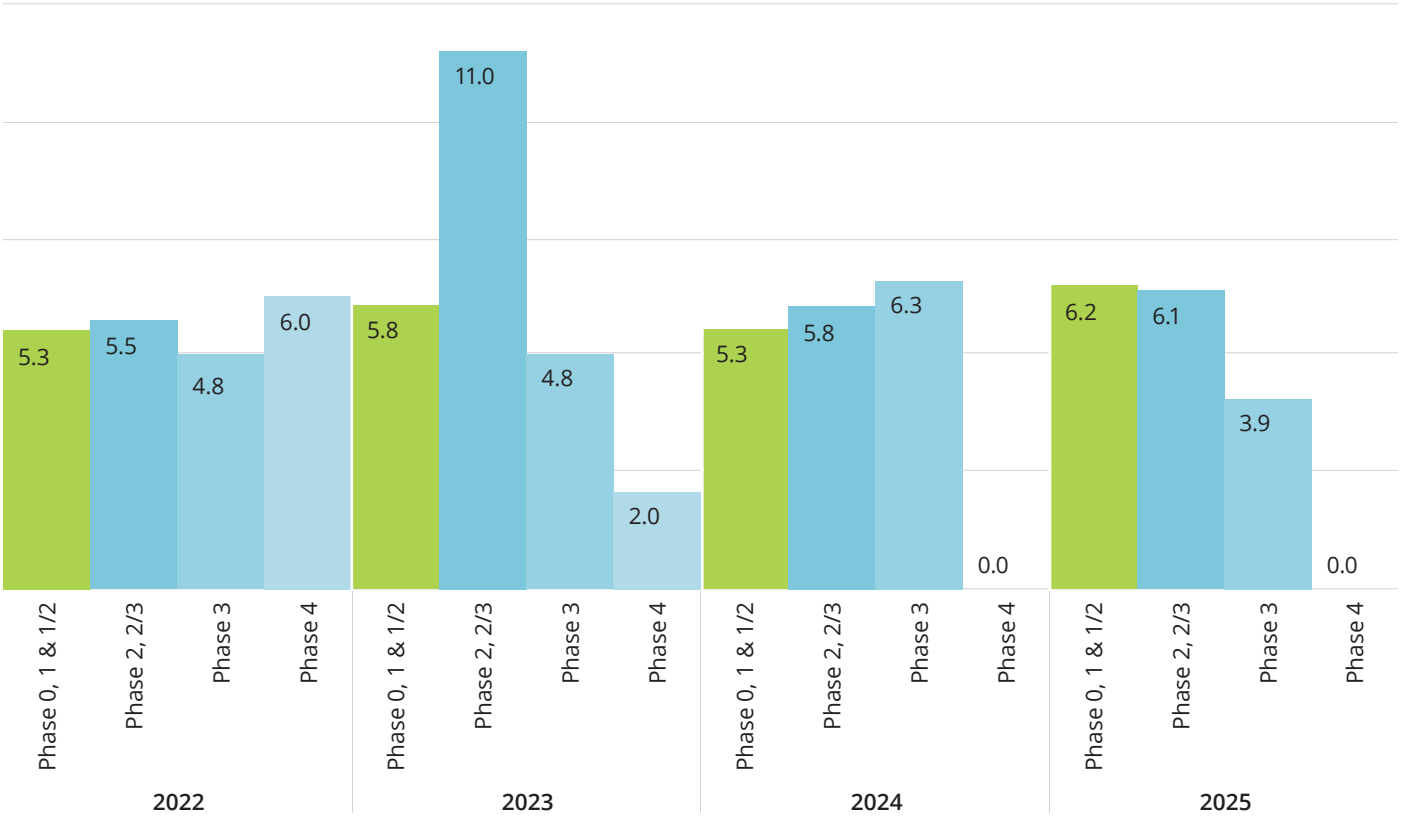
In contrast, recruitment to non-FTIH Early Phase studies remained relatively stable, with 391 participants recruited in 2022 and 387 in 2025 indicating that growth in Early Phase recruitment was primarily driven by increasing participation in FTIH trials.

Together, these findings indicate that growth in FTIH activity was driven by both an increase in the number of FTIH trials and increased participant recruitment within those trials. By 2025, FTIH studies represented the majority of both Early Phase participant recruitment and Early Phase recruiting trials.

Using Clinibase data, which captures a broader range of information throughout the life of each trial, CTA continued to examine participant recruitment among trials that have completed their recruitment component and are classed as "Closed to Accrual" (Figure 8).

The updated data for 2025 remains consistent with previous findings. Early Phase trials recruited an average of between 5.3 and 6.2 participants per "Closed to Accrual" trial across the reporting period, which was broadly comparable to the averages observed for Phase 2 and Phase 3 trials. While Early Phase studies often recruited slightly fewer participants than some later phase categories, the difference was not consistent across years and appears less pronounced than may have previously been assumed.

## **Figure 8:** Average number of participants per "Closed to Accrual" trial




Importantly, the increasing focus on Early Phase and First Time in Human (FTIH) studies has not yet been associated with a substantial decline in average recruitment per closed trial. The Early Phase average remained relatively stable across all four years and reached 6.2 participants per closed trial in 2025.

As noted previously, these analyses exclude trials that are mid-recruitment, where patients are still being actively approached, and includes only trials that were "Closed to Accrual" during the reporting year. While closed to new participants, these studies continue to remain active for many years while participants are treated, monitored and followed up after recruitment has ceased.

Figures 4-8 support the current broader awareness that Early Phase activity is becoming increasingly important to the Victorian cancer clinical trials landscape. The portfolio appears to have crossed a threshold where FTIH studies now represent the majority of Early Phase activity by both recruitment and trial count, representing an important paradigm shift rather than simple year-to-year variation.

Increased FTIH recruitment is not just a consequence of having more FTIH trials. Figures 6 and 7 together show that both metrics have increased:

| Year | FTIH participants | FTIH trials | Participants per FTIH trial |
|---|---|---|---|
| 2022 | 206 | 62 | 3.3 |
| 2025 | 486 | 112 | 4.3 |

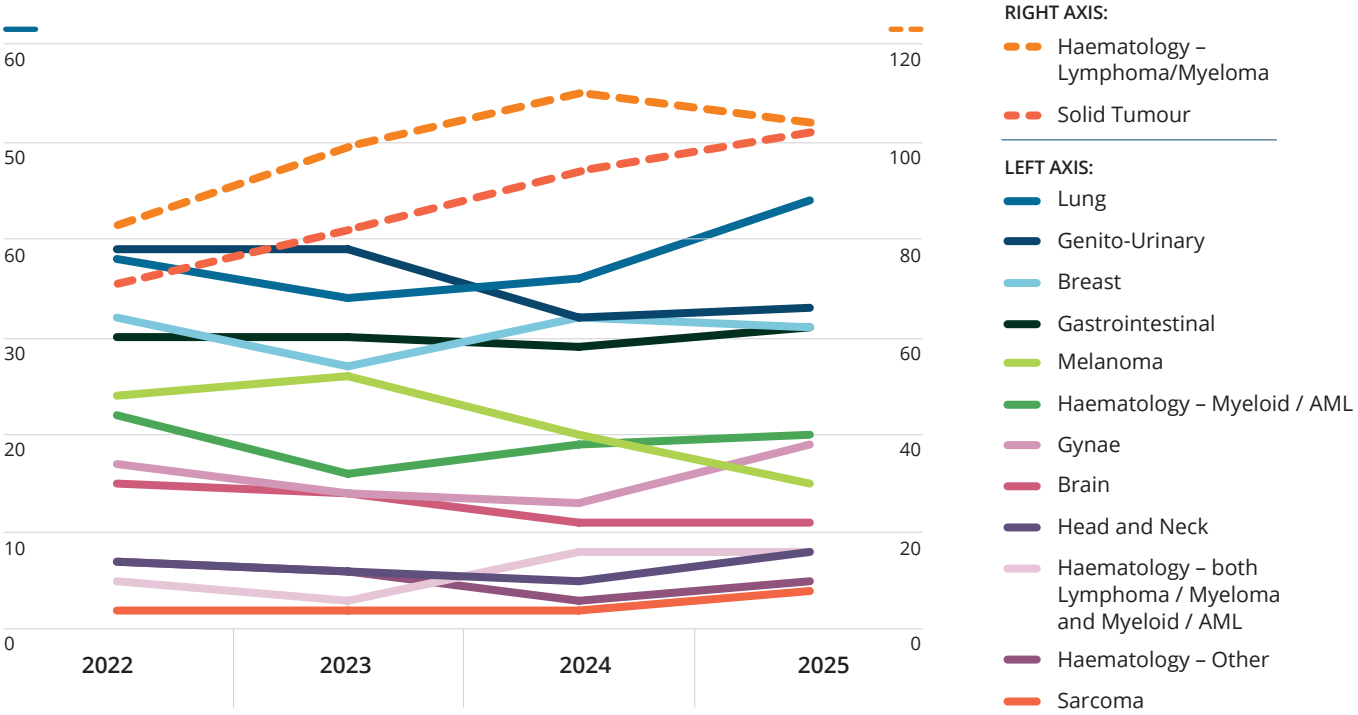
Furthermore, Early Phase average recruitment per closed trial remaining stable, in fact slightly higher in 2025 than all prior years reported.

These data point to a greater expansion of an established capability rather than simple growth in trial numbers.

A cautious interpretation is that increasing FTIH activity may indicate Victoria's increasing influence and purposeful selection in earlier stages of therapeutic development.

# Tumour Stream

**Figure 9:** Number of unique trials that recruited participants by tumour stream



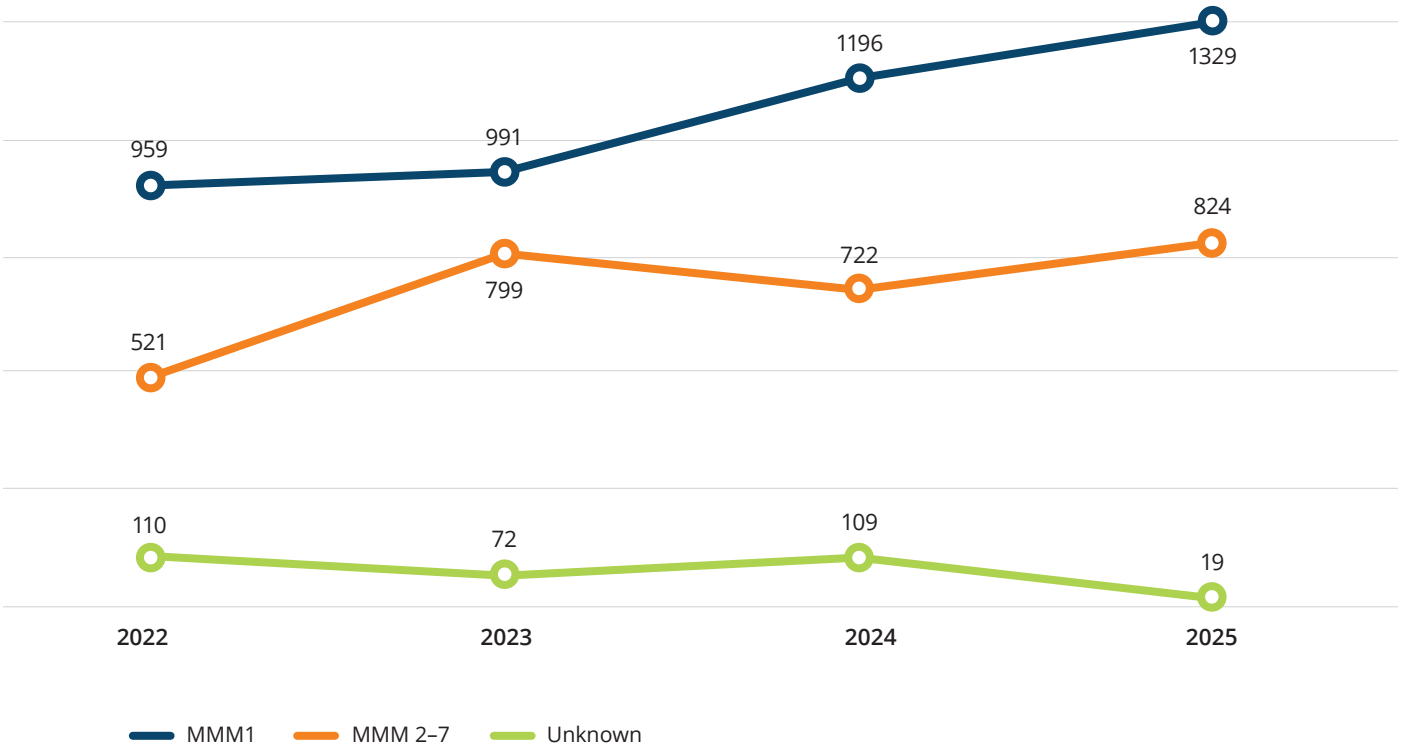

An important limitation of tumour-stream analysis within our Census relates to the Solid Tumour category. Many Solid Tumour studies are umbrella trials that contain multiple disease-specific cohorts or trial arms within a single protocol. While participant recruitment is recorded at the study level within the Census dataset, information regarding the specific tumour-stream cohort or trial arm entered by an individual participant is not currently collected. As a result, participants recruited to Solid Tumour studies cannot be reliably attributed to a specific cancer type, limiting direct comparison between Solid Tumour recruitment and tumour-specific cancer incidence data.

