



**The New Zealand
Cancer Control Strategy
ACTION PLAN 2005 – 2010**

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Citation: Cancer Control Taskforce. 2005.
The New Zealand Cancer Control Strategy: Action Plan 2005–2010.
Wellington: Ministry of Health.

Published in March 2005 by the Ministry of Health.
PO Box 5013, Wellington, New Zealand

ISBN 0-478-25783-X (Book)
ISBN 0-478-25786-4 (Internet)
HP4036

This document is available on the Ministry of Health's website:
<http://www.moh.govt.nz/cancercontrol>

Foreword

In 2003, I launched the New Zealand Cancer Control Strategy. A Cancer Control Taskforce was also appointed, comprising experts in the cancer control field, to develop a plan to help realise the Strategy. The Action Plan outlined in this document has done just that and I am delighted to receive this advice on how we tackle such an important issue.

Cancer touches many people in many different ways. Too often, cancer is associated with death and despair, and not unjustly so given that approximately 7,500 New Zealanders die from the disease each year. Notably, the rates are higher for Māori and Pacific peoples and for those who are less well off.

However, many people with cancer do survive and a great number of early cancer deaths can be prevented. With improved prevention, better treatment and greater collaboration across the health sector the incidence and impact of cancer can be greatly reduced. By ensuring that interventions are as effective for populations with higher rates of cancer morbidity and mortality as the general population, the overall health disparities that are so evident in this country can begin to close.

I understand that implementing this Action Plan will be an enormous and ongoing task. In recognition of this, I will be establishing a Cancer Control Council to provide leadership in cancer control, to monitor and review implementation of the Strategy and to foster collaboration and co-ordination across the sector.

The Ministry of Health will also be appointing a Principal Advisor Cancer Control. The Principal Advisor's role will help drive implementation of the Strategy within the Ministry, as well as assisting with co-ordinating the efforts of the Council, the Ministry and the wider sector. I expect this person to be a pivotal leader in cancer control.

One of the first tasks of the Council will be to establish a Cancer Control Collaborative which will foster the collaboration at a national level of various groups and activities involved in cancer control. At a regional level, the establishment of cancer networks will serve to formally recognise existing collaborative efforts, as well as creating new ones.

I would like to thank the Cancer Control Taskforce for the work they have put into developing this Action Plan. It has been an enormous undertaking.

Finally I wish to acknowledge and thank all those currently working in the area of cancer control. Your support and commitment is vital to the ongoing implementation of the Action Plan and I hope that we can all work together to make it a success.



Hon Annette King
Minister of Health

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Overview

Cancer affects most of us at some point in our lives. We may be diagnosed with cancer ourselves or have family members, friends or neighbours with the disease. Cancer conjures up fears and anxieties, more so than many other diseases. Many are unaware of the recent advances in both reducing the risk of developing cancer and in treating and caring for those who have developed the disease. At present, we have the knowledge to prevent at least one-third of cancers. Depending on the availability of resources, it is also possible to detect at an early stage, and effectively treat, a further third of cancers. When cancer cannot be cured or held in remission, advances in the prevention and relief of suffering can greatly improve the quality of life of people with cancer and their families and whānau.

Cancer is a complex group of diseases. The term covers over a hundred diseases with different causes and requiring different treatment methods. Its prevention, detection, diagnosis, treatment and care involve a wide range of organisations and health professionals, both government and non-government.

As in many other countries, the number of people who develop cancer in New Zealand is increasing. Much of this increase is due to a growth in the population as well as the ageing of the population. Currently, about 16,000 New Zealanders develop cancer each year, while about 7,500 die as a result of cancer. Recent forecasting suggests that the number diagnosed will increase to 22,000 per year by 2011, placing increasing pressure on our health system.

The New Zealand Health Strategy (Minister of Health 2000) includes among its short- to medium-term population health objectives a reduction in the incidence and impact of cancer. In response, the Ministry of Health and the New Zealand Cancer Control Trust – representing the non-government sector – jointly produced the New Zealand Cancer Control Strategy (Minister of Health 2003). Launched in August 2003, the Strategy was the first step in the development and implementation of a comprehensive cancer control programme for New Zealand. The purposes, principles and goals of the Strategy are enduring; the objectives (and associated areas for action) are priorities in the short to medium term.

This Action Plan was developed by the Cancer Control Taskforce (see Appendix 1) supported by a Secretariat (see Appendix 2). The Plan outlines actions necessary for achieving the goals and objectives set out in the Cancer Control Strategy. As the Strategy provides the rationale for recommended action, it should be considered alongside the Action Plan.

Purpose of Action Plan

The New Zealand Cancer Control Strategy provides a high-level framework for reducing the incidence and impact of cancer in New Zealand and reducing inequalities with respect to cancer. This Action Plan outlines in detail how the Strategy's objectives can be achieved. There are synergies between aspects of this Action Plan and some other government health strategies and guidelines (see Appendix 3).

The actions identified in the Action Plan extend across the cancer control continuum, which includes primary prevention, screening, early detection, diagnosis and treatment, rehabilitation and support, and palliative care. They also include workforce development, research, data collection and analysis.

The Action Plan will have particular relevance to government and non-government agencies whose work impacts on the delivery of services and activities across the continuum of cancer control, individuals involved in the management and delivery of services, and those with cancer, their family and whānau.

A wide range of organisations and individuals are already involved in the control of cancer in New Zealand. The New Zealand Cancer Control Strategy (Minister of Health 2003) and its Action Plan together provide an integrated approach to the planning, development and delivery of existing and new cancer control activities and services. The Action Plan incorporates and builds upon existing activities which contribute to cancer control. In many cases the recommended actions are designed to:

- close existing gaps in services, or reduce duplication
- ensure greater co-ordination of services being developed
- ensure that scarce and finite resources are used efficiently and effectively.

The Cancer Control Strategy as the Framework for Action

The Action Plan is derived from and is directly linked to the New Zealand Cancer Control Strategy (Minister of Health 2003). The Strategy's high-level framework to guide existing and future action is as follows:

The overall purposes of the Strategy

The overall purposes of the Strategy are to:

- reduce the incidence and impact of cancer
- reduce inequalities with respect to cancer.

The principles of the Strategy

All cancer-related activities should reflect the principles of the Strategy (refer to page 19 of the Strategy). Namely, they should ensure that high quality, evidence-based services are delivered in a timely manner to meet the needs of the population. Cancer services need to address health inequalities among different population groups, particularly for Māori as they experience persistently worse cancer outcomes. Central to any effective approach is the need to put the person at the centre of the service, to respect the diversity in the community and involve consumers in the planning and delivery of services.

The goals of the Strategy

The six goals of the New Zealand Cancer Control Strategy are:

- Goal 1:** Reduce the incidence of cancer through primary prevention
- Goal 2:** Ensure effective screening and early detection to reduce cancer incidence and mortality
- Goal 3:** Ensure effective diagnosis and treatment of cancer to reduce cancer morbidity and mortality
- Goal 4:** Improve the quality of life for those with cancer, their family and whānau through support, rehabilitation and palliative care
- Goal 5:** Improve the delivery of services across the continuum of cancer control, through effective planning, co-ordination and integration of resources and activity, monitoring and evaluation
- Goal 6:** Improve the effectiveness of cancer control in New Zealand through research and surveillance.

