Where are we going with cancer treatment in New Zealand?

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In 2018, the Government directed the Ministry of Health to develop a new set of performance measures to improve health outcomes for New Zealanders. This is intended to prioritise population health outcomes with a view to health resource optimisation. The Ministry aims to have the new measures in place in early 2019. In developing these new measures, the Ministry has been asked to consider the following criteria:

- a mix of health system and population health improvement measures
- alignment with government priorities, for example, child wellbeing and mental health
- be quantified and timed
- availability of data to monitor progress
- sector engagement and support
- focus on health issues with alignment to socio-economic determinants

One of the important aspects of these changes will be the application of these new measures to cancer treatment. Our survival rates from cancer lag behind those of Australia, our most vulnerable populations continue to experience poorer outcomes from cancer than other New Zealanders and the costs of cancer care keep on increasing exponentially. The previous government had the ministry focusing on faster cancer treatment times and national tumour standards stream pathways. The national tumour standards had both cancer stream specific and generic factors in the pathway. All pathways also had a focus on improved data collection. These developments appear, however, to have run out of steam under the present government.

Concern about the lack of a coordinated plan in cancer treatment led to a recent “Cancer care at a Crossroads“ conference in Wellington a month ago. The aim of this conference was to develop a vision for long-term cancer control, specific to the needs of Aotearoa/New Zealand. This week’s edition of the Journal documents some issues with cancer treatment.

The paper by Koea et al focuses on the development of the cancer service at Waitemata District Health Board (DHB), New Zealand’s largest single health provider with a catchment of about 600,000. In this study they used a survey to assess patients’ views on currently available services. The questionnaire that was used was developed for the National Health Service (NHS) in Britain. In the reported study they assessed patients in 2013 and again in 2015 across all tumour streams. Not surprisingly they showed an improvement in most aspects of care, however the proportion of patients invited to participate in cancer research decreased from 35.9% to 21.4% (p<0.001). What is interesting is no similar measuring tool designed specifically for New Zealand exists, which would permit limited comparison and benchmarking across other DHBs.

Yee et al report significant variation in time to diagnosis of non-emergency referrals of symptomatic patients subsequently shown to have colorectal cancer in Bay of Plenty DHB. The High Index of Suspicion target for fast-track diagnosis is 14 days from receipt of the referral letter. In fact, only a quarter of their study population patients followed this pathway, with a median time to their diagnosis of 21 days from general practitioner (GP) referral date. This was in contrast to a median of 67 days for all other patients who did not enter this pathway. When the national criteria for assessment were applied, the patients allocated a Grade 1 urgency by the specialist waited a median of 26 days for diagnosis, compared with over
100 days for those who were graded less than Grade 1. Patients referred by their GP with new lower gastrointestinal symptoms who went direct to colonoscopy had a median time to diagnosis of 32 days, while those who were seen in clinic had median time to diagnosis 81 days. They found that GPs were failing to identify and correctly refer nearly half of those who did satisfy the criteria. A standardised referral form which prompts the inclusion of all required information and findings would also potentially improve the referral pathway, a step many DHBs have already undertaken. Thus, how you enter the colorectal cancer diagnostic pathway matters.

The issue of variation in treatment of patients in colorectal cancer is also the focus of a paper released on 4 March on the Ministry of Health website. The opaque titled and misreported Bowel Cancer Quality Improvement Report 2019, builds on the out-of-date Piper study. This report shows clearly the variation that is occurring in treatment and outcomes between district health boards across all indicators. This is despite the establishment of a national bowel cancer working group in 2011, with the purpose being to improve the care of patients with colorectal cancer.

Some of the more interesting statistics from this report are:

The majority of people (71%) were diagnosed with bowel cancer following referral to a clinic, the proportion of patients diagnosed following a referral from screening services was 3%, and 26% were diagnosed following presentation at an emergency department.

The 90-day post-operative mortality in patients undergoing major resection reported in the NBOCA audits for the four-year period 2013–16 was 3.8%. In the 2017 report, the 90-day mortality in patients undergoing emergency surgery was significantly higher than for those having elective surgery (10.3% compared to 1.9%). There was wide variation in 90-day mortality between trusts.

In people with colon cancer, the 90-day mortality following resection was 4.8%. People who have emergency surgery do worse. Of people with colorectal cancer, the proportion who undergo major surgical resection performed as an emergency in New Zealand was 19.6%. In people with colon cancer, the rate of emergency surgery was 24.7%, and in people with rectal cancer the rate was 4.4%. The highest rates of emergency surgery were for Māori (23.8%), females (21.1%), people younger than 50 years (27.1%) old and those over 75 years old (21.2%), again reflecting that our most vulnerable populations continue to experience poorer outcomes.

**Figure 1:** Proportion of people diagnosed with bowel cancer following presentation at an emergency department, by district health board of domicile, 2013–16.
There are large variations also documented in how people are treated, for instance who gets an operation, who gets radiotherapy, what sort of radiotherapy is given (short course versus long course). While some of these variations may have very good reasons such as local resourcing, given that the decisions should be built on the same evidence base, then the level of variation is a surprise.

Hopefully then with the ministry’s new focus on population health outcomes, and their stated goal of attempting to ensure that health resources are used optimally, we will see less of this variation and faster, more evidence-based treatment. While we wait for the Ministry’s new set of performance measures, we hope that it enables a more coordinated national plan and direction of cancer treatment.

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Nil.

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