Aide-Mémoire

Budget 2022 Bowel Screening Tagged Contingency: Talking points for CBC

Date due to MO:	20 February 2025	**Date of Meeting:**	24 February 2025
Security level:	IN CONFIDENCE	**Reference:**	H2025061690
To:	Hon Simeon Brown, Minister of Health		
Consulted:	Health New Zealand: ☒		
Proactive release:	This **Budget 2022 Bowel Screening Tagged Contingency: Talking points for CBC** is proposed by the Ministry of Health for proactive release: ☒		

Contact for telephone discussion

Name	Position	Telephone
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Budget 2022 Bowel Screening Tagged Contingency: Talking points for CBC

Date due:	20 February 2025		
To:	Hon Simeon Brown, Minister of Health		
Security level:	IN CONFIDENCE	**Health Report number:**	H2025061690

Details of meeting:	1.00pm, Monday 24 February 2025
Cabinet Committee:	Cabinet Business Committee
Purpose of Meeting:	You are seeking approval from the Cabinet Business Committee to re-purpose and drawdown the Budget 2022 Bowel Screening Tagged Contingency.
Ministry representatives	The officials available to be in attendance and provide support are: • Dr Andrew Old, Deputy Director-General, Public Health Agency • Clare Possenniskie, Manager, Public Health Policy and Regulation, Ministry of Health • Dr Susan Parry, Clinical Lead, National Bowel Screening Programme, Health New Zealand.
Comment:	This aide-mémoire provides talking points to support you taking the paper to the Cabinet Business Committee. Reactive questions and answers are attached as **Appendix 1**.

Dr Andrew Old
Deputy Director-General
Public Health Agency I Te Pou Hauora Tūmatanui

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Appendix 1: Reactive questions and answers

Background on the original proposal

What was the intent of the original proposal?

The intent of the original proposal (to lower the screening age to 50 for Māori and Pacific) aimed to address a difference between ethnic groups, which is that a greater percentage of bowel cancers occur in Māori and Pacific peoples at an earlier age, before they are eligible for screening (at the current age of 60).

Approximately 21% of bowel cancers that occur in Māori and Pacific people occur in people aged 50-59 years, compared to 10% of the bowel cancers in non-Māori non-Pacific peoples.

Does this mean Māori (and Pacific peoples) are more likely than non-Māori to be diagnosed with bowel cancer?

Current data indicates that Māori (and Pacific) have similar rates of bowel cancer compared to non-Māori (as shown in the table below). However, of those Māori who are diagnosed with bowel cancer a greater proportion are diagnosed before they become eligible for screening (i.e., before the age of 60) than non-Māori. This is because of the younger age structure and lower life expectancy of these populations.

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

Impact of the proposed change

What is the impact of the proposed change in the use of the Budget funding?

Lowering the screening age from 60 to 58 years for the total population will increase the number of people eligible for screening and prevent more cancers and deaths compared to the previous government's proposal.

	Previous proposal (age extension for Māori and Pacific peoples to 50 years old)	Current proposal (age extension to 58 years for the total population)	Difference (gain)
Additional people eligible for screening over a two-year period	114,045	122,524	8,479
Number of additional cancers prevented over 25 years	553	771	218
Number of additional deaths prevented over 25 years	390	566	176

Will there be any benefits for Māori and Pacific peoples from this proposal?

My proposal to lower the screening age to 58 years for the total population will result in more Māori and Pacific people eligible for screening and prevent more cancers and deaths within these communities when *compared to the current eligibility age*.

Low bowel screening participation rates are a significant issue for Māori and Pacific peoples. I am determined to see this change, which is why a portion of the funding is allocated to initiatives to improve screening participation rates.

This will help increase the number of Māori and Pacific peoples who participate in bowel screening and the number of cancers and deaths prevented in these communities.

What is the impact for Māori of this proposal compared to the original proposal?

Under this proposal fewer cancers and deaths will be prevented among Māori *compared to the original proposal*.

	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**

**** note that the two scenarios were not specifically modelled together and therefore adding the two together should be taken with caution and all figures are indicative.***

Age extension

Why has the Budget 2022 tagged contingency not been drawn down already?