Important facts about cancer

- Cancer is now a leading cause of death, accounting for 29 percent of deaths from all causes.
- Cancer causes about 7500 deaths per year currently, and this is expected to rise to about 9000 by 2012.
- Currently about 16,000 New Zealanders develop cancer each year, and this is expected to increase to 22,000 by 2011.
- Survival rates are improving for those diagnosed with cancer.
- About 70 percent of patients with cancer are admitted to hospitals.
- Cancer is a significant cause of disability and lost years of independent life.

The need to reduce the incidence and impact of cancer

The incidence of all adult cancer in New Zealand is expected to increase by 7 percent in males and by 6 percent in females between 1996 and 2011. Over this same period cancer mortality rates are expected to decrease by 20 percent in males and by 11 percent in females (Ministry of Health 2002).

From 1996 to 2011 the number of males with cancer will increase by 50 percent to 11,005 and the number of females will increase by 44 percent to 10,772 per year. As a result of these predicted increases, the demand on government and non-government agencies involved in cancer control will increase significantly. The planning and delivery of cancer control services and activities need to be aligned with this progressive increase in the cancer burden.

The need to reduce inequalities with respect to cancer

Reducing the health inequalities of different population groups is a key principle of the New Zealand Health Strategy (Minister of Health 2000), and District Health Boards (DHBs) have a statutory responsibility for reducing health inequalities under the New Zealand Public Health and Disability Act 2000.

In New Zealand, as elsewhere, there are differences in health status related to socioeconomic status, ethnicity, gender and where people live. Differences in access to health care services and in the care received have a considerable impact on people's health status and mortality and are particularly relevant when it comes to providing cancer services.

As a group, Māori have poorer health status than non-Māori, no matter what their level of education or income or their occupation. The same is true for Pacific peoples, whose health status falls midway between that of Māori and the European and Other group (Howden-Chapman and Tobias 2000). Cancer mortality is an important contributor to this gap in health status for both Māori and Pacific peoples, with deaths from cancer having increased in both these groups while decreasing in the other ethnic groups (Ajwani et al 2003). In the case of Māori men, the age-standardised cancer mortality rates are 2.0 times greater than for non-Māori and non-Pacific men while mortality from cancer among Māori women is 2.1 times greater than for non-Māori. In the period 1996 to 1999, prostate cancer mortality rates among non-Māori and non-Pacific men were half those of Māori, while breast cancer mortality rates in the wider population were 60 percent those of Māori women.

For Pacific peoples, cancer is a major cause of mortality and morbidity, and there is evidence that the burden of cancer (especially lung and colorectal) is increasing in this ethnic group and is making an increasing contribution to health inequalities (Ministry of Health and Ministry of Pacific Island Affairs 2004).

The relatively high rates of breast and cervical cancer mortality in Pacific women may in part be associated with lower rates of access to and participation in the national cancer screening programmes, as evidenced by data from the National Cervical Screening Register and BreastScreen Aotearoa (Ministry of Health and Ministry of Pacific Island Affairs 2004).

Actions to address health inequalities should tackle social and economic inequalities as well as improving access to and effectiveness of health and disability services. Various tools have been developed to provide assistance in developing interventions with an equity focus. The Ministry of Health commonly uses the Reducing Inequalities Intervention Framework (Ministry of Health 2002a) and the Health Equity Assessment Tool (Te Rōpū Rangahau Hauora a Eru Pōmare et al 2003). These tools are outlined in Appendix 5 and can be applied to all actions in the Action Plan.

Implementing the Action Plan

The complex field of cancer control covers the work of a wide range of organisations and health professionals. Agencies from both the government and non-government sectors are involved in the many aspects of cancer prevention, detection, screening, diagnosis, treatment, support and rehabilitation, and palliative care. By promoting an integrated approach to the control of cancer in New Zealand, the New Zealand Cancer Control Strategy aims to encourage and assist government and non-government service providers to work more closely together, and to enable all providers to have a common understanding of where they fit into the overall spectrum of cancer control.

Leadership for implementation

On 4 November 2004 the Minister of Health announced the establishment of an independent Cancer Control Council to provide a sustainable focus on cancer control. Its role will be to provide leadership in cancer control, to monitor and review implementation of the Strategy and to foster collaboration and co-ordination. The Council will be supported by a dedicated secretariat to develop and deliver its work programme.

The Minister of Health also announced the establishment of the position of Principal Advisor Cancer Control in the Ministry of Health. The role of the Principal Advisor is to drive implementation of the Strategy, foster collaboration and co-operation, attend meetings of the Council to report on progress with implementation, and assist with co-ordinating the efforts of the Council, the Ministry and the wider sector.

Working collaboratively and co-operatively

In recent years an increasing number of agencies have been working collaboratively in the area of cancer control. This co-operation has been through formal partnerships, by undertaking joint projects, establishing memoranda of understanding and pooling resources. Collaborative initiatives can provide a range of benefits, including resource efficiencies, consistency in action, enhancing the impact of each organisation's contribution, and focusing effort and resources where the greatest health gain can be obtained.

It is intended that both national and regional structures will be developed to enhance co-operation and collaboration for cancer control. At a national level, the Cancer Control Council will establish a Cancer Control Collaborative to identify groups and activities around the country contributing to cancer control, and foster collaboration between them.

Although informal collaboration already exists at a regional level, the establishment of regional networks will formally recognise these activities. The networks will facilitate the co-ordination of services across health providers at the primary, secondary and tertiary levels by regularly bringing the various providers and consumer organisations together to ensure effective co-operation and the integration of services, where appropriate. The networks will also provide a mechanism for organisations and people to work with each other to plan and co-ordinate services in line with clearly defined national standards of treatment. As well, they could provide a forum to look at issues that are of particular concern to patients, such as referral patterns, access and service provision.

Agencies responsible for action

The following agencies and sectors have an important role in cancer control, and their co-operation, collaboration and commitment are essential to the implementation of the Cancer Control Strategy. This list is by no means complete, and does not include important links with other sectors and organisations which are necessary for the success of the Strategy. Examples include those involved in standards, audit, research, workforce development, education and training.

Ministry of Health

As the chief advisor to the Government on health, the Ministry's primary responsibility is to ensure the health and disability support system is working well. Across its many functions the Ministry works to shape the health and disability system to be fair, and ultimately to make a significant contribution to achieving the Government's desired outcome of healthy New Zealanders.

In the Ministry of Health's *Statement of Intent 2004-2005* (Ministry of Health 2004a) the expectation is that the Ministry:

- provides policy advice on improving health outcomes, reducing inequalities and increasing participation
- acts as the Minister's agent
- monitors the performance of DHBs and other health sector Crown entities
- implements, administers and enforces relevant legislation and regulations
- provides health information and processes payments

- facilitates collaboration and co-ordination within and across sectors
- provides nationwide planning and maintenance of services frameworks
- plans and funds public health, disability support services and other service areas that are retained centrally.

The Ministry's role in relation to cancer control is to implement some specific actions in the Action Plan. The Ministry also has a responsibility to oversee the implementation of the Strategy by setting the accountability and operating frameworks, support the implementation and monitor performance of DHBs and providers of health and disability support services (Ministry of Health 2004).

District Health Boards

DHBs are required by government statute to effectively fund and manage health and disability services to improve the health status of their populations. In doing this, they are guided by the objectives of the New Zealand Health Strategy (Minister of Health 2000) and the New Zealand Disability Strategy (Minister for Disability Issues 2001). Cancer control is a key government priority.