The distribution of recruiting trials across tumour streams remained broadly consistent throughout the reporting period (Figure 9). Haematology-Lymphoma/Myeloma and Solid Tumour studies (represented on the secondary axis) continued to represent the largest tumour-stream categories and accounted for most of the growth in recruiting trials between 2022 and 2025. The number of recruiting Solid Tumour trials increased from 71 to 102 (+44%), while Haematology-Lymphoma/Myeloma trials increased from 83 to 104 (+25%). Together, these two streams accounted for almost half of all recruiting trials in 2025.

Outside these larger tumour streams, activity was generally stable, although some variation was observed. Lung trials increased from 38 to 44 trials per annum (+16%) across the reporting period, and Gynae grew from 17 to 19 per annum (+12%). The number of recruiting Melanoma trials declined from 24 in 2022 to 15 in 2025, a decrease of 37.5%.

# City to Country

**Figure 10:** Number of new participants by residential address MMM code




As referenced in the Victorian Cancer Plan 2024-28 an area of ongoing and significant focus is the equitable provision of trials to regional participants.[5] Goal five of that Plan aims to increase the overall number of new clinical trial enrolments in rural and regional areas of Victoria by 30% between 2023 and 2040. The Plan notes that "Geographical disparities can limit participation in clinical trials, with rural and regional Victorians facing significant barriers such as limited access to trial sites, transportation challenges and socioeconomic constraints."

Many initiatives across the state continue to contribute toward the achievement of this outcome, and CTA warmly recognises the efforts of all regional site staff to increase their capacity and expertise in delivering trials, as well as metropolitan site staff who facilitate and advocate for travel support for regional participants.

This Census references the Modified Monash Model[6] version 2023 for classification of participant residential postcodes in regional and rural areas. The same reference set was used for last year's report and as such no postcode re-classification has been applied.

## Where did trial participants come from?

A substantial proportion of participants continued to be recruited from regional and rural residential postcodes throughout the reporting period (Figure 10).

From 2022 to 2025, 4,475 new participants were recruited from metropolitan residential postcodes (MMM 1) and 2,866 new participants were recruited from regional and rural residential postcodes (MMM 2-7). Excluding participants with unknown residential postcode information, regional

**Figure 11:** Number of participants recruited by site location

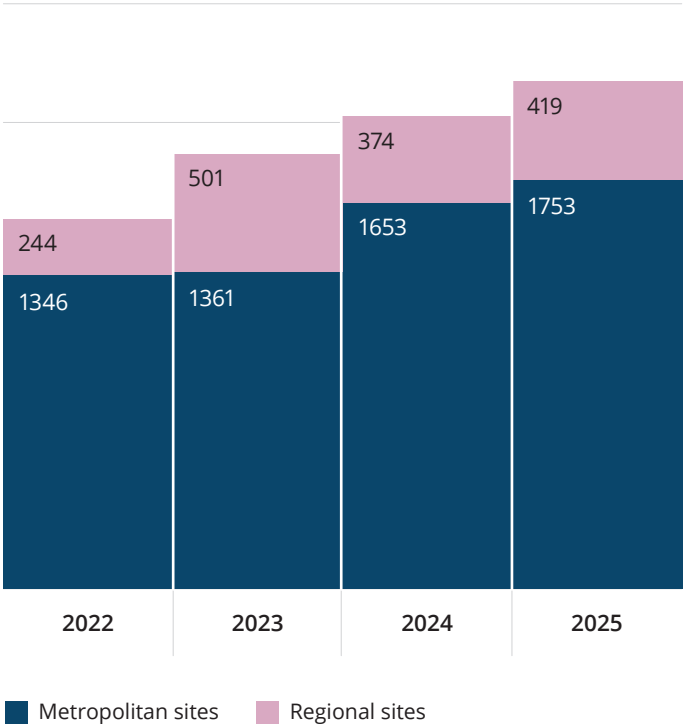
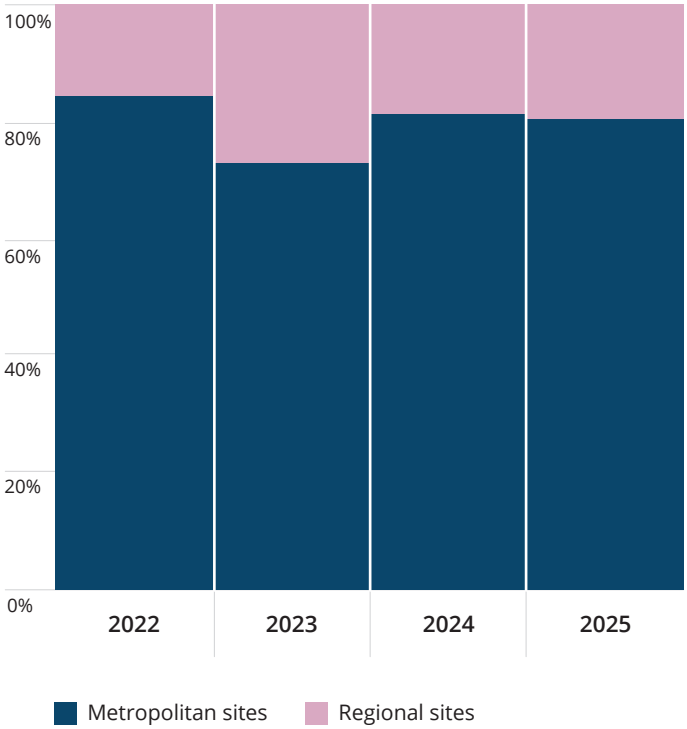



**Figure 12:** Proportion of participants recruited by site location




and rural participants represented 39% of all participants recruited during the reporting period.

From 2024 to 2025 regional and rural participant recruitment increased from 722 to 824. This increase occurred alongside a substantial improvement in residential postcode completeness, with unknown participant locations decreasing by more than 80% compared with 2024, indicating that postcode data is being more rigorously entered in Clinibase.

While improved data capture may have contributed to the observed increase, the improved completeness of residential postcode information represents a positive development for monitoring regional participation and equity of access to cancer clinical trials, supporting the key regional equity deliverable of the Victorian Cancer Plan 2024-28.[5]

## Where were trial participants treated?

Of the 2,172 cancer clinical trial participants recruited across Victoria in 2025, 19% participated in a trial at a regional site location (Figures 11 and 12). This represents a modest increase from 18% in 2024 but remains below the peak of 27% observed in 2023.

Regional-site recruitment increased from 374 participants in 2024 to 419 participants in 2025, representing growth of 12% over the year. Across the reporting period, regional-site recruitment increased from 244 participants in 2022 to 419 participants in 2025, an increase of 72%.

While metropolitan sites continued to recruit the majority of participants, regional sites accounted for approximately one in five participant recruitments in both 2024 and 2025.

# Across Generations

**Figure 13:** Number of participants recruited by age group

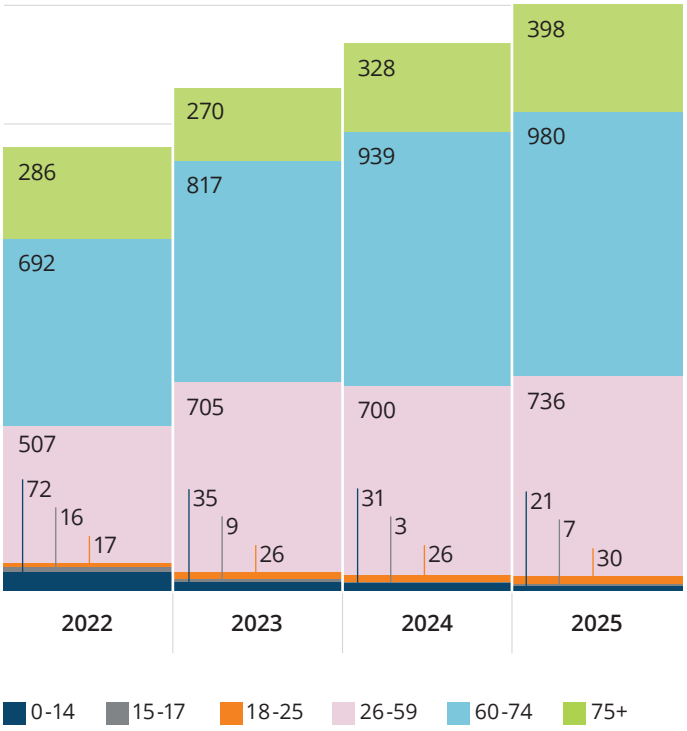
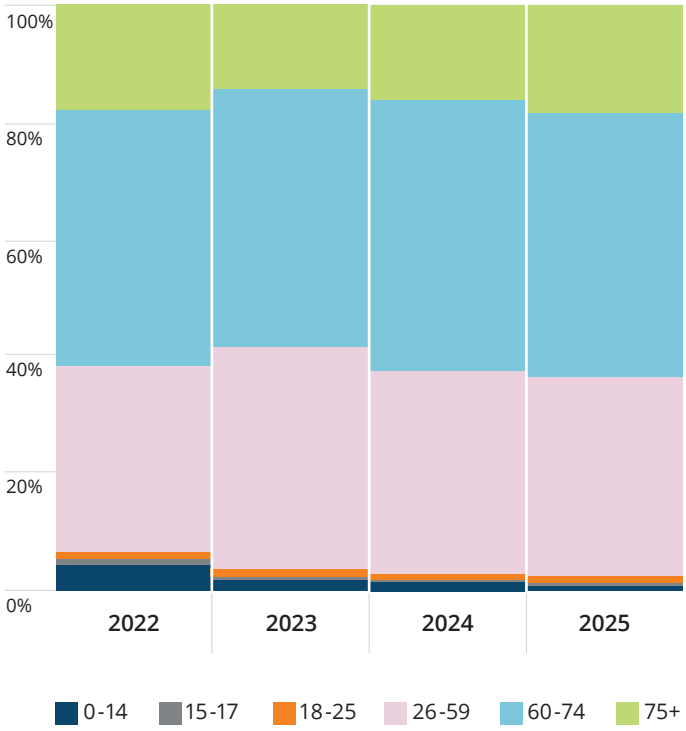



**Figure 14:** Proportion of participants recruited by age group



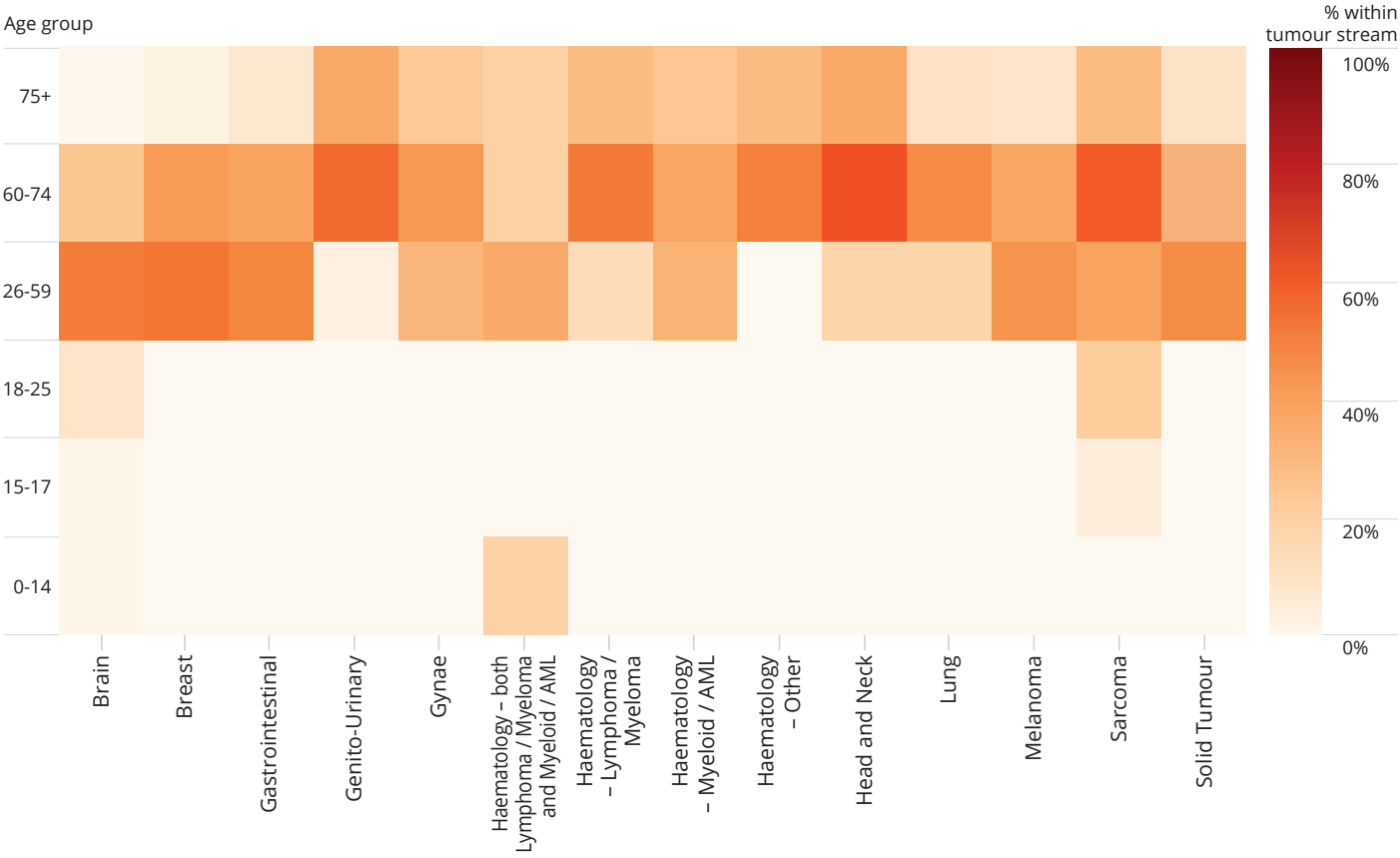

The distribution of participant recruitment by age group remained broadly consistent across the reporting period, with the highest representation of clinical trial participants continuing to be observed in the 60-74 year age group (Figures 13 and 14).

