

# Canterbury

District Health Board

Te Poari Hauora o Waitaha

## Submission on New Zealand Cancer Action Plan 2019–2029

**To:** Ministry of Health

**Submitter:** Canterbury District Health Board

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**Proposal:** The Ministry of Health is seeking your feedback on the [New Zealand Cancer Action Plan 2019–2029](#). The plan enables the Ministry of Health, the sector and all those affected by cancer to work collaboratively to prevent cancer and improve detection, diagnosis, treatment and care after treatment. Feedback is sought from all New Zealanders, particularly people who are affected by cancer and their family/whānau, and all those involved in cancer from prevention, early detection, diagnosis, treatment and care after treatment.

# **SUBMISSION ON THE NEW ZEALAND CANCER ACTION PLAN 2019–2029. TE MAHERE MŌ TE MATE PUKUPUKU O AOTEAROA 2019–2029**

## **Details of submitter**

1. Canterbury District Health Board (CDHB).
2. The submitter is responsible for promoting the reduction of adverse environmental effects on the health of people and communities and to improve, promote and protect their health pursuant to the New Zealand Public Health and Disability Act 2000 and the Health Act 1956. These statutory obligations are the responsibility of the Ministry of Health and, in the Canterbury District, are carried out under contract by Community and Public Health under Crown funding agreements on behalf of the Canterbury District Health Board.
3. The Canterbury DHB has a legislated responsibility to promote hauora/wellbeing for individuals and communities (New Zealand Public Health and Disability Act [NZPHDA], 2000; Health Act 1956). Health outcomes of other population groups highlight they are greatly advantaged compared to Māori. This demands an equity focus that works to reduce health disparities experienced by Māori and other disadvantaged population groups. Creating equity for Māori is of primary importance (NZPHDA, 2000, clause 22(1e)), and Māori involvement in decision making processes is both, a Treaty responsibility and implied in NZPHDA (2000, clause 22(1f)), that requires consultation with disadvantaged groups.

## **General Comments**

4. We welcome the opportunity to comment on the New Zealand Cancer Action Plan 2019–2029 (the Plan).
5. The Plan's stated commitment for New Zealanders to experience equitable cancer outcomes is an important priority identified in the plan. In New Zealand, Māori are 20 percent more likely to get cancer and nearly twice as likely to die from cancer compared to non-Māori.<sup>1</sup> This is one example of the substantial inequity in health outcomes experienced by Māori throughout New Zealand. The Canterbury District Health Board recognises that health service-related inequity—including differential

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<sup>1</sup> New Zealand Cancer Action Plan  
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access and quality of health services—contributes to these disparities and must be addressed in order to eliminate health inequities for Māori.

6. The CDHB supports the Plan and has a number of recommendations for consideration which would further improve health outcomes for the community.

### Specific comments

#### **Outcome 1: New Zealanders have a system that delivers consistent and modern cancer care – Te huanga 1: He pūnaha atawhai**

7. The New Zealand Cancer Action Plan recognises that Pākehā have significantly better health outcomes than Māori and Pacifica (p. 9). To address inequity in outcomes it is vital that services are specifically focused on reducing, rather than exacerbating inequity. Current cancer referral rates and screening protocols, for example, are disadvantaging Māori, who are affected by cancers earlier in life.<sup>2 3 4 5</sup> Consequently, the cancer is often advanced by the time it is diagnosed, compromising outcomes and contributing to high Māori mortality. The Canterbury DHB recommends that research to maximise preventive, diagnostic and treatment outcomes for Māori and Pacifica is explicitly included in the plan.
8. At present cancer care is inequitably distributed across DHBs and within DHBs there is an urban and rural divide creating access issues (p. 7). The need to access frequent treatments, for example, can lead to significant travel and accommodation costs that are not adequately covered by National Travel schemes. Many families affected by cancer do not qualify for additional support from WINZ, which can lead to poorer outcomes for patients who compromise their treatment regimes in order to meet other financial commitments and responsibilities. The Canterbury DHB recommends the Plan considers financial compensation and support for patients.

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<sup>2</sup> Harris, R., Cormack, D., Tobias, M., Yeh, L. C., Talamaivao, N., Minster, J., & Timutimu, R. (2012). Self-reported experience of racial discrimination and health care use in New Zealand: results from the 2006/07 New Zealand Health Survey. *American journal of public health, 102*(5), 1012-1019.

<sup>3</sup> Lamb, D. S., Bupha-Intr, O., Bethwaite, P., Murray, J., Nacey, J., Russell, G., & Delahunt, B. (2008). Prostate Cancer-Are Ethnic Minorities Disadvantaged?. *Anticancer research, 28*(6B), 3891-3895.

<sup>4</sup> Seneviratne, S., Campbell, I., Scott, N., Shirley, R., Peni, T., & Lawrenson, R. (2015). Ethnic differences in breast cancer survival in New Zealand: contributions of differences in screening, treatment, tumor biology,

<sup>5</sup> Seneviratne, S., Lawrenson, R., Harvey, V., Ramsaroop, R., Elwood, M., Scott, N., ... & Campbell, I. (2016). Stage of breast cancer at diagnosis in New Zealand: impacts of socio-demographic factors, breast cancer screening and biology. *BMC cancer, 16*(1), 129.