The DHBs are involved in the delivery of services across many aspects of the cancer control spectrum, particularly in the areas of diagnosis and treatment. DHBs, in their roles as funders of health services, will be expected to have a major role in implementing the New Zealand Cancer Control Strategy. They will be expected to report on progress towards implementing the Strategy through formal accountability measures to the Ministry of Health.

DHBs have been asked by the Ministry of Health to consider the New Zealand Cancer Control Strategy and to report on cancer control-related activities in their annual district plans.

Non-government organisations

The active involvement of the non-government sector is essential if implementation of the Strategy is to have maximum effect. New Zealand has a wide range of voluntary organisations, community groups and support groups, including Māori and Pacific organisations, whose activities contribute to the control of cancer. Some of these groups provide specific services through government contracts (eg, to provide primary health care and/or health promotion). In most parts of New Zealand a significant proportion of palliative care is provided by hospices and community organisations, which are partially funded by government, with the remainder of support derived from public donation, fundraising and voluntary assistance.

There are also a number of cancer charities that receive no government funding. Some of these, such as the Cancer Society, have played a pioneering role in the development of cancer services in New Zealand and continue to be active in the areas of cancer prevention and health promotion, patient and family support, advocacy and research. The commitment of the non-government sector to cancer control is also reflected in the formation of the New Zealand Cancer Control Trust (funded by the Cancer Society of New Zealand and the Child Cancer Foundation). The Trust facilitated and worked in partnership with the Ministry of Health to develop the New Zealand Cancer Control Strategy.

Professional groups

A wide range of health professionals are involved in cancer control. The professional organisations representing them have an important role to play in implementing the Strategy and its Action Plan, particularly in relation to workforce training, continuing professional development and standards of care.

Evaluation, Monitoring and Review

Evaluation

Evaluation is required to determine whether the Action Plan is achieving its overall purposes of reducing the incidence and impact of cancer and reducing inequalities. It is also required to ensure that the various actions prescribed in the plan are meeting their expected outcomes, and that the milestones for each action are being achieved.

Ongoing monitoring and periodic independent review are the primary mechanisms for evaluation. These will provide government and non-government stakeholders with clear and credible accountabilities against which the actual performance of the Action Plan and Strategy can be measured and reported.

Monitoring and review will also allow individual stakeholders to track their performance with respect to the actions they are involved in, and will be the basis for modifying actions to improve their effectiveness.

Monitoring

Monitoring overall progress towards achieving the purposes of the Strategy (reducing incidence, impact and inequalities) will be an important role of the Cancer Control Council and involve routine data collection and analysis by the New Zealand Health Information Service (NZHIS). This will require improvements in the use, efficiency and scope of national data collection and reporting. Adopting a national cancer data set and establishing the linkages between the Cancer Registry and clinical, pathology and palliative care data sets (Minister of Health 2003) will greatly improve assessments, not only of incidence and mortality, but also of the efficiency of treatment and access to care across the country.

Improved and consistent collection of ethnicity data will allow more effective monitoring of inequalities. An expanded and enhanced Cancer Registry will be required to process, analyse and facilitate research on this expanded volume and range of data (Minister of Health 2003). Information will also need to be collected from a wide variety of other sources and assessed to measure progress with particular actions (eg, cancer prevention, developing standards and guidelines, optimising treatment, and meeting various workforce needs).

The results of monitoring will be disseminated through annual progress reports to the Minister of Health and Parliament by the Cancer Control Council. These annual reports will provide the basis for periodic review.

Review

Periodic review of implementation will provide a basis for any major changes in the implementation plan. Ongoing monitoring and periodic review will help to ensure that actions are achieving the desired effects. New objectives can be added or substituted as research identifies more effective ways of reducing both the incidence and impact of cancer and health inequalities.

The Action Plan

The actions in the following plan are directed towards achieving the goals and objectives of the New Zealand Cancer Control Strategy. The objectives are grouped under the goals of the Cancer Control Strategy which cover the cancer continuum starting with primary prevention and ending with research and surveillance. For each objective (or group of objectives, where these are closely related) there is a template which identifies desired outcomes/ results, specific actions, key stakeholders, milestones, measures and timeframes.

The Action Plan has an initial five-year timeframe for implementation. By the end of this five-year period it is expected that considerable progress will have been made towards building on existing cancer control activities and implementing the many 'new' actions.

All of the actions in the Action Plan are worthwhile contributions to cancer control. It is acknowledged that not every action within the Action Plan will be able to be tackled at once. Some can be implemented in the short to medium term. Other actions, perhaps of greater impact, will take longer to initiate. Designations of 'phase 1' in the Plan generally mean actions are to occur within the first one to two years; those designated as 'phase 2' generally mean they will occur within three to five years. Adjustments may be made to this phasing depending, for example, on new evidence or additional resources. A list of abbreviations used for key stakeholders in the Action Plan is in Appendix 6.

The Cancer Control Taskforce has considered all of the actions in the Action Plan and determined that the themes and actions in the following table are high priority intended for immediate implementation.

Overall priorities for phase 1 implementation

- Establish regional cancer networks.
- Expand smoking cessation services and programmes for Māori women.
- Implement Healthy Eating – Healthy Action.
- Implement strategies to improve coverage of BreastScreen Aotearoa in areas where the need for increased coverage has been identified.
- Ensure timely and acceptable access to cancer services by establishing standards.
- Establish multidisciplinary care for cancer patients.
- Pilot studies to map and analyse cancer patients' journey and clinical pathway.
- Establish groups to develop guidance for children, adolescents and adults.
- Implement and evaluate pilot survivorship programmes for children and adolescents.
- Implement the New Zealand Palliative Care Strategy.
- Develop a workforce plan for cancer control, ensuring consideration of cancer workforce shortages for Māori and Pacific peoples.
- Plan for capital expenditure on cancer control, including equipment, drugs and new initiatives.

- Apply the Health Equity Assessment Tool (HEAT) to policy and funding decisions regarding cancer control.
- Support Māori-led cancer services where possible and ensure that all mainstream cancer services have a cultural framework for Māori that aligns with He Korowai Oranga.
- Develop a five-year rolling plan for research relating to cancer control.
- Develop a nationalised, standardised clinical cancer data set.

(Please note that every alternate outcome in the Action Tables has been shaded for ease of reading.)

Reduce the incidence of cancer through primary prevention

Objective 1: Reduce the number of people who develop cancers due to tobacco use and second-hand smoke

Introduction

This section of the Action Plan, while explicitly focusing on the prevention of cancer, links closely with *Clearing the Smoke: A five-year plan for tobacco control in New Zealand (2004–2009)* (Ministry of Health 2004).

Clearing the Smoke outlines the Government's strategic approach to addressing one of the 13 key priorities in the New Zealand Health Strategy: reducing smoking. The tobacco control plan provides a comprehensive framework of activities, which may be delivered by a range of providers and organisations at national, regional and local levels. The plan builds on and enhances existing tobacco control services as well as identifying new areas for action.

Tobacco is a major preventable cause of cancer in the New Zealand population and is responsible for about 25 percent of all cancer deaths. Tobacco-related cancers, for which the Māori rate is substantially higher than the non-Māori rate (eg, Māori lung cancer mortality rates are currently three times higher than non-Māori rates), include cancers of the lung, stomach, cervix and liver. In terms of adverse health outcomes from tobacco-related disease, the burden is greatest among Māori and lower socioeconomic status men and women. A recent Ministry of Health study has

found that at least one-third of the shorter life expectancy of those living in the most deprived areas of New Zealand is accounted for by smoking (Ministry of Health 2001b).