Participants aged 60-74 accounted for approximately 45% of all recruitment throughout the reporting period and increased from 692 participants in 2022 to 980 participants in 2025. Growth in participant recruitment was also observed among participants aged 26-59 years and those aged 75 years and over.

While the overall age profile remained stable, the number of participants aged 75 years and over increased from 286 in 2022 to 398 in 2025; of note, though this age group represented a similar proportion of recruitment across the reporting period, the absolute number of participants in this age group increased by almost 40%.

Participants younger than 26 years continued to represent a relatively small proportion of total recruitment to Victorian cancer clinical trials.

## **Figure 15:** Age distribution by tumour stream for trials in 2025




While Figures 13 and 14 demonstrate the overall age distribution of clinical trial participants, Figure 15 provides additional insight into how participant age profiles vary across tumour streams.

The 2025 data show that most tumour streams were predominantly represented by participants aged 60–74 years, consistent with the broader age distribution observed across the Victorian cancer clinical trial portfolio. Genito-Urinary, Lung and Haematology-Lymphoma/Myeloma trials were particularly concentrated among older participants, with the majority of recruitment occurring within the 60–74 and 75+ age groups.

In contrast, Brain, Breast trials demonstrated a broader distribution across adult age groups, with a greater proportion of participants aged 26–59 years. Across most tumour streams, recruitment of participants younger than 26 years remained comparatively uncommon.

While participants younger than 26 years represented a relatively small proportion of overall recruitment, the heatmap demonstrates that recruitment within these age groups was concentrated within a limited number of tumour streams. Brain and several haematological tumour streams showed representation across paediatric, adolescent and young adult age groups, whereas many tumour streams, including Lung, Genito-Urinary and Gastrointestinal trials, were predominantly represented by older adult participants. This highlights the differing age profiles of tumour streams and the concentration of younger participant recruitment within a relatively small subset of the clinical trial portfolio.

# Sex Representation

**Figure 16:** Number of participants by sex

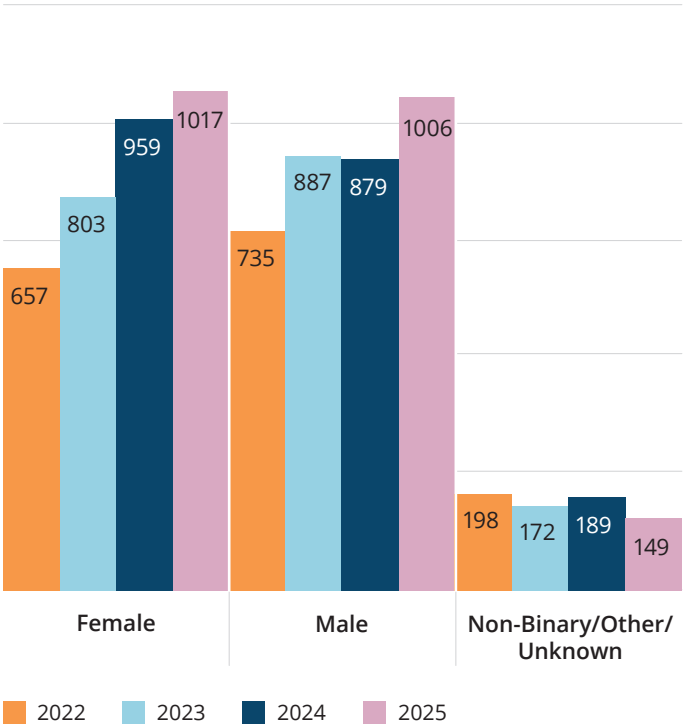
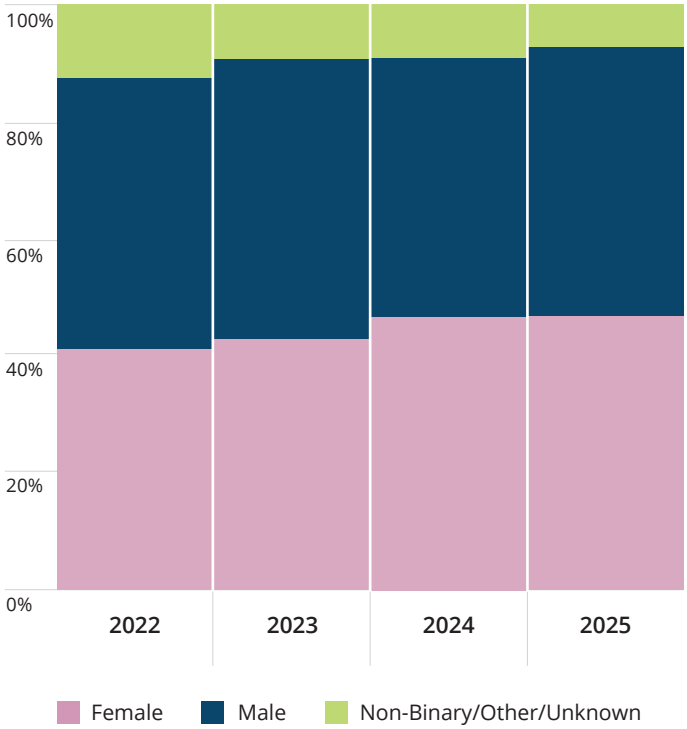



**Figure 17:** Proportion of participants by sex




Figures 16 and 17 demonstrate continued growth in recruitment of both female and male clinical trial participants across the reporting period. Female participant recruitment increased from 657 participants in 2022 to 1,017 participants in 2025, representing an increase of 55%, while male participant recruitment increased 37% from 735 to 1,006 participants over the same period.

The proportion of female participants increased from 41% of all participants in 2022 to 47% in 2025. When considering participants with known sex only, female participants represented approximately half of all recruitment in both 2024 and 2025, accounting for 52% of participants with known sex in 2024 and 50% in 2025.

The number of participants recorded as Non-Binary/Other/Unknown decreased from 198 in 2022 to 149 in 2025, reducing from 13% to 7% of total participant recruitment. This likely reflects improved completeness of sex reporting among participating sites.

Please note that fewer than five participants per year were recorded as Non-Binary. These participants have been grouped within the category Non-Binary/Other/Unknown. Some Census sites were also unable to provide participant sex information due to data privacy restrictions, and these participants have been included within the same category.

# First Nations Participation

**Figure 18:** Number of First Nations participants

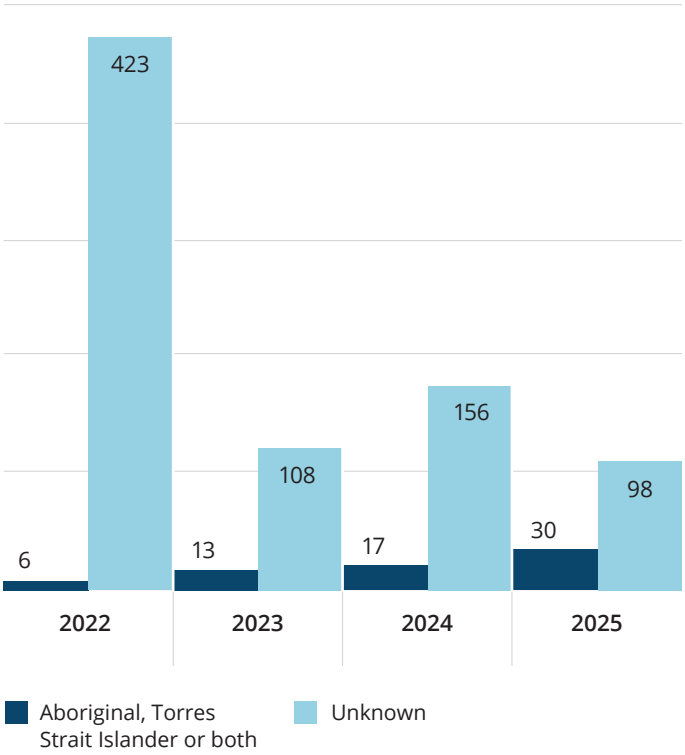
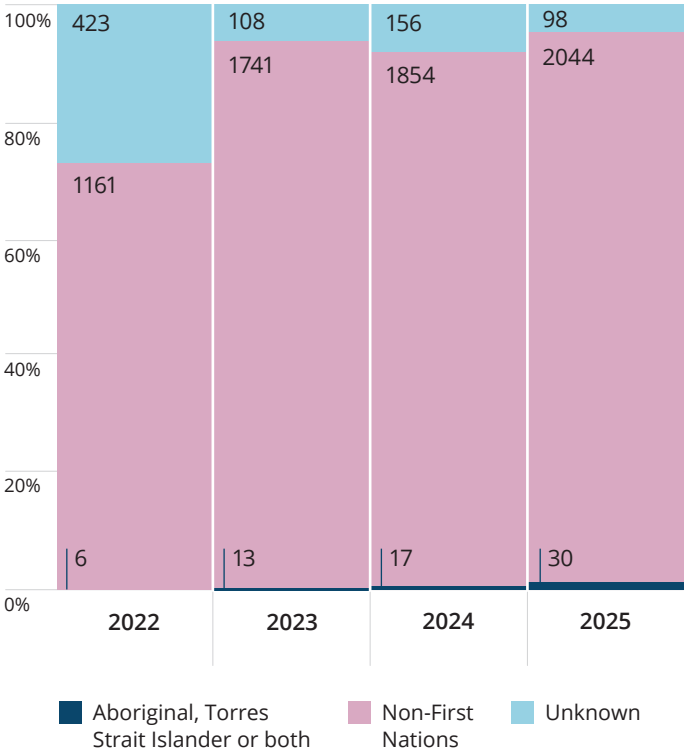



**Figure 19:** Proportion of First Nations participants




Aboriginal and Torres Strait Islander peoples continue to experience disproportionately poorer cancer outcomes compared with non-Indigenous Australians.[7] At present, cancer is the leading cause of death among Aboriginal and Torres Strait Islander peoples, accounting for 23.4% of all losses.[8] Improving equity in cancer outcomes for First Nations peoples remains a central priority within the Australian Cancer Plan.[9]

Our data indicates continued improvement in recording of First Nations participants to cancer clinical trials across Victoria (Figures 18 and 19). The number of participants identifying as Aboriginal, Torres Strait Islander, or both increased from 6 participants in 2022 to 30 participants in 2025. Over the same period, the number of participants with unknown First Nations status decreased substantially from 423 to 98. As a proportion of all participants, the unknown category decreased from 27% in 2022 to 5% in 2025, indicating a substantial improvement in the collection of First Nations identification data across participating sites.

Over the same period, the number of participants with unknown First Nations status decreased substantially from 423 to 98. As a proportion of all participants, the unknown category decreased from 27% in 2022 to 5% in 2025, indicating a substantial improvement in the collection of First Nations identification data across participating sites.

Together, these findings demonstrate meaningful improvement in the visibility of First Nations participation within the Victorian cancer clinical trial sector.

CTA supports continued initiatives aimed at improving equity of access to cancer clinical trials and improving cancer outcomes for First Nations peoples.

# Cultural Diversity

**Figure 20:** Number of participants by language spoken at home

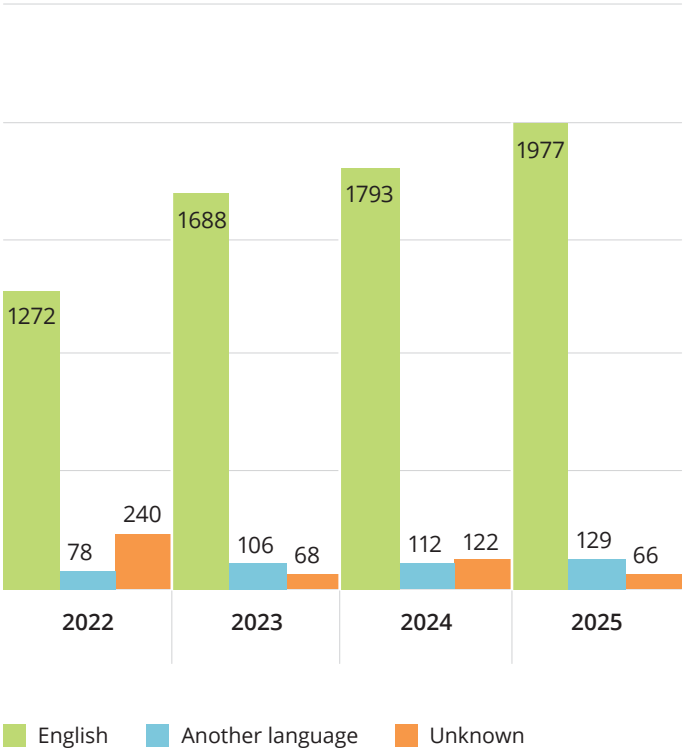
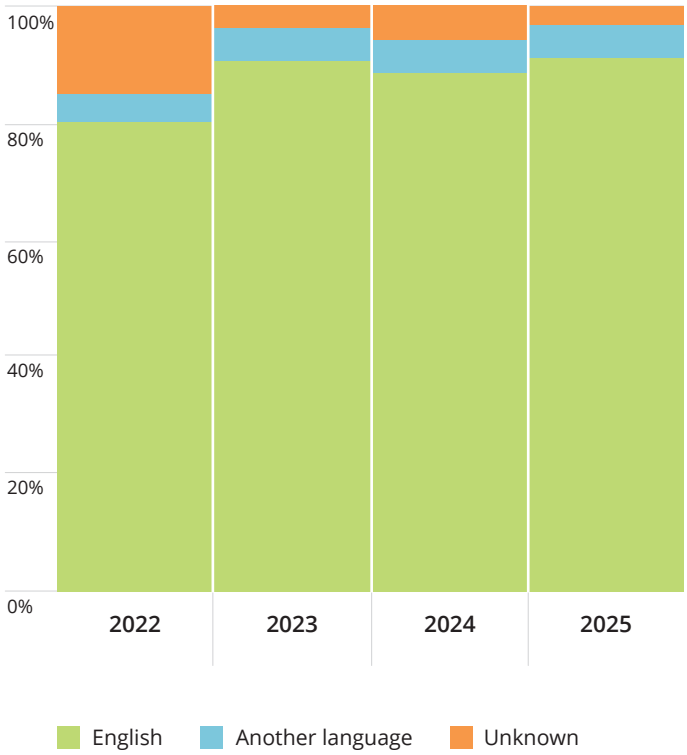



**Figure 21:** Proportion of participants by language spoken at home




Australia's population is diverse; in 2021, 28% of Australia's resident population were born overseas and 22% of people living in Australia who were Australian born have one or both parents born overseas.[10,11] However, national health data on populations of people from diverse backgrounds is sparse.[12] The data that is available indicates that people from diverse backgrounds experience greater adversity in accessing culturally responsive care and information due to communication barriers, poorer health literacy, and cultural variations.[13,14,15,16]

One indicator of cultural diversity collected through Clinibase is language spoken at home, which provides insight into participation among people who speak a language other than English at home.