Approval to draw down the funding was to occur following a small-scale rollout of lowering the screening age to 50 years for Māori and Pacific peoples in three pilot districts – Waikato, Midcentral, and Tairāwhiti. The Waikato pilot ended in December 2024 and the other two are due to end later in 2025.

This Government has now decided to take a different approach.

Can a lower starting age for bowel screening for the total population be funded?

No, because colonoscopy capacity is a key pressure point and outyears funding available is not sufficient to fund a screening age lower than 58 for the total population. But I do see this as a first step towards progressively lowering the bowel screening age over time as colonoscopy capacity and resourcing allows.

How were the options identified and informed?

Modelling of a number of potential screening strategies was undertaken using a Microsimulation Screening Analysis Colorectal Cancer Model. This model was developed by Erasmus University Rotterdam in the Netherlands and has been extensively validated, giving credibility and reliability to its results. The Australian bowel screening programme has also worked with the Erasmus University Medical Center.

Based on that modelling, officials provided me with the options which would deliver strong health gains and could be delivered within the Budget 2022 tagged contingency and the additional colonoscopies anticipated in the original proposal.

What were the modelling results for the other options considered?

	Lowering the screening age to 58 years	Lowering the screening age to 58 years for the total population and to 56 years for Māori and Pacific peoples	A one-off screening at 56 years old for the total population	Original proposal: lowering the screening age to 50 years for Māori and Pacific peoples
Additional colorectal cancers prevented over 25 years	771	918	679	553
Additional deaths prevented over 25 years	566	678	617	390

Screening participation initiatives

Is there any modelling to support the focus on lifting participation rates?

Modelling from Erasmus University estimates that achieving the 60% participation target for Māori and Pacific peoples aged 60–74 years would prevent 244 more colorectal cancer cases and 154 deaths over 25 years when compared to current participation levels.

Are those in rural areas also a priority group?

Overall, rural populations are well served by the bowel screening programme. Current participation in rural areas is 60.1%, compared to 56.2% in urban areas.

A large portion of the funding for screening participation initiatives is in the first four years – what is the impact of this? Will these initiatives stop?

Funding for these initiatives is concentrated in the first four years alongside the roll out of the age extension to establish effective communications and delivery models which the programme can then maintain ongoing.

The funding costs for initiatives in the first four years is largely made up of establishment costs particularly for initiatives such as barcoded kits which require the development of IT functionality.

It is expected that once these initiatives are developed using the funding allocated in the first four years, many will be able to continue with a smaller allocation of funding. Other initiatives such as the national promotional campaign, are only intended to run within the first four years.

Implementation

Why do we need to grandparent Māori and Pacific aged 50-59 years who started bowel screening in the three pilot districts into the screening programme?

When the three pilots end (in December 2024 in Waikato and in late 2025 in Tairawhiti and MidCentral) participants who began bowel screening as a part of the pilot will be offered ongoing screening until they reach 58 years old (and enter the national bowel screening programme).

Health NZ has advised that screening for these participants cannot stop unless they were formally advised and consented to this at the start of the pilot. It is also not clinically appropriate to cease screening a population once it has begun.

The practice of 'grandparenting' a population is not new. It also happened after the original bowel screening pilot in Waitematā, where people were screened from 50 years of age, but the bowel screening programme later set the eligibility age at 60 years.

Do you have any indication of which districts could potentially receive the age extension in the first tranche?

Not at this stage. Which districts will be in each tranche will be determined by considering local health need and current service capacity. Consultation also needs to occur with districts and regions before this is confirmed. This consultation will commence as soon as the age extension is announced and will inform the implementation plan Health NZ will be providing to me in April.

What are colonoscopy wait times currently and how significant is the impact likely to be on colonoscopy wait times?

Colonoscopy capacity is a significant consideration as colonoscopy services are currently struggling to meet clinical wait time requirements for symptomatic patients.

As of August 2024, only 41% and 54% of non-urgent and surveillance colonoscopies were completed or waiting within the recommended timeframes compared to the target of 70%.

My proposal for age extension will result in a small 2% increase of overall colonoscopies performed.

Health NZ have also advised me they are actively working on managing colonoscopy capacity.