With smoking rates remaining at around 50 percent for Māori and over 30 percent for Pacific peoples, as opposed to approximately 22 percent for other New Zealanders, additional effort is required for these groups.

The following activities have been drawn from the tobacco control plan for specific emphasis and focus in this Action Plan.

Action Table

Goal 1, Objective 1: Reduce the number of people who develop cancers due to tobacco use and second-hand smoke

Outcomes/results	Specific actions	Key stakeholders	Milestone/measures/phasing
1. Reduction in the exposure to second-hand smoke for all New Zealanders.	Support the ongoing implementation of the Smoke-free Environments Amendment Act 2003.	MOH, DHBs, primary and public health service providers, NGOs (eg, CSNZ).	Increase in the number of smokefree settings. <i>Phases 1 and 2</i>
	Continue to strengthen the smokefree legislation and regulations.		Percentage of indoor workers exposed to environmental tobacco smoke during working hours reduced. <i>Phase 1</i>
	Enhance campaigns to reduce second-hand smoke in non-regulated environments such as homes, cars etc.		Increase in the number of smoke free homes and cars. <i>Phases 1 and 2</i>
2. Reduction in levels of tobacco consumption and smoking prevalence.	Consider establishing an ongoing tobacco taxation policy.	MOH, and the tobacco control sector (eg, ATAK, ASH, Smokefree Coalition, CSNZ).	Government decision regarding the desirability of an ongoing tobacco taxation policy. <i>Phase 1</i>

Outcomes/results	Specific actions	Key stakeholders	Milestone/measures/phasing
3. Increased quitting rates especially among the most at risk groups.	Provide effective and culturally appropriate smoking cessation services, including enhanced services for Māori women, Pacific peoples, and groups with higher smoking rates.	MOH, the Quit Group, Aukati kaipaipa, DHBs primary and public health service providers.	Reduction in adult smoking prevalence to 20 percent or less by the <i>end of Phase 2</i> .
	Investigate and implement effective smoking cessation programmes such as Quit and Win for low socioeconomic status communities.	MOH, DHBs, smoking cessation providers, primary and public health service providers.	Reduction in tobacco products sold to 1000 cigarette equivalents or less per adult by the <i>end of Phase 2</i> .
	Develop and further enhance effective smoking cessation mass communication campaigns for Māori and Pacific peoples.	MOH, cessation service providers.	Reduction in Māori and Pacific Peoples smoking rates at a rate that reduces current disparities with non-Māori, non-Pacific population. <i>Phase 2 and beyond</i>
	Enhance social marketing campaigns to reduce second-hand smoke in non-regulated environments such as homes, cars, etc. (Note: see also Outcome 1.)	MOH, DHBs, HSC, tobacco control service providers.	Exposure to second-hand smoke reduced. <i>Phase 1</i>
4. Reduction in the rate of young people taking up smoking, especially groups with higher rates of smoking.	Undertake research into young people's initiation to smoking.	MOH, HSC.	Initial research programme completed. <i>Phase 1</i>
	Implement strategies to reduce smoking initiation among young people.	MOH, DHBs, public and primary health providers NGOs (eg, CSNZ).	Strategies launched. <i>Phase 1</i> Reduction in percentage of younger smokers, by sex, age and ethnicity. <i>Phase 2</i>

Outcomes/results	Specific actions	Key stakeholders	Milestone/measures/phasing
5. Reduction in Māori smoking rates.	<p>Develop further initiatives to reduce Māori smoking rates, including:</p> <ul style="list-style-type: none"> ensuring health and related services are proactive in tobacco control. promoting Māori smoking cessation promoting risk awareness for Māori increasing the focus on whānau health encouraging primary care and hospital services to record smoking status of all clients and initiate referral systems to cessation services. 	MOH, research funders, tertiary education institutes, TCRSSG, DHBs, PHOs cessation providers.	<p>Initiatives are identified and implemented. <i>Phase 1</i></p> <p>Review undertaken. <i>Phase 2</i></p> <p>Number of Māori accessing services recorded. <i>Phase 1</i></p> <p>Smoking status recorded. <i>Phase 1</i></p>
6. Reduction in Pacific smoking rates.	Initiate and pilot a Pacific smoking cessation programme within the context of primary health care in high need areas.	MOH, Pacific providers, PHOs cessation service providers.	Pilot initiated. <i>Phase 1</i>
	Facilitate and support further research into Pacific smoking and interventions.		Evaluation completed. <i>Phase 2</i>
7. Increased emphasis on tobacco control throughout the health and disability sector.	PHOs and GPs to incorporate information on smoking and quitting smoking into their clinical practice and health promotion plans.	MOH, DHBs, PHOs and other primary care service providers.	Research undertaken. <i>Phase 1</i>
	Raise the importance of tobacco prevention work with DHB senior management, boards and committees.		Information on smoking cessation included in health promotion plans. <i>Phase 1</i>
	DHBs specify smoking rates / tobacco control activities in district annual plans.		District annual plans will identify specific activities being planned and undertaken by DHBs to reduce smoking rates. <i>Phase 1</i>

Outcomes/results	Specific actions	Key stakeholders	Milestone/measures/phasing
8. Improved leadership and co-ordination of the tobacco control programme at national and regional levels.	Regional and national leadership and co-ordination services established to encourage co-operation, co-ordination and ongoing dialogue regarding tobacco control activities.	MOH, regional and national co-ordination providers.	Effective regional co-ordination services, and national networks established. <i>Phase 1</i> Joint national planning undertaken annually. <i>Phase 2</i>
9. A workforce that is trained in tobacco control and meets the needs of the population.	Workforce development plan to include a section on tobacco control with: <ul style="list-style-type: none"> tobacco control training in the curriculum for nurses, doctors, and public health professionals an ongoing tobacco control training programme to upskill the health sector workforce, especially for those delivering to population groups with high smoking rates. (Note: see Goal 5, Objective 1, Outcome 85.)	MOH, CTA, tertiary education institutes and professional groups.	Workforce development plan completed. <i>Phase 1</i> Implementation of plan commenced. <i>Phase 2</i>

Outcomes/results	Specific actions	Key stakeholders	Milestone/measures/phasing
10. Improved quality of understanding and availability of research information on tobacco control.	Develop a comprehensive tobacco control monitoring and evaluation programme.	MOH, TCRSSG, research funders (eg, HRC, CSNZ), tertiary education institutes, tobacco control providers.	Research and evaluation findings inform tobacco control policy and practice. <i>Phase 2</i>
	Establish a tobacco control research programme to ensure co-ordination and information sharing of tobacco research.		
	Compile research on smoking cessation for Māori and Pacific peoples, which identifies potential barriers and success factors.		
	Work with research funders and providers to improve research to identify motivators, inhibitors, and resilience factors that enable young people not to take up smoking.		

Objective 2: Reduce the number of people developing physical inactivity and obesity-related cancers

Objective 3: Reduce the number of people developing nutrition-related cancers

Introduction

This section of the Action Plan, while explicitly focusing on the prevention of cancer, links closely with Healthy Eating – Healthy Action (HEHA). HEHA (Ministry of Health 2003b) outlines the Government’s strategic approach to addressing the three priorities in the New Zealand Health Strategy: improve nutrition, reduce obesity, and increase the level of physical activity. The HEHA implementation plan provides a comprehensive programme of activities to be delivered by a range of providers and organisations at national, regional and local levels. The plan builds on and enhances existing nutrition, physical activity and obesity services, as well as identifying new areas for action.