The number of participants who reported speaking a language other than English at home increased from 78 participants in 2022 to 129 participants in 2025 (Figure 20). Over the same period, the number of participants with unknown language information decreased substantially from 240 to 66, reflecting improved completeness of data collection across participating sites.

Taken together, Figures 20 and 21 demonstrate the value of considering both count and proportion perspectives. While the number of participants speaking a language other than English at home increased across the reporting period, their representation within the overall participant cohort remained broadly consistent at approximately 6%, once improvements in data completeness are taken into consideration.

Improving culturally responsible clinical trial participation remains an important area of focus for Victorian clinical trial sites.

# Trial Sponsorship

**Figure 22:** Proportion of recruitment to commercially sponsored versus non-commercially sponsored cancer clinical trials

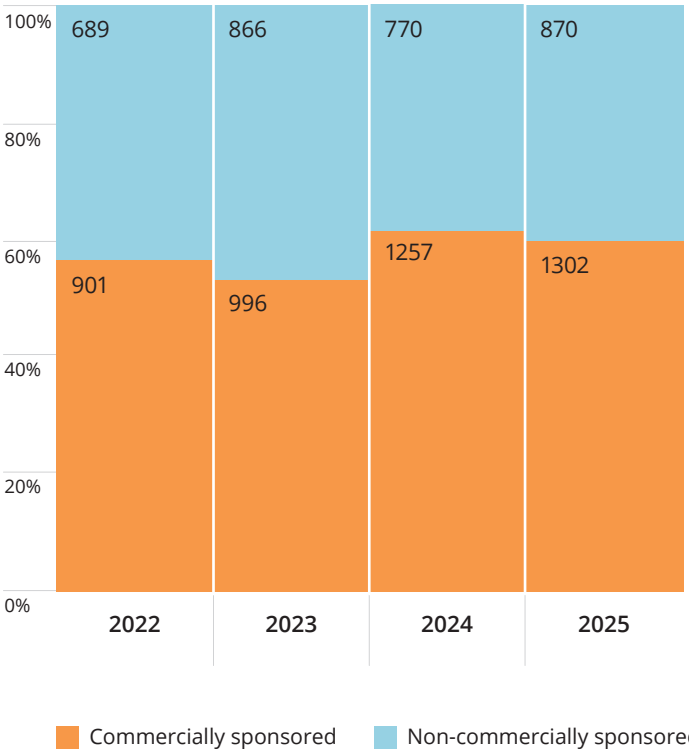
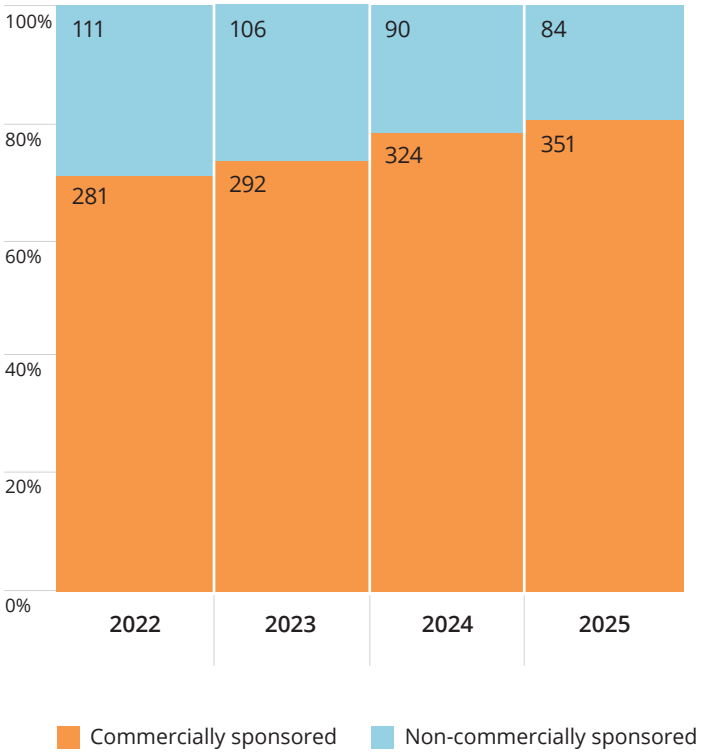



**Figure 23:** Proportion of unique recruiting commercially sponsored versus non-commercially sponsored cancer clinical trials




Analysis of trial sponsorship demonstrates that commercially sponsored trials continue to represent the majority of both participant recruitment and recruiting trial activity within the Victorian cancer clinical trial portfolio (Figures 22 and 23).

In 2025, 60% of participants were recruited to commercially sponsored trials, compared with 40% recruited to non-commercially sponsored trials. Across the reporting period, recruitment to commercially sponsored trials increased 45% from 901 participants in 2022 to 1,302 participants in 2025.

The number of unique recruiting commercially sponsored trials also increased 25% from 281 to 351 over the same period, while the number of unique recruiting non-commercially sponsored trials declined 24% from 111 to 84.

Despite representing fewer recruiting trials, non-commercially sponsored studies continued to recruit more participants per trial on average than commercially sponsored studies. In 2025, non-commercially sponsored trials recruited an average of 10.4 participants per recruiting trial, compared with 3.7 participants per recruiting commercially sponsored trial.

These findings highlight the differing contribution of commercially and non-commercially sponsored studies within the Victorian cancer clinical trial portfolio, with commercially sponsored studies accounting for the majority of recruiting activity and non-commercially sponsored studies continuing to contribute substantial participant recruitment relative to the number of recruiting trials.

# Trial Sponsorship and Site Location

**Figure 24:** Recruitment at metropolitan and regional sites for commercially sponsored and non-commercially sponsored trials

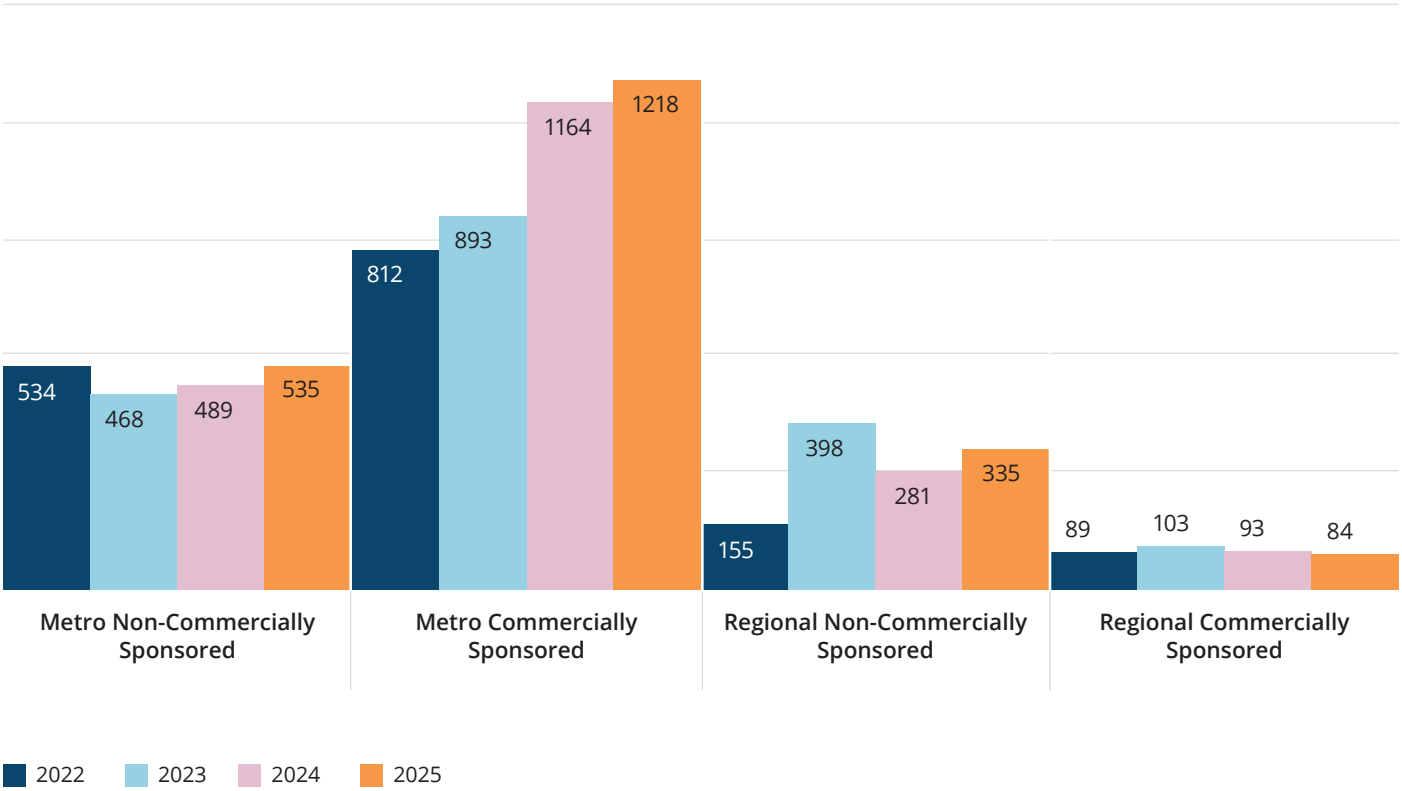



Figure 24 highlights the continuing difference between metropolitan and regional recruitment patterns when trial sponsorship type is considered. There is already an understanding across our sector that regional sites are under-represented in recruitment to commercially sponsored clinical trials. We acknowledge and applaud the significant and continuing efforts of many colleagues across our sector in tackling this ongoing and important issue.

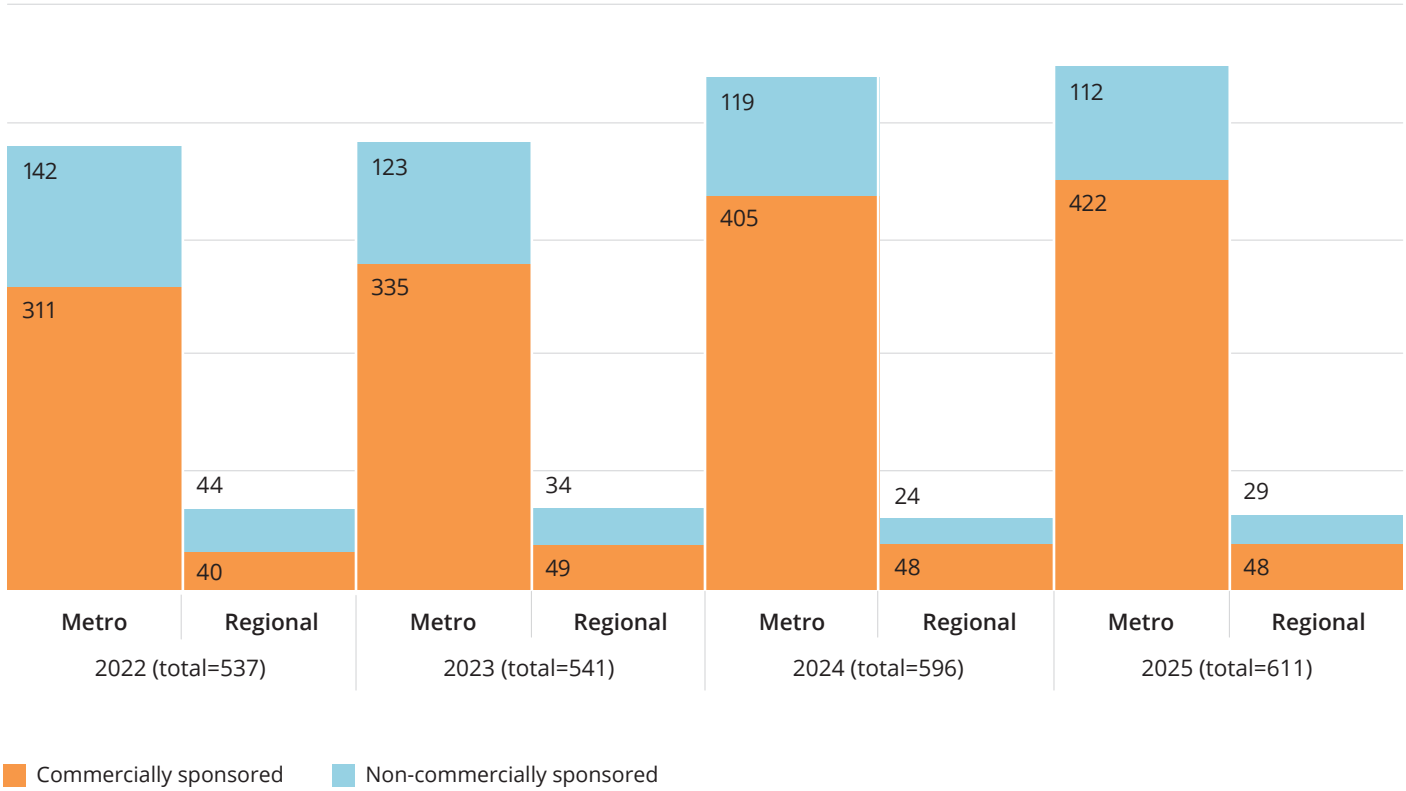
Across the reporting period, 4-6% of all Victorian participants were recruited to commercially sponsored trials at regional sites, compared with 48-57% recruited to commercially sponsored trials at metropolitan sites.

