

# The Government's pathetic response to lowering the age of bowel cancer screening

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In the buildup to the 2023 general election, the televised leader's debate gave a chance for the public to see the main parties explain their policies and inform voters on how they would approach issues. The leaders of the two main parties were asked about whether they would lower the bowel cancer screening age. Both Chrises (Hipkins and Luxon) stated they would match Australia for bowel cancer screening, which at that time would have seen the age lowered from 60 to 50, and to 45 for some people.<sup>1</sup> Eighteen months later, Australia has further lowered the age of colorectal cancer (CRC) screening to 45, and made it available to anyone from 40 following the patient having a discussion about the issues with their general practitioner<sup>2</sup>—while in Aotearoa New Zealand, the new minister of health announced on 6 March the lowering of the age from 60 to 58.<sup>3</sup>

This announcement came alongside the decision to abandon the planned lowering of the screening age from 60 to 50 for Māori and Pacific peoples. The money that had been budgeted for this will now be used fund the cost of lowering bowel screening for everyone to 58, as it was claimed by the minister that this will diagnosis more cancers. Māori historically had lower rates of bowel cancer; however, this gap is rapidly closing. Māori are diagnosed at a younger age, experience higher rates of emergency presentation and are more likely to have advanced disease at diagnosis. Once diagnosed they face a significantly higher risk of death from bowel cancer. The disparities are driven by multiple factors, including inequitable access to diagnostic investigations and treatment. Given these challenges, Māori and Pacific peoples stand to benefit significantly from earlier screening. Lowering the screening age would have been a meaningful step toward reducing these inequities, and the decision to withdraw funding for this initiative also disregards Te Tiriti o Waitangi obligations.

The reason why reducing the age of screening is important is because CRC is increasing dramatically

in those under 50 (early onset colorectal cancer [EOCRC]), while incidence in the total population is decreasing. The reason for this dramatic increase in younger people with bowel cancer is unknown; however, we do know that the best predictor of survival is stage at diagnosis, and that early diagnosis is likely to be beneficial and that population screening may facilitate this.<sup>4,5</sup> A recent New Zealand study<sup>6</sup> found that there were 56,761 new cases of CRC diagnosed in New Zealand between 2000 and 2020, of which the incidence of EOCRC increased by 26% per decade overall, and for Māori increased by 36% per decade.<sup>5</sup>

Patients with CRC are either diagnosed by the development of symptoms or by screening. In younger patients, particularly, waiting for symptoms to develop and then investigating them is a logistical challenge. Symptoms such as rectal bleeding, abdominal pain and altered bowel habit are non-specific, and very common in the general community with the vast majority of times due to benign pathology. As such, the significance of these symptoms in patients with CRC is easily overlooked, especially in young people. One study reported that the median time from symptom onset to starting treatment in those under 50 years of age was 217 days compared with 29.5 days in those over 50 years of age.<sup>7</sup> There are also many barriers to patients accessing primary health, with these being most pronounced in certain populations including younger patients,<sup>8</sup> as well as certain ethnic and lower socio-economic status groups.<sup>9</sup> There is also evidence these populations are less likely to be referred on for investigation or assessment by specialist services,<sup>10</sup> driving inequities in the diagnosis of bowel cancer.<sup>4</sup> While improving the diagnosis of symptomatic patients is critical, the reality is that for many patients, by the time symptoms appear, the cancer has already spread. This is most pronounced in younger individuals and Māori, who with our current approach face unacceptably high rates of stage 4 disease at diagnosis (up to 36%).<sup>11</sup>

Diagnosis of bowel cancer *prior* to the onset of symptoms remains the best way to improve survival. Screening asymptomatic patients (with faecal immunochemical test [FIT] and subsequent colonoscopy with a positive FIT) has been proved to be effective in older patients (>60 years).<sup>12</sup> Bowel cancers diagnosed by screening prior to symptoms developing have far better outcomes, with studies showing a 74% lower CRC-specific mortality compared with symptom-detected cancers.<sup>6</sup> In younger populations, the decreasing incidence rates of CRC previously made cost effectiveness, compliance and therefore benefit questionable. Now, with the increasing incidence of CRC in those under 50 years of age, modelling suggests screening with FIT and colonoscopy is cost effective from 40 years of age.<sup>13</sup> There is evidence that some countries screening below 50 have prevented the rise in EOCRC incidence.<sup>4</sup>