Several common cancers have been clearly demonstrated to be associated with the risk factors poor nutrition, physical inactivity and obesity. These include cancers of the colon, rectum and breast (particularly post menopausal). The evidence for the links between various cancers and these risk factors are summarised in

the *Food and Nutrition Guidelines for Healthy Adults: A background paper* (Ministry of Health 2003). Further research that may confirm these associations is being undertaken in the European Prospective Investigation into Cancer and Nutrition (EPIC).

The HEHA strategic plan (Ministry of Health 2003b) and background paper (Ministry of Health 2003a) clearly identify the impact on the health of the population of poor nutrition and a lack of physical activity. In 1997, an estimated 209 cancer deaths (from oesophageal, stomach, colorectal and lung) were attributable to fruit and vegetable consumption patterns. In addition to the protective effect of fruit and vegetable intake, these foods also tend to be low in energy density and if encouraged are likely to replace more energy dense foods and assist in obesity prevention. Small improvements in these risk factor levels could prevent hundreds of deaths from non-communicable diseases annually (Ministry of Health and Auckland University 2003).

The 1997 National Nutrition Survey (NNS97) clearly identified the increasing prevalence of obesity in New Zealand (Russell et al 1999). The survey found that 35 percent of the New Zealand adult population were overweight, while a further 17 percent were considered obese. Pacific and Māori women were more likely to be obese than European/other women. The 2002 Children’s Nutrition Survey showed similar obesity patterns to those found in adults (Ministry of Health 2003d). About a third of all New Zealand children were classified as overweight. Obesity levels were highest in, particularly males, followed by Māori children, especially girls, while European/ other children were the least likely to be overweight or obese.

Physical activity is also important in obesity and cancer prevention. Physical activity in varying levels of intensity has been reported by the International Agency for Research on Cancer (IARC) as being protective for cancers of the breast, endometrium, colon, rectum, lung, and possibly prostate (IARC 2002). Men from varying ethnic groups have been found by New Zealand Sport and Physical Activity surveys to have similar activity levels (SPARC 2003), but Māori and European women were found to be more active than Pacific women. Men and boys have been found to be more active than women and girls. The 1996 New Zealand Health Survey (Ministry of Health 1999) found that people of a lower socioeconomic status tended to participate in less physical activity.

Many of the following specific cancer prevention activities have been drawn from the HEHA implementation plan for special emphasis in this Action Plan. The Healthy Eating – Healthy Action implementation plan includes a review of the effectiveness of the proposed actions.

Action Table

Goal 1, Objective 2: Reduce the number of people developing physical inactivity and obesity-related cancers

Goal 1, Objective 3: Reduce the number of people developing nutrition-related cancers

Outcomes/results	Specific actions	Key stakeholders	Milestones/measures/phasing
11. Increase in physical activity among vulnerable populations.	Maintain and expand the Green Prescription programme, including provision for 60 minutes per day of moderate physical activity, where appropriate.	MOH, SPARC, DHBs.	Number of green prescriptions issued by gender and ethnicity. <i>Phase 1</i>
	Further adapt the Green Prescription programme to ensure it reaches Māori, Pacific peoples and low socioeconomic groups.	MOH, SPARC.	Programme adapted and available. <i>Phase 1</i>
	Raise awareness of the link between cancer risk and inadequate physical activity.	SPARC, CSNZ.	Increased awareness via SPARC/CSNZ survey. <i>Phase 1</i>
	Consider the inclusion of a nutrition component in Green Prescriptions.	MOH, SPARC, NHF, ANA.	Programme adapted and available if appropriate. <i>Phase 1</i>

Outcomes/results	Specific actions	Key stakeholders	Milestones/measures/phasing
12. Reduced levels of obesity in vulnerable populations, particularly Māori, Pacific peoples and low socioeconomic groups.	Increase investment in initiatives to improve nutrition and promote healthy weight for low socioeconomic groups.	MOH, DHBs, NGOs (eg, ANA members) and primary and public health providers.	Increased levels of investment in nutrition and healthy weight/physical activity programmes. <i>Phase 1</i>
	Encourage increased investment in community based initiatives to improve nutrition and promote healthy weight for Māori.	MOH, SPARC.	Increased levels of investment and participation in Māori-led nutrition and healthy weight programmes. <i>Phase 1</i> Measurements from nutrition surveys. <i>Phase 1</i>
	Explore opportunities to include traditional and contemporary physical activity, including kapa haka, waka ama, etc into programmes for Māori.	SPARC.	Increased use of traditional Māori activities in physical activity programmes. <i>Phase 1</i>
	Support childhood obesity programmes for Pacific peoples, including in schools and churches.	MOH, Pacific providers, schools, MOE.	Enrolment of Pacific peoples in physical activity programmes. <i>Phase 1</i>
	Engage PHOs, paediatricians and nutritionists in a strong partnership with schools through the Health and Physical Education Curriculum.	MOH, MOE, Schools, DHBs, PHOs, HTANZ.	Engagement with schools. <i>Phase 1</i>

Outcomes/results	Specific actions	Key stakeholders	Milestones/measures/phasing
13. Increased consumption of fruit and vegetables.	Develop a strategy to increase the consumption of fruit and vegetables.	MOH, Fruit and Vege Key Stakeholders Group.	Strategy developed. <i>Phase 1</i>
	Implement the fruit and vegetable strategy.		Strategy implemented. <i>Phase 2</i>
	Roll out the 'Free Fruit in Schools' programme to low decile schools (dependent on a positive evaluation of the current feasibility pilot).	MOH, MOE.	Increased fruit and vegetable consumption among school children within targeted schools. <i>Phase 1</i> Ongoing monitoring of uptake of free fruit in schools. <i>Phase 2</i>
	Facilitate the development of community gardening programmes for low income communities.	MOH, Pacific providers, NGOs.	Number of programmes initiated. <i>Phase 1</i>
14. Increased awareness and knowledge of healthy nutritious foods.	Develop a social marketing campaign, which provides clear messages to encourage the consumption of healthy nutritious foods.	MOH, NGOs (eg, CSNZ, ANA), HSC.	Survey to monitor: <ul style="list-style-type: none"> reach knowledge and awareness uptake of messages change in behaviour. <i>Phase 1</i>
	Increase awareness of the link between inadequate nutrition and cancer risk.	CSNZ, MOH.	

Outcomes/results	Specific actions	Key stakeholders	Milestones/measures/phasing
15. Increased emphasis on nutrition and physical activity throughout the health and disability sector.	DHBs specify nutrition and physical activity interventions in their district annual plans and incorporate into clinical practice.	MOH, DHBs, PHOs, GPs.	Further survey of DHBs and PHOs to monitor changes in practice promoting nutrition and physical activity messages. <i>Phase 2</i>
	PHOs and GPs incorporate information on the protective effects of a nutritious diet and physical activity in preventing cancer.		
16. Improved quality and availability of research information on interventions to prevent cancer.	Initiate specific research into mechanisms for behavioural change in relation to nutrition and physical activity to prevent cancer, including effective interventions for specific at-risk groups such as Māori and Pacific peoples.	MOH, HRC, Ministry of Research, Science and Technology, CSNZ, research funders, tertiary education institutes.	Research and evaluation findings inform the development of interventions to improve nutrition, increase physical activity and reduce obesity. <i>Phase 2</i>
17. Workforce that is trained in nutrition and physical activity and meets the needs of the population.	<p>The workforce development plan to include a section on nutrition and physical activity with:</p> <ul style="list-style-type: none"> • an assessment of current capacities, deficits and future needs • a training programme in nutrition and physical activity to address identified needs • ongoing training programmes in nutrition and physical activity to upskill the current health sector. <p>(Note: see Goal 5, Objective 1, Outcome 85.)</p>	MOH, CTA, tertiary education institutes and professional groups.	Training programmes developed and implemented. <i>Phase 2</i>

Objective 4: Reduce the number of people developing skin cancer due to UV radiation exposure

Introduction

Skin cancer is by far the most common cancer affecting New Zealanders.