The majority of participant recruitment occurring at regional sites continued to be associated with non-commercially sponsored trials. In 2025, approximately 79% of recruitment occurring at regional sites was to non-commercially sponsored studies, compared with 74% in 2024 and 63% in 2022.

In contrast, metropolitan recruitment was predominantly associated with commercially sponsored studies throughout the reporting period. Commercially sponsored trials accounted for approximately 61% of metropolitan recruitment in 2022, increasing to approximately 69% in 2025.

These findings indicate that non-commercially sponsored trials continue to play a critical role in supporting cancer clinical trial access at regional Victorian sites, while commercially sponsored recruitment activity remains concentrated within metropolitan trial centres. Non-commercially sponsored trials are important trials; they are relatively easier to be selected for as a participating site, can be simpler to initiate, often provide drug access that would otherwise not be available to a patient, extend sector knowledge and provide valuable evidence for timing pre-and post-surgery, dose pacing and combination regimes, and are important for sites increasing their overall trial portfolio. However, such trials rarely cover their costs within trial units, placing a significant financial burden on trial units to support non-commercially sponsored activity.

## **Figure 25:** Number of non-unique trials that recruited participants by year, sponsorship type and site location




## A function of trial availability

To better understand the recruitment patterns shown in Figure 24, Figure 25 further examines the sponsorship profile of recruiting trials available at metropolitan and regional sites.

As this analysis seeks to represent trial availability at individual sites, multi-site trials recruiting participants at both metropolitan and regional locations are counted separately and therefore these data are not reported as unique trials.

Commercially sponsored trials continued to comprise an increasing majority of the metropolitan recruiting portfolio, moving from 69% in 2022 to 79% in 2025. A similar trend was observed in regional settings, where commercially sponsored trials increased from 48% of the recruiting portfolio in 2022 to 62% in 2025.

This represents a continued increase in the availability of commercially sponsored trials at regional sites compared with earlier reporting years. However, despite commercially sponsored studies comprising the majority of the regional recruiting portfolio in 2025, participant recruitment at regional sites remained predominantly associated with non-commercially sponsored trials (Figure 24).

Figures 24 and 25, taken together, indicate that while commercial trial availability at regional sites has increased substantially, participant recruitment remains predominantly associated with non-commercial studies.

These findings suggest that increased commercial trial availability at regional sites has not yet translated into proportional participant recruitment within those studies; though these studies may contribute to further regional commercially sponsored trial recruitment in 2026. Continued growth in commercially sponsored trial activity may support the long-term sustainability of regional trial programs, while also creating opportunities for future growth in regional participant recruitment.

# Rural/Regional Travellers

**Figure 26:** Number of participants with an MMM2-7 residential address recruited at a metropolitan site

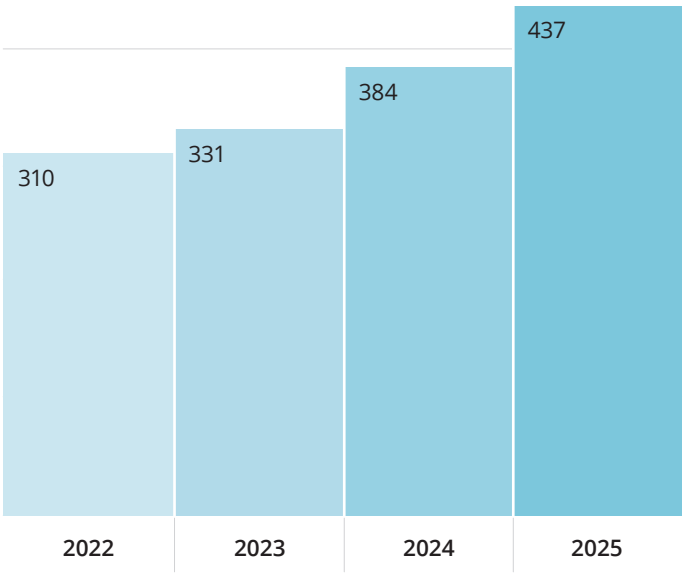



**Figure 27:** Number of participants with an MMM2-7 residential address recruited at a metropolitan or regional site by sponsorship type

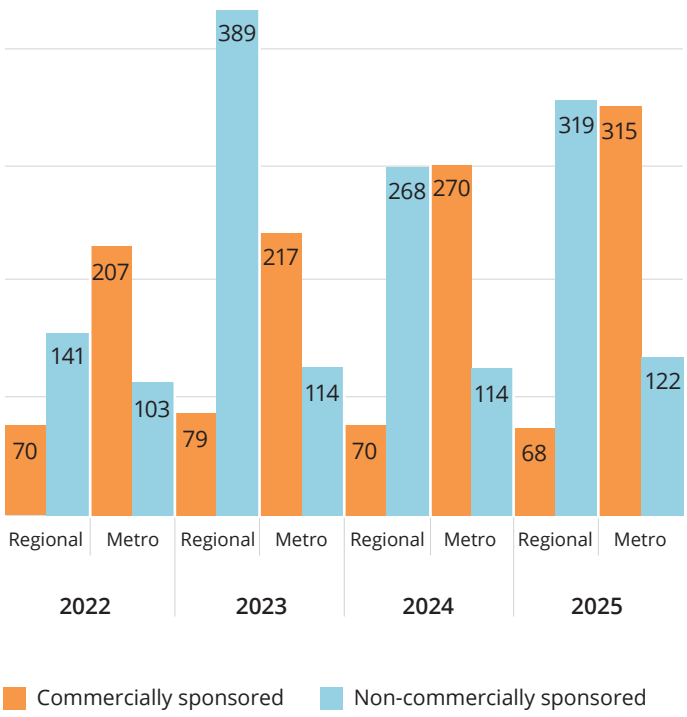



Figure 10 demonstrated that a significant proportion of Victorian cancer clinical trial participants resided in regional and rural locations (MMM2-7). Figure 26 extends this analysis by examining where these participants were recruited to a clinical trial.

As noted in Figure 2, trial accessibility is largely site-specific, with the majority of trials opening at a single site across our state. Coupled with rigorous inclusion and exclusion criteria, this often necessitates travel for participants from rural and regional residential postcodes to access particular trial opportunities.

Across the reporting period, a substantial number of regional and rural participants were recruited to clinical trials at metropolitan sites. Figure 26 shows the number increased from 310 participants in 2022 to 437 participants in 2025, the highest level observed during the reporting period. In 2025, 437 of 824 regional and rural participants (53%) were recruited at metropolitan centres.

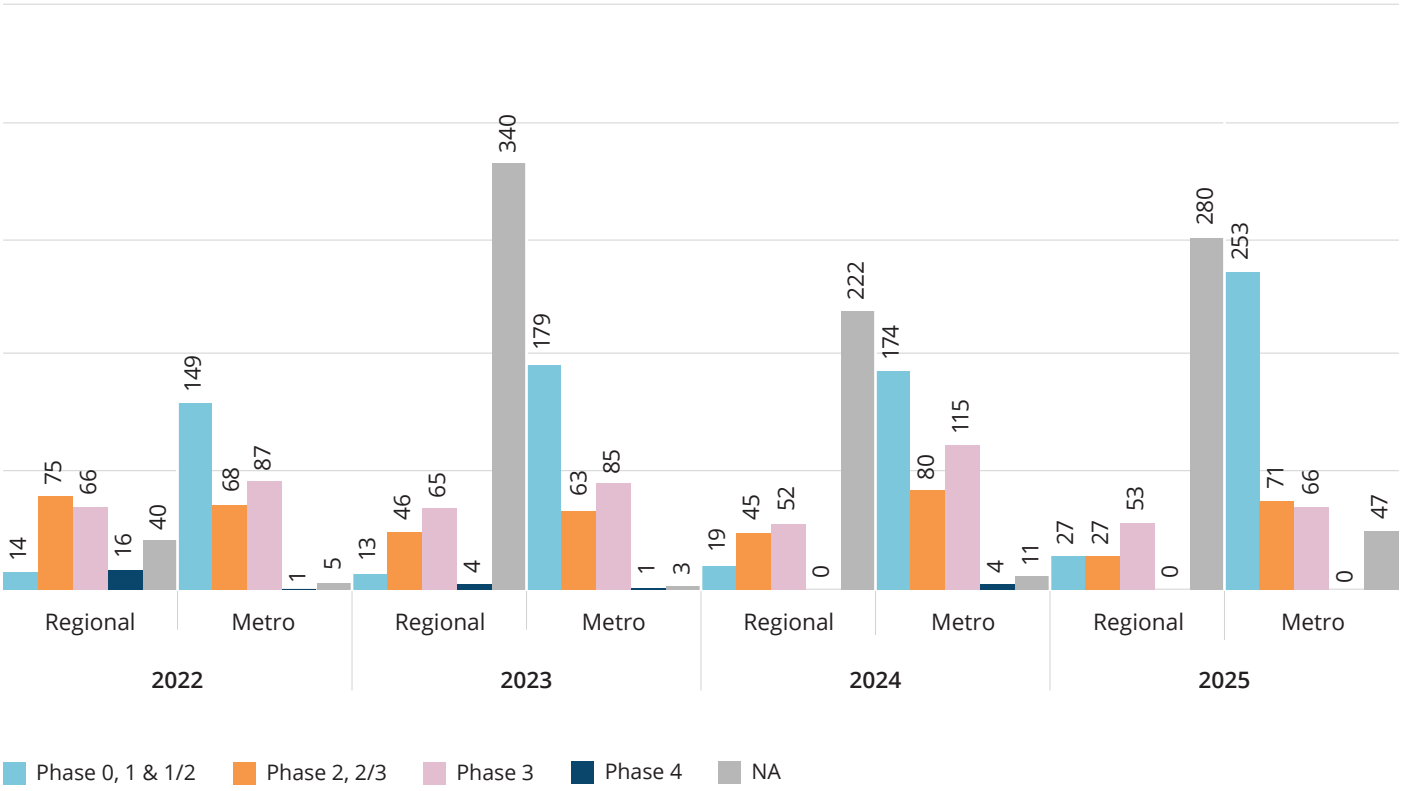
## More likely to travel to access commercially sponsored clinical trials

Figure 27 extends the analysis presented in Figures 10 and 26 by examining the sponsorship profile of clinical trials accessed by participants residing in MMM2-7 locations.

In 2025, 319 of 387 MMM2-7 participants (82%) recruited at regional sites were enrolled in non-commercially sponsored trials. In contrast, 315 of 437 MMM2-7 participants (72%) recruited at metropolitan sites were enrolled in commercially sponsored trials.

These findings are consistent with the broader patterns observed in Figures 24 and 25 and suggest that while non-commercially sponsored studies continue to play a critical role in supporting regional trial access, commercially sponsored trial participation for both metropolitan and regional participants remains concentrated within metropolitan centres.

**Figure 28:** Number of participants with an MMM2-7 residential address recruited at a metropolitan or regional site by phase




## More likely to travel to access Early Phase trials

Figure 28 further analyses recruitment of rural and regional participants at metropolitan sites in terms of trial phase.

In every year within the reporting period, the predominant feature of regional and rural travel is to access Early Phase trials. In 2025, 253 regional and rural participants were recruited to Early Phase trials at metropolitan sites compared with 27 participants recruited to Early Phase trials at regional sites.

Figure 28 extends the analysis presented in Figures 26 and 27 by examining the phase profile of clinical trials accessed by participants residing in MMM2-7 locations.

Among regional and rural participants recruited at metropolitan sites, Early Phase studies (Phase 0, 1 and 1/2) represented the largest trial category in every year analysed. In 2025, 253 of 437 regional and rural participants recruited at metropolitan sites (58%) were enrolled in an Early Phase trial.

