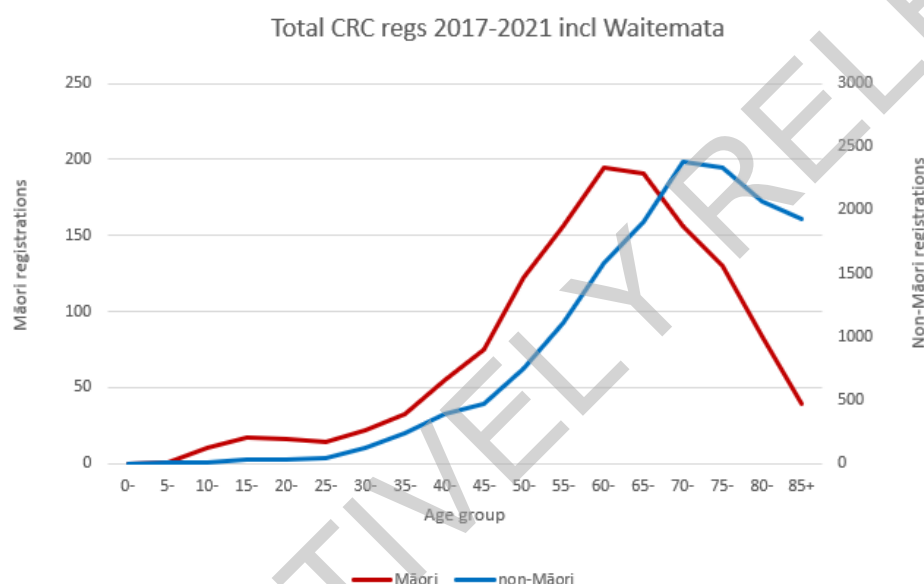


Can you please provide the absolute numbers – including the prevalence peak, etc.

Actual number of colorectal cancer registrations 2017-2021 by prioritised ethnicity

Asian	Māori	European/Other	Pacific
814	1,298	13,801	439

And we have updated the graph comparing the peak of Māori and non-Māori colorectal cancer registrations using data from 2017-2021



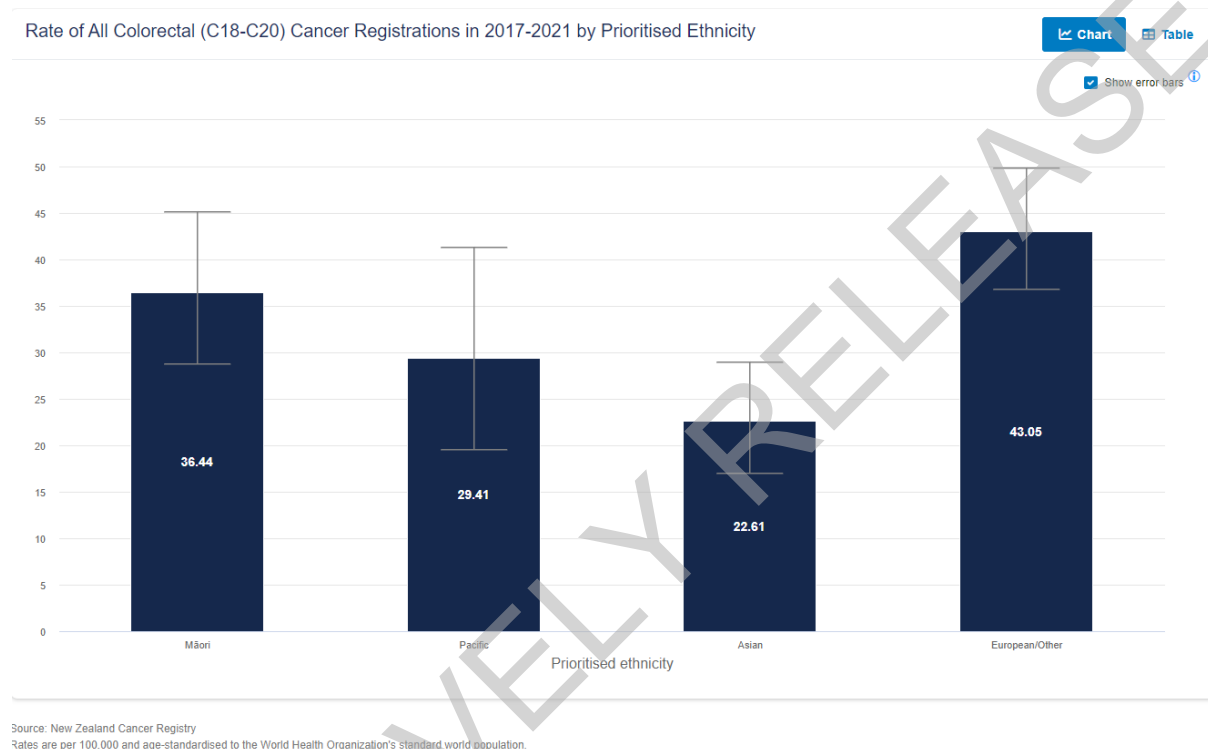
Can you please provide the incidence by age graph

Age-specific incidence rate for Bowel cancer by ethnicity, 2018-2022, per 100,000 population

Age group/Ethnicity	Asian	Māori	Other	Pacific
<50	4.7	7.0	12.5	7.7
50-59	35.9	57.8	70.7	57.7
60+	130.4	176.4	270.0	155.5

The graph below also shows the confidence intervals for the aged standardised rate by prioritised ethnicity.

While the rates seem quite different eg Māori 36.44 per 100,000 and Pacific 29.41 compared to 43.05 for European/Other, the confidence intervals are reasonable large and overlap so we can't say, for instance, that Māori or Pacific have a statistically significant lower age standardised rate of colorectal (bowel) cancer than European/Other.



Erasmus report – can you please confirm if this sentence is correct from the report “more Māori lives could be saved by increasing participation rates and 2 year reduction” and that this is more effective?

The table below provides a comparison of the additional colorectal cancers and deaths that have been modelled under the scenarios (lowering the screening age for Māori to 50, lowering the age for Māori to 58 and increasing participation for Māori in the current screening age to 60%).

	Original proposal: lowering the screening age to 50 years for Māori	Increasing participation for Māori in the current screening age range (60-74) to 60%	Lowering the age for Māori to 58 (with a participation rate of 52%)	Lowering age to 58 for Māori and increasing participation to 60% *
Additional colorectal cancers prevented over 25 years	443	195	129	324
Additional deaths prevented over 25 years	293	116	87	203

* Please note:

1) that Erasmus did not model the two scenarios (lowering the age to 58 and increasing participation) together and therefore adding these too together should be taken with some caution (for instance, it may be slightly less than these numbers as by going down to 58 years some of the 60+ cases will be identified earlier).

2) The modelling provides indicative comparisons of the impact of different strategies. The numbers should not be regarded as absolute.

The report does state that “Increasing Māori participation to 60% appears more efficient” [than the original proposal to lower to 50]. Note that the reference to being more efficient is in terms of the number of colonoscopies required per colorectal death prevented. This largely reflects the increase in incidence of bowel cancer with age.