Around 300 New Zealanders die from skin cancer every year and most of these deaths are from melanoma. In 1999, 75 people died from non melanoma squamous cell cancer while 231 died from melanoma (www.nzhis.govt.nz/stats/cancerstats/html). Melanoma was also the third most common female cancer and the fourth most common male cancer registered in New Zealand in that year. Melanoma is the most serious form of skin cancer and New Zealand has one of the highest melanoma death rates in the world (www.cancernz.org.nz).

Most skin cancers are considered to be caused by excess exposure to solar ultra violet radiation (UVR), and so are potentially readily preventable. New Zealand's high prevalence of skin cancer is consistent with the fact that New Zealand experiences up to 50 percent higher levels of UVR in summer months than countries at comparable latitudes in the Northern Hemisphere (McKenzie et al 1999).

In recognition of the role of harmful UVR exposure in skin cancer incidence the WHO recently stated that the 'encouragement of sun-protective behaviour is the most effective public health measure to reduce the incidence of skin cancer.' Individual

sun protective behaviours can be encouraged through health promotion efforts that aim to raise awareness, increase knowledge, and improve protective attitudes and behaviours. They may impact on individuals through a variety of routes, including the education system (for school students), the workplace (for outdoor workers), via community action (sun protection practices at preschools and sporting facilities), or through the mass media (either for segments of the population or for the general population). While there has been an emphasis on raising awareness of the need for sun protection among individuals through communications/mass media campaigns over recent years, there is also a need for public policy for skin cancer control within a range of settings.

Although excess exposure to UVR can be harmful at all ages, such exposure during childhood and adolescence contributes significantly to lifetime skin cancer risk. It is during this period of life that most sun exposure occurs (although an increase in indoor activities, such as the use of television, videos and computers, may be causing a reduction). There is a need to develop and promote cancer control policies that address sun protection as part of a holistic approach that also encompasses physical activity (recognising that adequate physical activity is required to prevent a range of diseases later in life). This should include the need for healthy policies and practices, such as covering up behaviour (use of hats and protective clothing) and sunscreen, as well as environments that include rescheduling physical activity outside peak UVR times and the provision of adequate shade. Childhood exposure seems to be important for melanoma risk, as is intermittent recreational exposure in adulthood, although total sun exposure and occupational exposure may also contribute.

Appropriate education from an early age can both reduce exposure in the most critical period of life and help to develop lifetime sun-protective attitudes and behaviours. For the reasons outlined above preventive efforts in New Zealand have focused on children and their caregivers, and on adolescents. This strategy is consistent with other countries such as Australia and the United States.

Primary prevention strategies need to target both the individual and appropriate organisations and structures. Such organisations include early childhood centres, schools, sporting and recreational organisations, and local government.

Key areas of focus for skin cancer prevention include:

- reducing exposure to UVR among children (12 years and under in particular)
- increasing understanding of sun behaviour among at-risk audiences
- increasing the provision of shade in public areas and settings
- reducing risks associated with the use of UVR-producing technology such as solarium and sunbeds.

This objective has been extensively based on a report by A I Reeder (2004) to the Skin Cancer Steering Committee.

Action Table

Goal 1, Objective 4: Reduce the number of people developing skin cancer due to UV radiation exposure

Outcomes/results	Specific actions	Key stakeholders	Milestones/measures/phasing
18. Reduce exposure to UVR among children (12 years and under).	Enhance social marketing strategies aimed at raising awareness, improving knowledge and developing lifetime sun protective attitudes and behaviours.	MOH, HSC, CSNZ, DHBs, PHOs, MOE, STA, NZPF, NZEI.	Increased investment by national organisations. <i>Phase 1</i>
	Encourage early childhood centres and primary and intermediate schools to adopt and implement the SunSmart Schools Accreditation programme (as recommended by the WHO and adopted in 2001 as a national-level strategy by CSNZ).		Sun safety included in all DHB public health plans. <i>Phase 2</i>
19. Increase sun protection policies and practices in secondary schools.	Support new and existing efforts to increase sun-protective attitudes and behaviour among secondary school students.	MOH, CSNZ, HSC, MOE, STA, PPTA, SPANZ.	Number of schools accredited. <i>Phase 2</i>
	Develop a national sun safety policy framework for schools.		Comprehensive national secondary school sun protection policy developed. <i>Phase 2</i>
	Encourage the development of a monitoring mechanism to assess the implementation of secondary school sun-protection policies and practices.		Sun protection policy and practice audit undertaken in schools. <i>Phase 1</i>
			Sun protection included in the curriculum. <i>Phase 2</i>

Outcomes/results	Specific actions	Key stakeholders	Milestones/measures/phasing
20. Reduce the number of outdoor workers who develop skin cancer.	Work with OSH to identify ways of strengthening the legal framework to protect outdoor workers from UVR.	CSNZ, HSC, MOH, OSH.	Occupational UVR exposure standard developed. <i>Phase 1</i>
	Increase awareness among both employers and outdoor workers regarding the risks from UVR exposure. Publicise employers' responsibilities.	CSNZ, OSH, DHBs, PHOs and employer organisations.	Awareness increased. <i>Ongoing</i>
	Collaborate with Australian Skin Cancer Steering Committee outdoor workers project team.	CSNZ, HSC.	Increased awareness of responsibilities. Participate on Committee. <i>Phase 1</i>
21. Improve understanding of at-risk audiences' sun related attitudes and behaviours.	Undertake research to better understand sun behaviour and attitudes to sun safety among caregivers, schools and outdoor workers.	CSNZ, HSC, research institutions (eg, universities) and DHBs.	Staged qualitative research programme developed and acted on. <i>Phase 1</i>

Outcomes/results	Specific actions	Key stakeholders	Milestones/measures/phasing
22. Increase shade provisions in public settings/ environments.	Support new and existing efforts for increased provisions of built and natural shade in a range of public settings and in public policies.	CSNZ, HSC, MOH territorial local authorities.	Shade provisions in place. <i>Phase 1</i>
	Support the development of standards and guidelines for shade in public settings.		Territorial local authorities' plans include focus on increasing shade. <i>Phase 2</i>
	Encourage the strengthening of legal frameworks to include shade provision (eg, the Building Act 1991 and Resource Management Act 1991).		
	Ensure all territorial local authorities' long-term community plans include a focus on increasing shade.		
23. Reduce the risks associated with solaria and sun lamp use.	In addition to ongoing efforts to work with the solaria industry, support new efforts for the safer operation and advertising of solaria, including regulation and monitoring.	CSNZ, HSC, solaria industry.	Regulations in place. <i>Phase 2</i>
	Promote the Australian/New Zealand Solaria Standard and alert solaria operators to its provisions.		Compliance rate with guideline and/or regulations. <i>Phase 2</i>
	Monitor compliance by the solarium industry to the guidelines issued by the joint Australia/New Zealand Standard for Solaria.		