Taken together, Figures 26, 27 and 28 suggest that many regional and rural participants who are recruited at metropolitan sites are accessing trial opportunities that are less commonly available within regional settings, particularly commercially sponsored and Early Phase studies

# Source of Commercially Sponsored Clinical Trials – Size of Sponsor

**Figure 29:** Proportion of unique recruiting commercially sponsored trials that were sponsored by large pharmaceutical companies

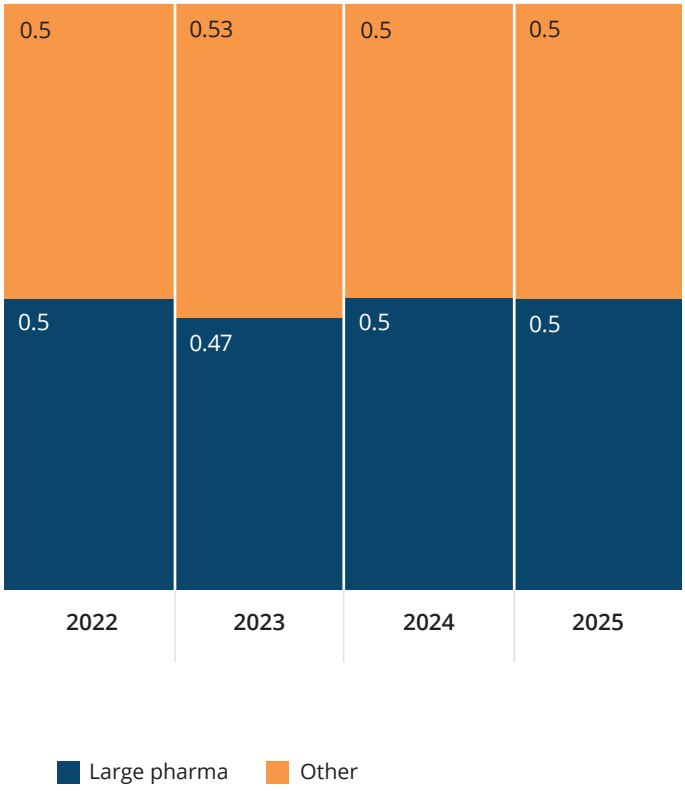
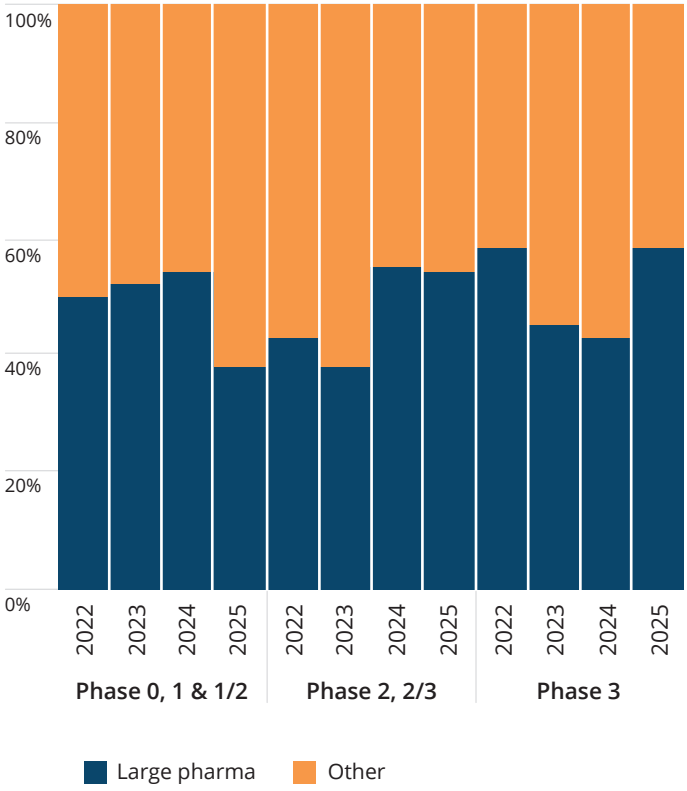



**Figure 30:** Proportion of unique recruiting commercially sponsored trials that were sponsored by large pharmaceutical companies by phase



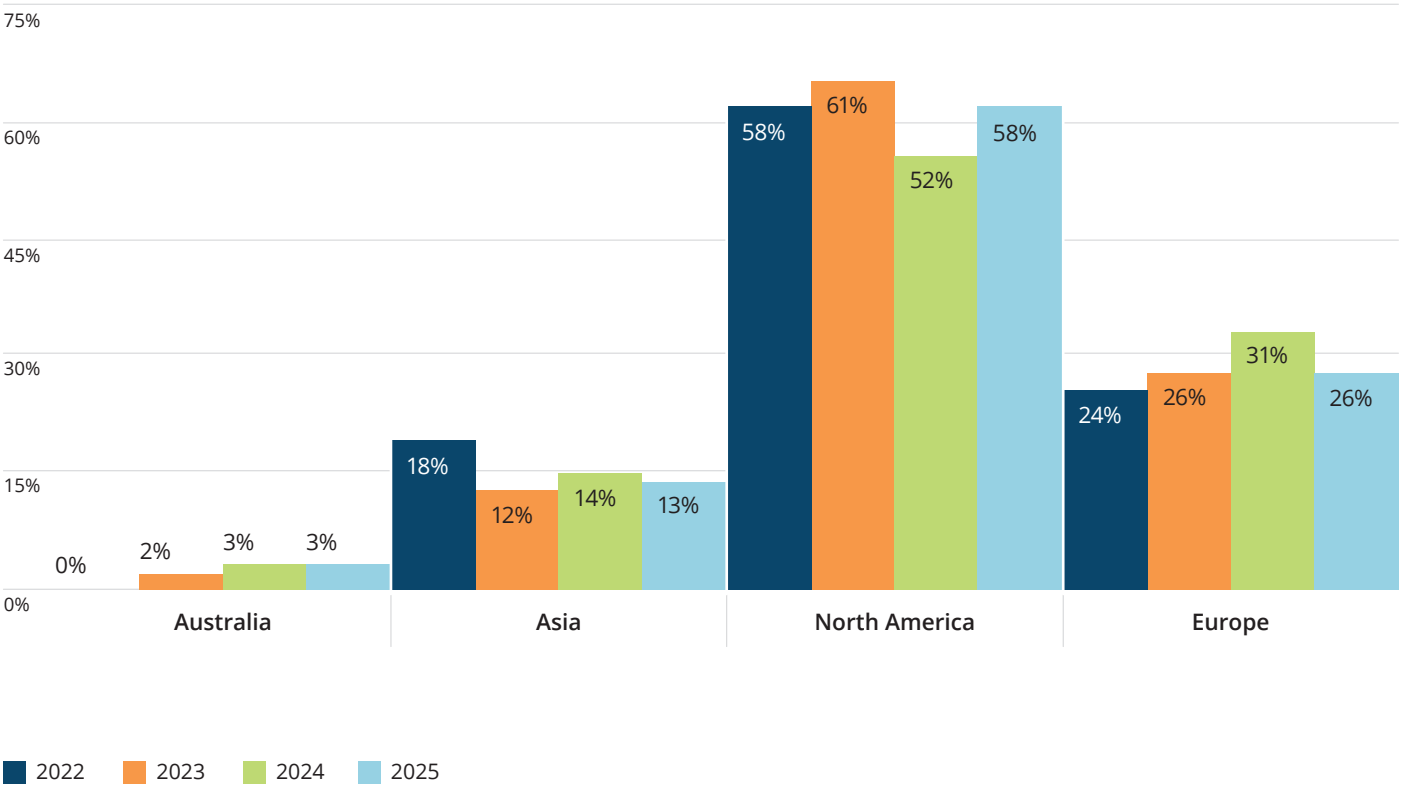

Globally, from 2014 to 2023, the proportion of commercially sponsored clinical trials initiated by large pharmaceutical companies across all tumour streams has decreased from 50% to 27%.[17] Large pharmaceutical companies were defined as those companies with greater than $10bn in annual sales.

Sponsorship of commercially sponsored cancer clinical trials by large pharmaceutical companies remained remarkably stable across the reporting period, accounting for approximately half of all commercially sponsored trials in every year analysed (Figure 29). Large pharmaceutical companies represented 50% of commercially sponsored trials in 2022, 47% in 2023, and 50% in both 2024 and 2025.

While large pharmaceutical companies continued to be active across Early Phase, Phase 2 and Phase 3 studies throughout the reporting period (Figure 30), Early Phase studies (Phase 0, 1 and 1/2) showed a notable increase in sponsorship by smaller organisations in 2025, rising from 46% in 2024 to 62%. This follows a globally recognised trend of emerging biotech companies increasingly leading early clinical development endeavours.

# Source of Commercially Sponsored Clinical Trials – Sponsor Region

**Figure 31:** Proportion of unique recruiting commercial trials by sponsor location




For the second consecutive reporting period, CTA is able to report the geographic distribution of commercial trial sponsorship across the Victorian cancer clinical trial portfolio (Figure 31).

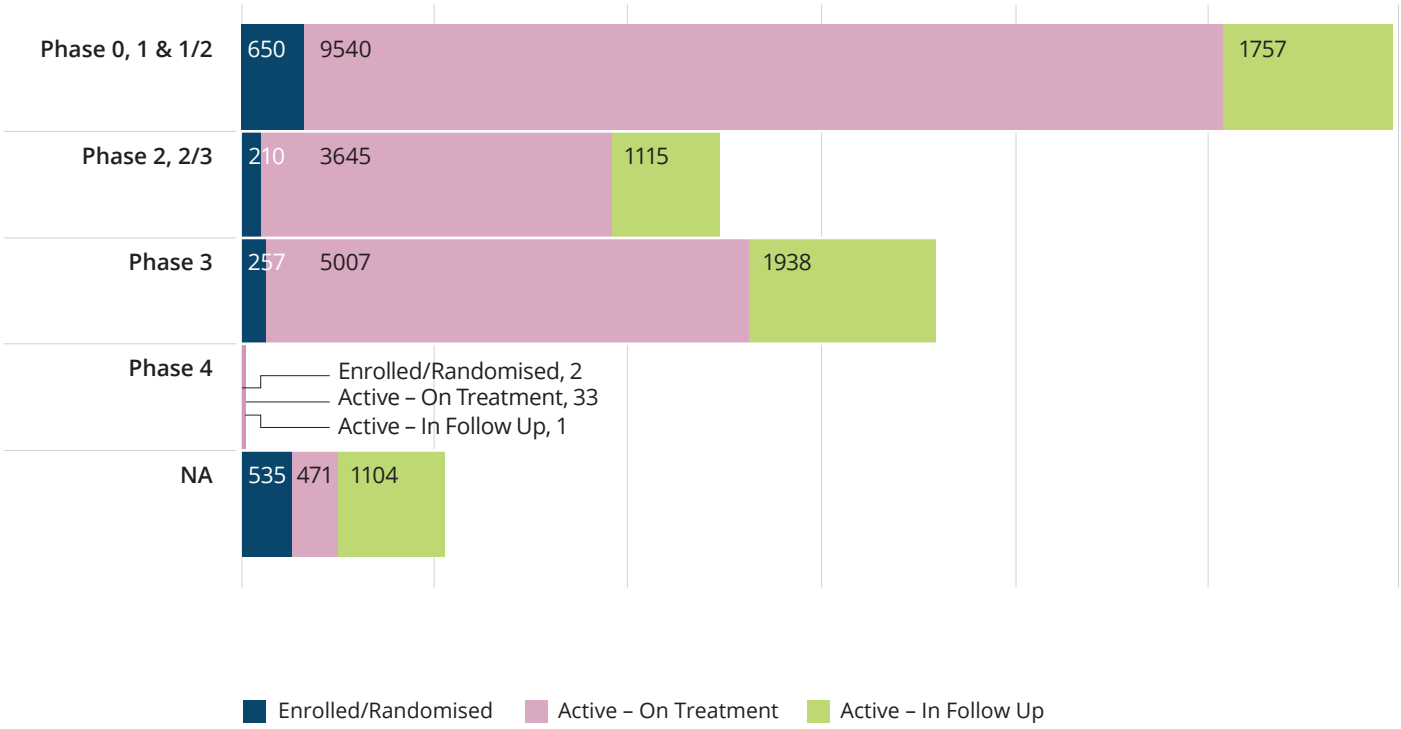
North America remained the dominant source of commercial trial sponsorship throughout the reporting period, accounting for between 52% and 61% of commercially sponsored trials in each year analysed. European sponsors represented between 24% and 31% of commercially sponsored trials, while Asian sponsors accounted for between 12% and 18%.

The increase in European sponsorship observed between 2022 and 2024 was not maintained in 2025, where European sponsors reduced to 26% of commercially sponsored trials. Nevertheless, European sponsorship remained above 2022 levels.

Overall, the geographic composition of commercial trial sponsorship remained broadly stable, with North American sponsors continuing to account for the majority of commercially sponsored cancer clinical trials undertaken in Victoria.

# More Than Recruitment

**Figure 32:** Number of participant visits across 2025 by visit type^




Traditionally, cancer clinical trial activity has been measured primarily through participant recruitment. However, recruitment represents only one component of the workload undertaken by clinical trial units. For sites using Clinibase within their standard workflow for study management, CTA is able to report participant visit activity in addition to participant recruitment (Figure 32).

## Enrolment is just the tip of the iceberg

Figures 1 and 8 demonstrated sustained growth in recruitment activity. Figure 32 extends this analysis by illustrating the ongoing workload associated with participant management after recruitment has taken place.

Across the available 2025 dataset, 26,265 participant visits were recorded, including 18,696 active on-treatment visits and 5,915 active follow-up visits. In contrast, enrolled or randomised participant visits represented only 1,654 records or 6%, highlighting that recruitment activity represents a relatively small proportion of the overall workload associated with delivering clinical trials effectively.

Early Phase studies accounted for 11,947 visits, representing approximately 46% of all recorded participant visits in 2025. Phase 3 studies generated 7,202 visits, while Phase 2 studies generated 4,970 visits. These findings reinforce the importance of considering participant management activity alongside recruitment when assessing the workload of Victorian clinical trial units, however, while visit count is a useful proxy for ongoing management burden, it does not measure staff hours, monitoring effort, pharmacy workload, protocol amendments, adverse event management, or other important components of trial operations.

^These Figures contain data from 16 of the 20 clinical sites that provided data to support this Census, as those 16 sites utilise Clinibase in the day-to-day management of their clinical trial portfolio.