9. Modern, comprehensive cancer care extends beyond acute treatment and focuses on physical and psychological rehabilitation of patients and whānau, and the Plan acknowledges the need for a holistic services and support (p. 31). The Canterbury DHB recommends that this includes support of whānau and patients to beyond treatment, with a focus on psychosocial and physical recovery. Services such as the Cancer Psychological and Social Support Service, palliative care services and NGOs provide social work and psychological/counselling support, however patient and whānau service delivery does not consistently continue beyond treatment or death. A greater focus on physical recovery post treatment through Physiotherapy and Occupational Therapy services is also recommended.
10. The Canterbury DHB supports that the Plan expresses a commitment to research and innovation to systematically improve evidence-based practice (p. 13), promising to increase kaupapa Māori research and evaluation capacity and capabilities (p. 16, p. 26).
11. The Canterbury DHB supports that the plan expresses commitment to responding to Māori health aspirations (p. 29). We recommend that there are mechanisms in place to ensure strong Māori and Pacifica representation at a governance and stewardship level to ensure accountability for work in accordance with Treaty principles. Māori and Pacifica must also be involved in the design and implementation of the plan at all levels and services resourced to meet the need.

**Outcome 2: New Zealanders experience equitable cancer outcomes – Te huanga 2: He taurite ngā huanga**

12. The Plan acknowledges inequities negatively impacting poorer communities, ethnic groups and potentially rural communities (p. 6-7). The Plan highlights a commitment to provide the best treatment and care to everyone “once a diagnosis is made”. It is important to highlight that cancer diagnosis in itself is a concern that needs to be addressed. Recent research, included the South Island *Routes to Diagnosis* project<sup>6</sup>, highlights significant differences in early diagnosis rates for Māori and Pākehā.
13. The disparities between Māori and Pākehā is attributable to two major causes. Firstly, at each step in the cancer treatment pathway (e.g. initial diagnosis, referrals

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<sup>6</sup> Jewell, Ursula, (2016) *Routes to Diagnosis End of Project Report*, SCN/Southern DHB  
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and treatment) proportionally fewer Māori are referred, resulting in an accumulative effect that sees significantly worse outcomes for Māori. Secondly, national treatment pathways are presently designed to address the need of the dominant population group, resulting in Māori being disadvantaged. The Canterbury DHB commends that the Plan highlights a commitment to work in partnership with Māori to develop and implement cancer services. The Canterbury DHB recommends that qualitative and quantitative research aimed to address the increasing disparities between Māori and Pākehā at each step of the cancer pathway needs to be undertaken and practitioner awareness and accountability measures devised.

**Outcome 3: New Zealanders have fewer cancers – Te huanga 3: He iti iho te mate pukupuku**

14. The Canterbury DHB supports the inclusion of a preventive approach to addressing cancer. Any health promotion initiatives must consider the potential of unintentionally exacerbating existing health inequities between Māori and other disadvantaged groups, and Pākehā. Research highlights the risk of health promotion exacerbating inequity for the least advantaged population groups due to reduced access and resources, which compromises the “choice” of healthy living outlined in the plan (p. 37). Consequently, to reduce disparity, health promotion efforts must be well planned and anticipate potential consequences of increasing inequality so that preventative measures can be designed in parallel. Similarly, the intent to devise “tailored health promotion” (p. 51), targeting Māori and Pacifica must ensure that it does not result in stigmatisation and responsabilisation.
15. The Canterbury DHB recommends that a population health approach to cancer must extend beyond the traditional health sector to include other agencies, such as the Ministry of Social Development and other stakeholders.

**Outcome 4: New Zealanders have better cancer survival – Te huanga 4: He hiki ake i te oranga**

16. Outcome four acknowledges the importance of early diagnosis and a coordinated sector approach. Important to the achievement of Outcome 4 is a well-resourced allied health and culturally competent workforce. The Canterbury DHB recommends that the Plan acknowledge the capacity for Allied Health professions to address physical and mental needs related to cancer, maximising quality of life and allowing reintegration toward normality post treatment.

17. To enable timely diagnosis for Māori and Pacifica, the Canterbury DHB recommends that cancer screening protocols be reviewed and adjusted to meet the needs of disadvantaged groups. The change in the minimum age for the National Bowel Screening programme from 50 to 60—while 50% of Māori bowel cancer diagnosed under the age of 60—is an example of how screening disadvantages Māori.<sup>7</sup> Further, access to treatment must be ensured and potential barriers prohibiting engagement, such as costs, be removed.
18. The Canterbury DHB oncology service has a well-developed relationship with the NGO sector supporting cancer patients and their whānau, such as the Cancer Society, however it is recommended that bi-cultural and cross-cultural approaches to service delivery is improved across the sector. Emphasis must be given to whanaungatanga and manākitanga in service development and delivery. This is an experience that disadvantaged groups do not have consistently and will inevitably contribute to decreased engagement with the sector and poor treatment outcomes.<sup>8</sup>
19. The Canterbury DHB recommends specific training within the health sector and beyond is made available relating to health outcomes and best practice for Māori and other disadvantaged groups in order to improve treatment outcomes and decrease inequity.

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## Conclusion

20. The CDHB does not wish to be heard in support of this submission.
21. Thank you for the opportunity to submit on New Zealand Cancer Action Plan 2019–2029, Te Mahere mō te Mate Pukupuku o Aotearoa 2019–2029.

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<sup>7</sup> Te Ohu Rata o Aotearoa. *The National Bowel Screening Programme is exacerbating Maori Health inequities* (A Te ORA Equity Series position statement).

<sup>8</sup> Jansen, P., & Smith, K. (2006). Maori experiences of primary health care. *NZFP*, 33(5), 298-300.

<sup>9</sup> Jansen, P., Bacal, K., & Buetow, S. (2011). A comparison of Māori and non-Māori experiences of general practice. *NZ Med J*, 124(1330), 24-30.

<sup>10</sup> Walker, T., Signal, L., Russell, M., Smiler, K., & Tuhiwai-Ruru, R. (2008). The road we travel: Māori experience of cancer. *Clinical Correspondence*.

**Person making the submission**



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Date: 22/10/2019

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