Objective 5: Reduce the number of people developing infectious disease-related cancers

Introduction

The presence of some infectious diseases has been associated with the development of liver cancer, cervical cancer and stomach cancer. For example, people who have had hepatitis B and C are more likely to develop liver cancer, and the presence of the human papillomavirus (HPV) is an essential factor in the development of cervical cancer. HIV/AIDS is a cause of cancers such as Kaposi's sarcoma and aggressive non-Hodgkin's lymphoma. These cancers are unequally distributed in the population. Māori, Pacific and Asian people in New Zealand have higher rates of chronic hepatitis B and C infection, so liver cancer is more common in these populations compared with the European/Pākehā population. Māori women have higher cervical cancer incidence and death rates than non-Māori women.

A vaccine to prevent human papillomavirus infection is currently under development and this has significant potential to reduce cervical cancer. A need for a focus on emerging technology in this area to properly address the use of this technology will have to be considered in any future review of this Action Plan.

The documents *An Integrated Approach to Infectious Diseases: Priorities for action 2002-2006* (Ministry of Health 2001), *The Sexual and Reproductive Health Strategy - Phase 1* (Ministry of Health 2001d), and the *HIV/AIDS Action Plan* (Ministry of Health 2003c) carry specific recommendations for risk reduction in sexually transmitted infections, and hepatitis B and C. The actions proposed here are directly linked to actions in those documents.

Action Table

Goal 1, Objective 5: Reduce the number of people developing infectious disease-related cancers

Outcomes/results	Specific actions	Key stakeholders	Milestones/measures/phasing
24. A raised awareness in the population, especially in high-risk groups, of the cancer risks associated with some infectious diseases.	Implement the health promotion actions identified in established policies, strategies and programmes relating to infectious disease, especially <i>An Integrated Approach to Infectious Disease, The Sexual and Reproductive Health Strategy: Phase 1</i> and the <i>HIV/AIDS Action Plan</i> .	MOH, DHBs, PHOs, NGOs, PHUs, HPS.	Complete stocktake of health promotion actions relating to infectious diseases. <i>Phase 1</i>
25. A reduced incidence of cervical and vaginal cancer.	Support and endorse the Sexual and Reproductive Health Strategy, especially promoting safer sex behaviours and delaying the onset of sexual activity. Monitor and assess developments in HPV screening and potential vaccination, and implement as appropriate when evidence shows these to be effective and feasible.	MOH (NSU), DHBs, PHOs and primary care providers, sexual health and family planning providers.	Reduction in reported STI rates. <i>Phase 2 and beyond</i>

Outcomes/results	Specific actions	Key stakeholders	Milestones/measures/phasing
26. A reduced incidence of hepatitis B in all New Zealanders, especially Māori, and Pacific and Asian peoples and health care workers.	<p>Endorse effective case-finding for hepatitis B in high-prevalence populations.</p> <p>Work with the hepatitis B vaccination initiatives to improve uptake.</p> <p>Ensure that individuals identified through the hepatitis B screening and follow-up programme receive appropriate surveillance for hepatocellular carcinoma.</p>	MOH, DHBs, PHOs and primary care providers, occupational settings, professional groups, NGOs, Māori providers, agencies involved in hepatitis B prevention, Department of Corrections.	<p>Long-term reduced incidence in hepatitis B related liver cancer.</p> <p><i>Phase 2 and beyond</i></p>
27. A raised awareness of the risks associated with intravenous drug use.	<p>Support actions outlined in the Integrated Approach to infectious diseases to prevent hepatitis B and C, including:</p> <ul style="list-style-type: none"> • effective health promotion initiatives • needle exchange schemes. 	PHOs, DHBs, MOH, Department of Corrections.	<p>Uptake of needle exchange programme.</p> <p><i>Phases 1 and 2</i></p> <p>Reduced hepatitis C rates (dependent on notification).</p> <p><i>Phase 2 and beyond</i></p>
28. Ensure that emerging links between infectious agents and cancer are assessed.	<p>Provide direction on how to respond to new evidence and identify where research is needed.</p> <p>Monitor emerging evidence on the links between infectious agents and stomach cancer.</p>	MOH, research organisations.	<p>Emerging links recognised and responded to.</p> <p><i>Phases 1 and 2</i></p>

Objective 6: Reduce the number of people developing alcohol-related cancers

Introduction

The National Alcohol Strategy 2000–2003 (Ministry of Health 2001c) indicates that over 80 percent of New Zealand's adult population drinks alcohol. While total alcohol consumption has declined over the past 10–15 years, there is considerable variation in the amount consumed by individuals. It is estimated that 10 percent of drinkers consume almost half of the total alcohol consumed. Young people who drink are drinking more heavily, more often, and start drinking at an earlier age than previously. While a lower proportion of Māori drink, young Māori appear to engage in heavier and riskier drinking than non-Māori, thus their future cancer risk is likely to be higher than that of non-Māori since the link between alcohol and cancer is dose related.

While only about half of the proportion of the Pacific population drink alcohol compared to the New Zealand European population, those among the Pacific population who do drink appear to exhibit a higher prevalence of risky drinking patterns. Ministry of Health data indicate that the proportion of Pacific drinkers engaging in hazardous drinking patterns in 1996/97 was approaching twice the proportion of New Zealand European drinkers engaging in hazardous drinking patterns (Ministry of Health 2003).

As part of the overall messages about the health effects of alcohol, there needs to be a raised public awareness of the association between alcohol and various cancers. Alcohol is classified as a carcinogen by the International Agency for Research on Cancer (IARC 1988). Alcohol can cause cancers of the oral cavity, pharynx, oesophagus, larynx and liver, and alcohol drinkers are at a higher risk of cancers of the breast, colon and rectum. Alcohol may also increase the risk of cancers of the stomach, small intestine, lung, cervix, uterus, ovary, prostate, bladder and kidney (IARC 1988; Collaborative Group on Hormonal Factors in Breast Cancer 2002; Bagnardi et al 2001). There is a linear relationship between alcohol and the risk of these cancers. The risk is higher among people who drink two or more drinks a day compared to those who drink less than this (Rehm et al 2003). For breast cancer, the risk is increased among women who drink one or more drinks a day. Cancer risk through alcohol consumption is further increased if the person is also a smoker. Overall, the less you drink, the lower the risk of cancer (Colditz and Hunter 2000). As yet there is insufficient evidence to clearly describe the association between cancer and patterns of drinking (Rehm et al 2003).

While alcohol is an important cause of some cancers, at modest consumption levels it has a protective effect against cardiovascular disease in at-risk people (Poikolainen 1995). This becomes more pronounced with age. A WHO working group concluded that the reduced risk for coronary heart disease has been found at the level of one drink every second day and that there is little additional reduction of risk beyond consumption of levels of about one drink

a day (WHO 1997). Taking into account the evidence regarding cancer and the cardiovascular benefits, the levels at which the net benefits are maximised appear to be as follows:¹

- pregnant women: none
- non-pregnant women: up to one standard drink per day
- men: up to two standard drinks per day.