## Not all visits are equal

The complexity of participant management can also vary substantially between trial phases and protocols; a single Phase 1 "On Treatment" visit can represent significantly more study coordinator and clinician hours, participant face-to-face time and workload around clinical management, compared to a Phase 3 "On Treatment" visit.

When participant visit activity is examined by phase, Early Phase studies accounted for almost half of all recorded visits within the available dataset. However, Phase 3 studies generated the highest number of visits per enrolled participant, averaging approximately 28 visits per enrolment compared with 18 visits per enrolment in Early Phase studies.

This suggests that while Early Phase studies contribute substantially to overall participant activity, later-phase studies may continue to generate considerable ongoing participant-management requirements over the life of a trial and is broadly consistent with the propensity of Phase 3 protocols to involve larger participant numbers, longer treatment periods, extended follow-up requirements and more longitudinal outcome collection.

## The hidden workload of participant screening

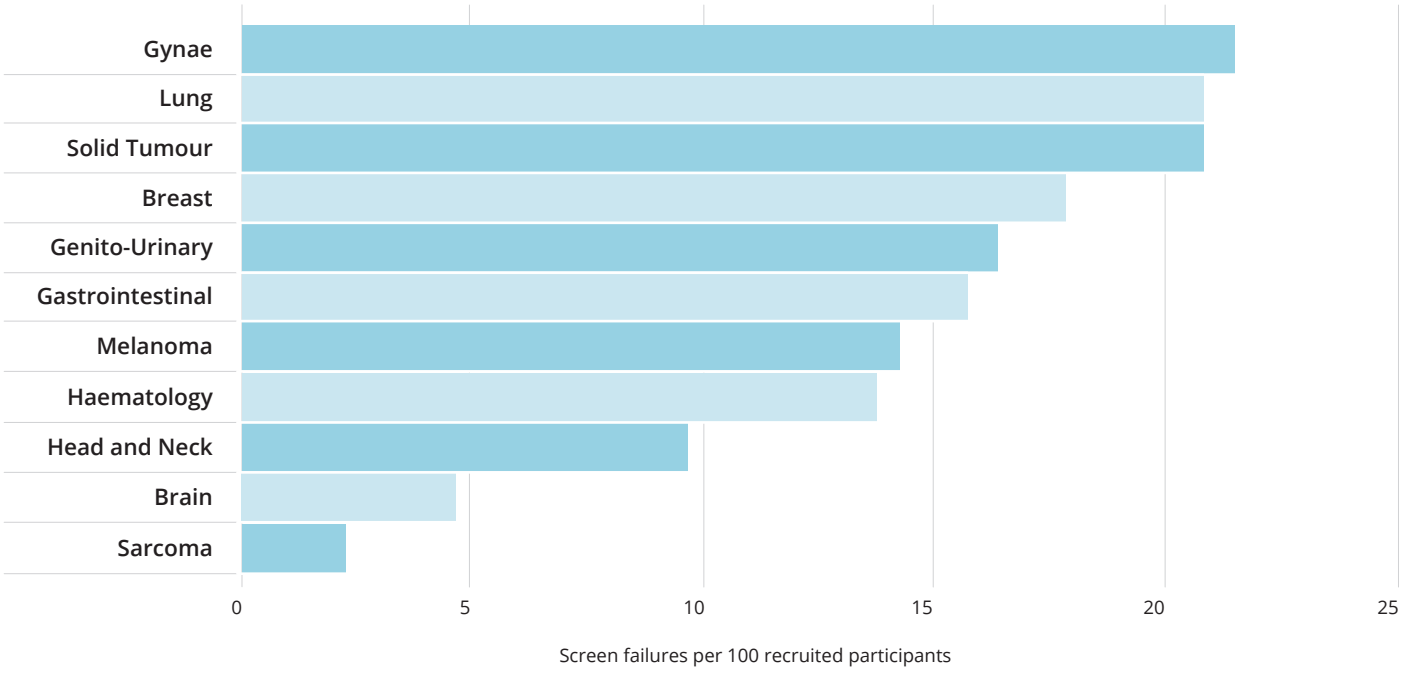
The participant visit data presented in Figure 32 provide insight into workload following recruitment; however, they do not capture the work associated with identifying and assessing potential participants prior to enrolment. Clinical trial screening requires substantial effort from clinicians, research nurses and study coordinators, including review of medical records against eligibility criteria, pathology and imaging assessments, informed consent processes and coordination of protocol-specific investigations including molecular testing. Although these individuals do not appear within recruitment statistics, they nonetheless represent a substantial component of clinical trial workload.

Data available from sites using Clinibase as part of their standard study management workflow allows analysis of screen failure data and indicates that 760 potential participants were screened for trial eligibility but ultimately did not proceed to enrolment. This occurred in addition to 4,532 participants who were successfully recruited, representing an average of approximately 17 screen failures for every 100 participants enrolled.

These findings reinforce that participant recruitment alone captures only a portion of the effort required to deliver cancer clinical trials and under-represents the true workload of clinical trial units, as considerable effort is also invested in identifying and assessing participants who ultimately do not enter a clinical trial.  A more complete understanding of sector workload should consider activities occurring before recruitment, during active treatment and throughout participant follow-up.

# More Than Recruitment (continued)

**Figure 33:** Screen failures per 100 recruited participants by therapeutic area




Screen fail burden was not distributed evenly across the portfolio. It is concentrated within particular trial designs and therapeutic areas. Gynaecological, Lung and Solid Tumour studies recorded the highest screening workload relative to recruitment, each generating approximately 21 screen failures per 100 recruited participants (Figure 33). In contrast, Brain and Sarcoma studies recorded fewer than five screen failures per 100 recruited participants.

Solid Tumour studies demonstrated one of the highest screening burdens within the Clinibase cohort, recording approximately 21 screen failures per 100 recruited participants. While the Census dataset does not capture the reasons for individual screening failures, this finding may partly reflect the increasing use of umbrella trial designs within the Solid Tumour portfolio. Such studies frequently contain multiple disease-specific cohorts and complex eligibility criteria, potentially increasing the number of participants who undergo screening but do not ultimately meet enrolment requirements. In addition, many Solid Tumour studies are Early Phase investigations, which often involve more restrictive eligibility criteria than later-phase studies. Further analysis would be required to determine the relative contribution of these factors.

The screen-fail analysis reinforces a broader theme emerging throughout the Census: participant recruitment represents only one component of clinical trial activity. Considerable effort is invested before a participant is enrolled, and this work is largely invisible within traditional recruitment metrics. Recruitment counts alone are a poor proxy for the effort required to operate some studies and under-represent the true workload of clinical trial units. As oncology trials become increasingly targeted and eligibility criteria become more complex, screening activity may represent a growing component of the overall workload associated with delivering cancer clinical trials. A more complete understanding of sector workload should consider activities occurring before recruitment, during active treatment and throughout participant follow-up.

CTA intends to continue exploring this area in future Census reporting to develop a more comprehensive understanding of clinical trial workload across the sector.

# Clinical Trial Recruitment and Cancer Incidence

**Figure 34:** Age-specific incidence rates for all cancers by sex in Victoria (2024)#

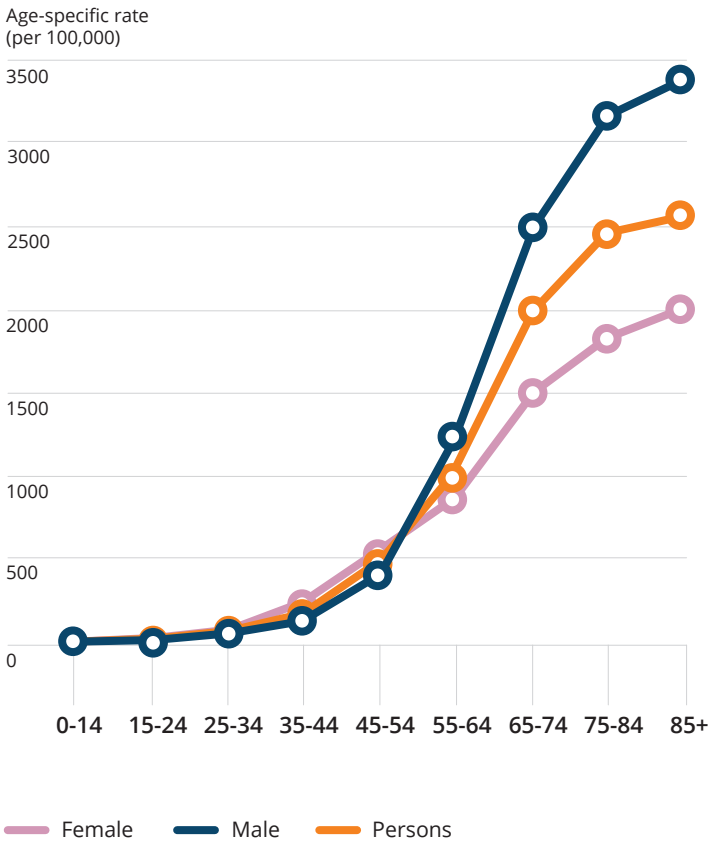
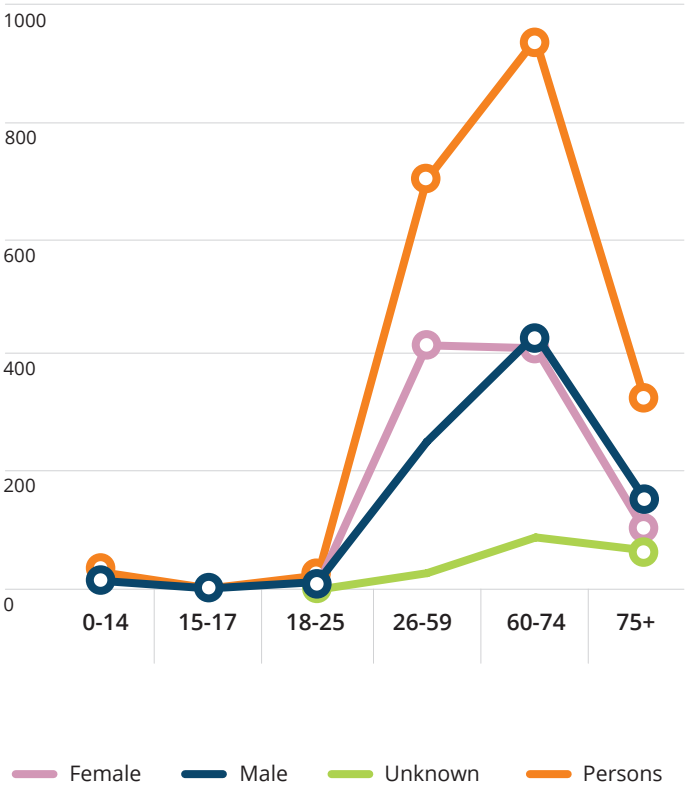



**Figure 35:** Recruitment by Age and Sex in 2024




The recent publication of the Cancer In Victoria 2024 Report by the Victorian Cancer Registry[18] allows for comparison between cancer incidence and clinical trial recruitment. There are some limitations to this comparison; cancer incidence data describe the year/age at which cancer is diagnosed, whereas clinical trial recruitment data describe the year/age at which a participant entered a clinical trial. These events do not necessarily occur at the same time. Many clinical trials are accessed after one or more standard therapies have been attempted, and some trial protocols require participants to have experienced disease progression post standard treatment. In addition, not all patients diagnosed with cancer are eligible for a clinical trial, some patients may be excluded from participation because of comorbidities or declining health status, and some eligible patients choose not to participate.

Further limitations apply when interpreting these data together. Clinibase does not currently capture all Victorian cancer services, and recruitment is recorded at the participant level rather than the cancer diagnosis level.

Moreover, the dataset does not distinguish between primary and secondary cancers. In addition, the Solid Tumour category includes umbrella studies containing multiple disease-specific cohorts, preventing direct comparison between some tumour-stream recruitment and cancer incidence data.

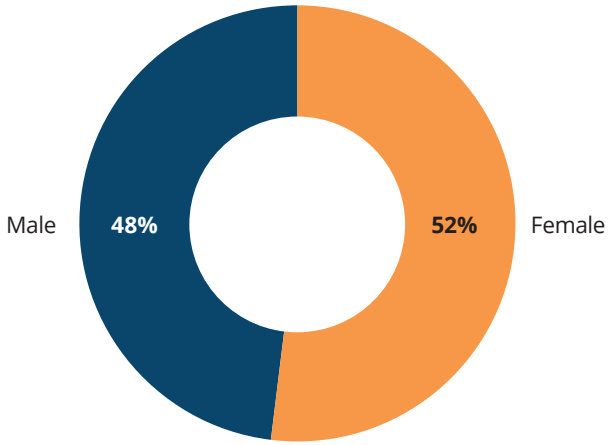
Notwithstanding these limitations, comparison of the two datasets provides useful context.

Figure 34 presents age-specific cancer incidence rates in Victoria (Cancer In Victoria 202418) while Figure 35 presents the age profile of participants recruited to cancer clinical trials during the same period.

This comparison shows that cancer incidence increases substantially with age and is highest among older Victorians, particularly those aged 75 years and over (Figure 34). In contrast, our data shows clinical trial recruitment is most concentrated within the 60-74 year age group, with lower recruitment observed among participants aged 75 years and over (Figure 35).

#Data recreated from The Cancer in Victoria 2024 report (Cancer Council Victoria 2025).

**Figure 36:** Sex of Participants recruited in 2024 (where sex is known)




On average, **109** Victorians are diagnosed with cancer every day.