The increasing incidence of CRC in those under 50 has been reflected in the recommendations for screening for several major organisations in the United States (the National Comprehensive Cancer Network,<sup>14</sup> the US Multi-Society Task Force on Colorectal Cancer<sup>15</sup> and the US Preventive Services Task Force<sup>16</sup>), which are now recommending that screening starts from age 45. American health insurance companies are now required by law to fund CRC screening in their patients from age 45.<sup>17</sup> There have been similar calls to lower the screening age to 45 across Europe,<sup>18</sup> but as yet none of these countries have followed Italy and Austria in screening below the age of 50.

New Zealand has had one of the highest incidence rates of colorectal cancer globally for the past several decades.<sup>19</sup> Yet despite this, the history of bowel cancer screening in New Zealand has been disgraceful, with a very long gestational period.<sup>20</sup> A 1998 report stated that the benefit of CRC screening was likely to be similar to breast screening (which was well established and benefit proven in New Zealand by 1998); however, it had many reservations best summarised in this quote from that report: *“Given the modest potential benefit, the considerable commitment of health sector resources, and the small but real potential for harm, population-based screening for colorectal cancer with faecal occult blood tests is not recommended in New Zealand.”*<sup>20</sup> Subsequent to this, a 2004 report in bowel cancer screening in higher-risk groups recommended screening in high-risk patients.<sup>20</sup> A further report in 2006 from the Colorectal Cancer Screening Advisory Group recommended a specific faecal occult test.<sup>21</sup>

Eventually in 2008, the incoming National Government was forced to support the introduction of screening after the exiting Labour Government included it in the electoral promises. This eventually led to a pilot in the Waitematā District Health Board Region, and then to a rollout of the national programme starting in July 2017 and finishing in May 2022. This 24-year period of delays, deferrals and procrastination with failure to deliver in a timely manner led to the potentially avoidable deaths of thousands of New Zealanders, which would have been avoided if screening had been introduced earlier. In any aspect of government responsibility other than health such omissions with such resulting mortality would likely have led to a royal inquiry.

A lot of this delay was said to be due to the need to increase colonoscopy capacity and quality, and the need for further infrastructure—however the length of time it took—reflects poorly on these efforts, and such justifications are being used again for the present inadequate response. This is especially difficult to justify given that modelling from the Government’s own bowel cancer screening pilot found that starting screening at age 50 would result in an average overall saving of \$98 per person screened:<sup>22</sup> evidence that much of the required investment to increase our screening resource will be returned with savings elsewhere, this being on top of lives saved. While we welcome the Government’s announcement of an extra \$603 million in funding for expensive new cancer treatments<sup>23</sup> (costing many thousands of dollars per patient treated for advanced colon cancer), doing so while neglecting proven, cost-effective screening methods that would prevent the need for these treatments in many cases entirely lacks both economic and common sense.

It is the gap between a government’s re-election promises and its ability to deliver that determines its creditability, and as a result its re-election chances. Unfortunately for the last Labour Government, this gap was huge. As that Government found out, it’s easy to promise things, it’s hard to deliver them. The combination of a changing economic environment, a better understanding of issues and the constant firefighting of urgent issues can mean that issues around delivering election promises and, more importantly, maintaining the strategic direction can get lost in the reality of getting through each day. That said, this is a clear example that the present Government is unable to deliver its pre-election promises and is doing as little as it can to give an impression of fulfilling

them, but the gap between what is needed and what it is being done is huge and will further undermine this Government's credibility.

This latest in a series of bad decisions and delays on bowel cancer screening will cost further

lives; the present Government's failure to deliver on its election promises is entirely consistent with the shocking approach to bowel cancer screening New Zealanders have had to live with and die because of since the 1990s.

**COMPETING INTERESTS**

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