There were 39,641 Victorians diagnosed with cancer in 2024, of whom 21,713 (55%) were males and 17,926 (45%) were females.[18]

These findings suggest that the age profile of clinical trial participation differs from the age profile of cancer incidence. However, the available data do not allow conclusions to be drawn regarding the reasons for this difference.

A similar pattern is observed when comparing sex distributions. Victorian cancer incidence data for 2024 indicate that males were slightly more likely to be diagnosed with cancer, with 55% male and 45% female. In contrast, females represented 52% of clinical trial participants with known sex in the Census dataset, while males represented 48% (Figure 36).

As with the age comparison, these differences should be interpreted cautiously. Cancer incidence reflects the population diagnosed with cancer during a given year, whereas clinical trial participation reflects a subset of patients who were eligible for, offered and consented to participate in a clinical trial. The available data do not permit conclusions regarding the reasons for the observed differences.

# Cancer Types – Incidence, Mortality and Recruitment

**Figure 37:** Cancer incidence for the 10 most commonly diagnosed cancers for Males and Females in Victoria (2024)#

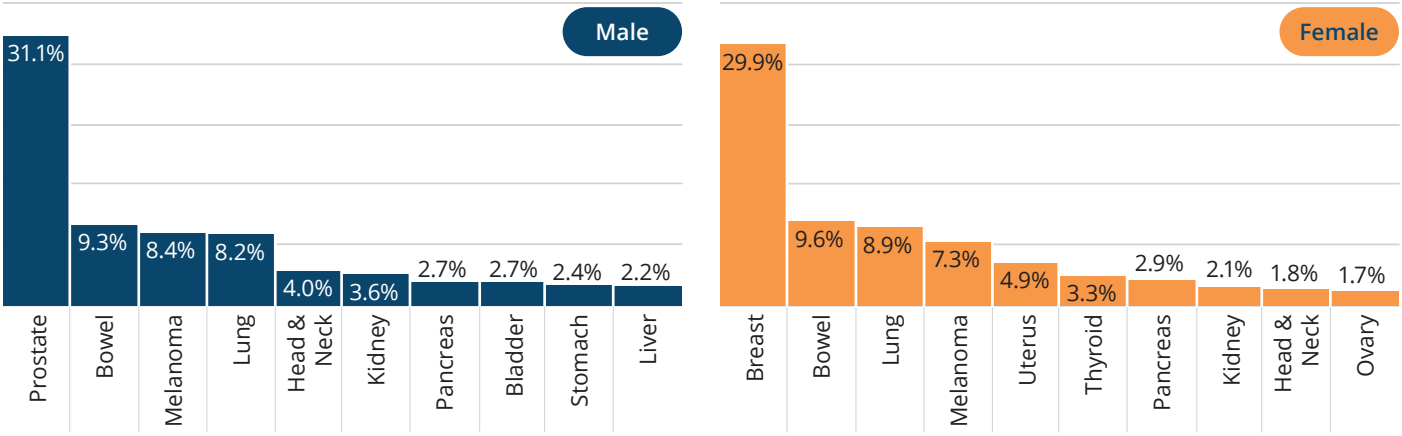



**Figure 38**: Cancer deaths for leading cancer types for Males and Females in Victoria (2024)#

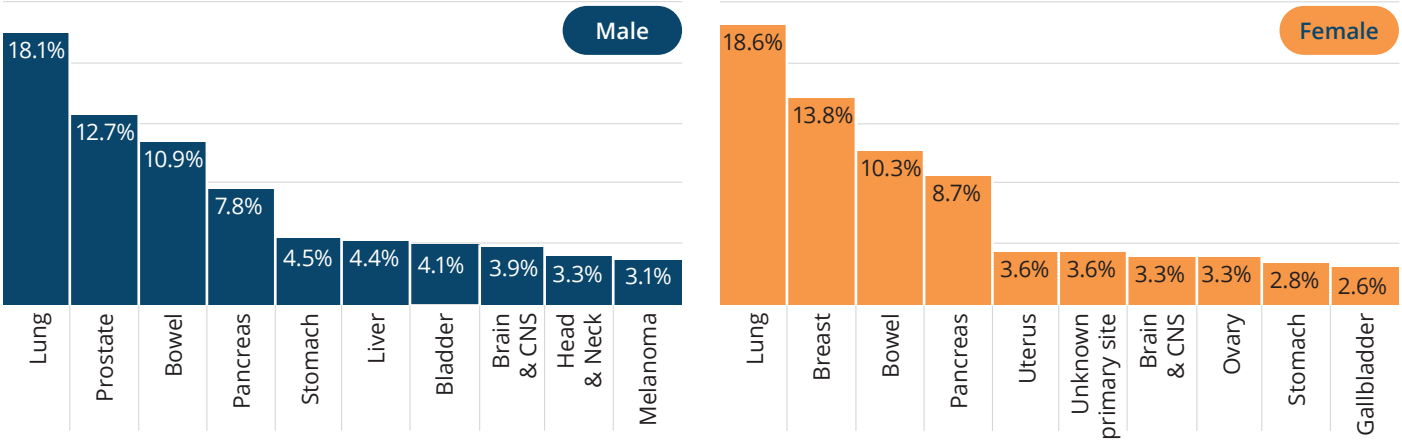
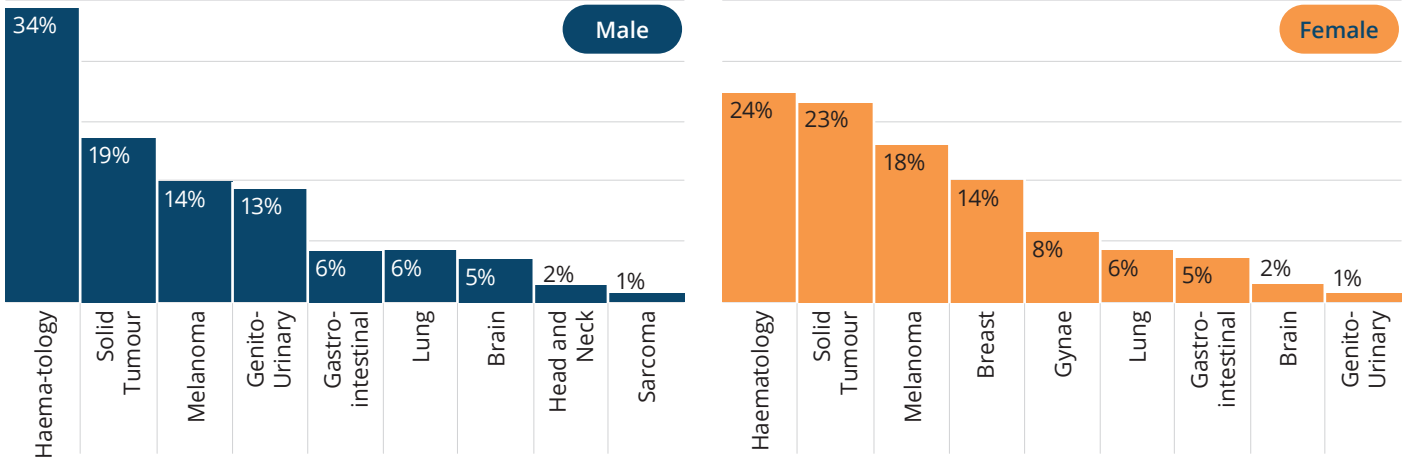



**Figure 39**: Male and Female participants by tumour stream recruited in 2024






#Data recreated from The Cancer in Victoria 2024 report (Cancer Council Victoria 2025).

Comparison of tumour-stream recruitment, cancer incidence and cancer mortality should be interpreted with considerable caution. Unlike age and sex, tumour-stream participation is influenced by the availability of disease specific standard treatment options, the availability of disease-specific clinical trials, eligibility criteria, treatment pathways, primary or secondary cancer diagnosis, and the structure of the Census dataset itself.

Several tumour streams do not map directly to cancer incidence and mortality categories. In particular, the Solid Tumour category contains umbrella studies that may enrol participants with a range of different cancer types, and the Census dataset does not currently differentiate participation at the individual trial-arm level. In recent years, umbrella trial designs have become increasingly common within oncology research, allowing multiple tumour-specific cohorts to be recruited under a single study protocol. As the Census does not currently capture recruitment at the individual trial-arm level, it is not possible to determine the extent to which growth in the Solid Tumour category reflects increased recruitment to specific tumour types or increased utilisation of umbrella trial designs.

Notwithstanding these limitations, the distribution of clinical trial participation within our data set differs markedly from the distribution of cancer diagnoses and mortality.

One notable finding of the diagnosis-participation comparison is observed within haematological malignancies. Blood cancers account for approximately 12% of the estimated 40,384 all new cancer diagnoses in Victoria in 2024[18], yet haematology studies represented a substantially larger proportion of clinical trial participation within the Census dataset. In the 2024 Census data, approximately one-quarter to one-third of both male and female clinical trial participants were recruited to haematology studies. There are several plausible factors contributing to this; a strong historical clinical trial culture within haematology, longer disease trajectories in some haematological malignancies, and differences in standard-of-care availability compared with other disease cohorts. While the reasons for this difference cannot be determined from the available Census data, it highlights the extent to which clinical trial participation patterns may differ from cancer incidence patterns.

Conversely, some of the most commonly diagnosed cancers appeared less prominent within the clinical trial recruitment profile. For example, breast cancer accounted for approximately 30% of cancer diagnoses among females but represented 14% of female clinical trial participants (Figures 37, 38 and 39), while Genito-Urinary cancers represented 13% of male clinical trial participants despite prostate cancer accounting for approximately 31% of male cancer diagnoses. Similarly, melanoma accounted for a larger proportion of clinical trial participation than cancer diagnoses in both males and females. These differences may be indicative of the availability of standard therapies and established treatment pathways in these tumour streams, reducing the circumstances in which patients require access to a clinical trial.

Comparison with cancer mortality data provides additional context. Lung cancer accounted for approximately 18% of cancer deaths in both males and females despite representing only approximately 8-9% of new cancer diagnoses. In contrast, lung cancer represented approximately 6% of trial recruitment within the Census dataset. While direct comparisons should be interpreted cautiously, this finding highlights that tumour streams with a substantial mortality burden do not necessarily account for a correspondingly large proportion of clinical trial participation.

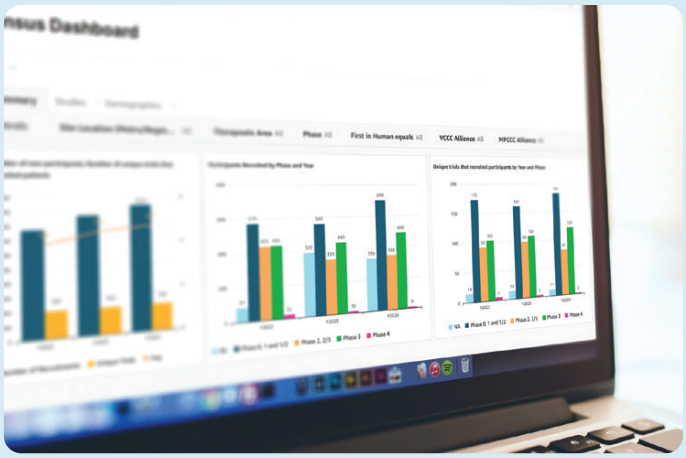
Interestingly, the relationship between recruitment and cancer mortality appears different for some tumour streams than the relationship between recruitment and cancer incidence. For example, breast cancer accounted for approximately 30% of cancer diagnoses among females but 14% of female clinical trial participants and 13.8% of female cancer deaths. Similarly, Genito-Urinary cancers represented 13% of male clinical trial participants, while prostate cancer accounted for approximately 31% of male cancer diagnoses but 12.7% of male cancer deaths. While these comparisons should be interpreted cautiously, they suggest that clinical trial participation in some tumour streams may align more closely with the cancers contributing most substantially to mortality than with the cancers contributing most substantially to incidence.

Melanoma demonstrated a different pattern, accounting for a larger proportion of clinical trial participation than either cancer diagnosis or cancer mortality in both males and females. This may reflect the strong historical research focus on melanoma and the substantial clinical trial activity associated with immunotherapy and targeted treatment development over the past decade.

A number of factors may contribute to the observed differences between cancer incidence, cancer mortality and clinical trial participation. Clinical trials are frequently accessed after one or more standard treatment options have been attempted and therefore do not necessarily occur at the time of diagnosis. Participation patterns are also influenced by the availability of disease-specific clinical trials, trial eligibility criteria, participant fitness for enrolment, patient choice, the maturity of standard treatment pathways and the structure of the clinical trial portfolio. Consequently, differences between diagnosis, mortality and participation profiles should not be interpreted as evidence of under-representation or over-representation without further analysis.

# Census Dashboard

As part of Cancer Trials Australia's custodianship of this data set, we are pleased to provide ongoing access to the sector, to allow key stakeholder groups to assess the impact of their dedicated efforts in improving trial availability and recruitment.



A dynamic dashboard is available at https://metrics.cancertrialsaustralia.com/ which contains anonymised data relating to this report.

# Towards the Future

This project presents a unique opportunity to provide meaningful analysis for sites in their pursuit of the best treatment options for their patients.

Cancer Trials Australia is incredibly proud to present this data, showcasing the hard work and dedication of all participating sites. Work continues to secure 2022-2025 data from additional sites and departments, and our metrics dashboard will be updated as additional data is secured.

We thank everyone who has contributed to this project to date and look forward to future editions.

For further information regarding this report, or to discuss accessing the available data set, please contact:

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^ These Figures contain data from 16 of the 20 clinical sites that provided data to support this Census, as those 16 sites utilise Clinibase in the day-to-day management of their clinical trial portfolio

# Data recreated from The Cancer in Victoria 2024 report (Cancer Council Victoria 2025).

# Footnotes


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