To protect people from alcohol-related harm, WHO suggests key measures that governments, industry and other agencies can take to limit its accessibility. These include reducing individual consumption by limiting the numbers, types and locations of outlets, as well as hours and days of sale; raising the legal age at which alcohol may be purchased; restricting advertising and marketing; and raising the price of alcohol through taxation (WHO 1995).

The National Drug Policy, which covers alcohol, illicit and other drugs as well as tobacco, is currently being revised. *The National Alcohol Strategy 2000–2003* (Ministry of Health 2001c) will be reviewed following the National Drug Policy revision and will include recommendations relevant to the implementation of this objective. The Alcohol Advisory Council of New Zealand (ALAC) strategic plan provides clarity for ALAC's contribution to the Government's overall goals and identifies as priority population groups Māori, young people and Pacific peoples (ALAC 2002). This plan also contributes to the Strategy's objective to reduce the number of people developing alcohol-related cancers in New Zealand.

¹ Note that these are upper limits and not recommended amounts to be consumed.

Action Table

Goal 1, Objective 6: To reduce the number of people developing alcohol-related cancers

Outcomes/results	Specific actions	Key stakeholders	Milestones/measures/phasing
29. More New Zealanders are aware that alcohol consumption increases the risk of certain cancers.	Ensure that the specific cancer risks associated with alcohol consumption are clearly identified in all future policies and information produced by key stakeholders, including the Government's National Drug Policy – National Alcohol Strategy when it is revised/updated.	MOH, ALAC, DHBs, NGOs with alcohol/cancer interests.	Identification of cancer risk associated with alcohol consumption identified in relevant strategies when they are revised/updated. <i>Phases 1 and 2</i> Information regarding cancer risks sent to key stakeholders. <i>Phase 1</i>
30. Drinking levels that minimise the risk of cancer.	Endorse and support the inclusion of alcohol-related initiatives in the revised National Drug Policy that minimises the risk of cancer.	MOH, ALAC, DHBs, NGOs with alcohol/cancer interests, and the alcohol industry.	Revised National Drug Policy that reflects alcohol-related cancer concerns. <i>Phase 2</i>
31. An improved evidence base on the impact of drinking patterns on cancer risk.	Support research and evaluation on the association between drinking patterns and cancer risk.	MOH, the proposed cancer research funders forum and tertiary education institutes.	Issue to be considered by the proposed cancer research funders forum (see Goal 6, Objective 1, Outcome 104). <i>Phase 1</i>

Objective 7: Reduce the number of people developing occupational-related cancers

Introduction

An estimated 600 cases of occupational cancer occur each year in New Zealand, many of which are preventable. Regulations are in place to protect workers against many known carcinogens. The Occupational Safety and Health Service (OSH) is responsible for ensuring that the legislative protection for workers is upheld in workplaces. Further efforts and actions are required to identify other potential carcinogens, develop strategies to reduce workers' exposure, and hence reduce the incidence of occupational cancers. As well as chemical exposures, second-hand smoke is also a risk in the workplace and should be considered by employers. Exposure to UV radiation is a further risk for outdoor workers and should also be considered (see Goal 1, Objective 4).

The planning of actions to support this objective should involve collaboration with organisations such as OSH and the Environmental Risk Management Authority (ERMA).

Action Table

Goal 1, Objective 7: Reduce the number of people developing occupational-related cancers

Outcomes/results	Specific actions	Key stakeholders	Milestones/measures/phasing
32. Reduced exposure to, and raised awareness of, carcinogenic compounds and contaminants in the workplace.	Work with OSH on future guidelines and information for employers and employees on hazard identification and protection.	OSH, ERMA, MOH, trade unions, employer organisations.	Guidelines developed as new risks emerge. <i>Phase 2</i>
	Compliance with legislation, including smokefree legislation, by employers and smokefree enforcement agencies.		
	Consider the implications of reports by the National Occupational Safety and Health Advisory Committee (NOHSAC), including the report published in late 2004.	OSH, MOH, researchers.	Implement cancer-related recommendations where applicable. <i>Phase 2</i>
33. Improve the evidence base for occupational exposure-related cancers and contaminants.	Support the OSH Cancer Panel Research Programme on occupational exposures and provide input where required to this project.	MFE, NZ Defence Force, Massey University CPHR.	<i>Phases 1 and 2</i>
34. Improved reporting of occupational cancers.	Work with OSH and NZHIS to facilitate the collection of data on occupational-related cancers.	MOH (NZHIS), OSH, trade unions, employer organisations.	<i>Phases 1 and 2</i>

Outcomes/results	Specific actions	Key stakeholders	Milestones/measures/phasing
35. Improved monitoring and surveillance of populations exposed to known carcinogens.	Monitoring and surveillance. Work with OSH (and ERMA) to encourage employers to undertake appropriate monitoring to safeguard the health of those at work.	MFE, MOH (NZHIS) research organisations, territorial local authorities, regional councils, primary care providers, OSH, ERMA, employer organisations.	Implement relevant recommendations from the 2004 NOHSAC report where applicable. <i>Phase 2</i>

Goal 2:

To ensure effective screening and early detection to reduce cancer incidence and mortality

Objective 1: At a national level, provide a strategic approach to cancer screening and the assessment and surveillance of those with familial risk to ensure quality, acceptability and effectiveness

Introduction

Clear processes are required for reviewing high-level recommendations regarding cancer screening and familial risk assessment in New Zealand. These should include the assessment of potential new screening programmes, regular review of current screening recommendations, identification of issues for which recommendations are required, and ongoing oversight of implementation of the recommendations. Currently, there is no high-level strategic oversight of these issues, or of those relating to early detection of cancer other than that obtained through organised screening.

High-level strategic oversight of existing and potential cancer screening, and of the assessment and surveillance of those with familial risk, is needed to ensure:

- clear and effective processes for the development and implementation of cancer screening policies

- improved understanding of cancer screening and familial risk assessment at all levels of the health sector
- culturally appropriate cancer screening services, including familial risk assessment
- a reduction in ad hoc cancer screening, unless there is strong evidence of potential benefits
- a reduction in inequalities between Māori and non-Māori in participation in the existing breast and cervical screening programmes as well as any future cancer screening programmes
- increased participation in existing and future cancer screening programmes by Pacific peoples
- improved cost-effectiveness of cancer screening and familial risk assessment
- enhanced participation of the non-government sector in the development and implementation of recommendations
- improved and timely access to treatment for those with screen-detected cancers
- improved quality of treatment services for those with screen-detected cancers.

The Strategy recommends the establishment of a national cancer screening committee to provide high-level strategic oversight of existing and potential cancer screening, and of the assessment and surveillance of those with familial risk. The Cancer Screening and Early Detection Expert Working Group also identified the

need for this committee to oversee issues relating to early detection of cancer other than that obtained through organised screening. Such a committee was proposed to be in addition to the existing screening programme advisory committees, which have an important role in providing strategic advice on existing programmes.

Since the launch of the New Zealand Cancer Control Strategy, the Minister of Health has established a National Screening Advisory Committee (NSAC). In light of this development, discussions are needed to determine the process by which high-level strategic oversight occurs for:

- existing and potential cancer screening
- the assessment and surveillance of those with familial risk
- issues relating to early detection of cancer other than that obtained through organised screening.

Those involved could usefully include members of the original Cancer Screening and Early Detection Working Group.

Also, since the launch of the Cancer Control Strategy the Minister of Health announced an extension of the age eligibility of BreastScreen Aotearoa to include women aged 45–69 years. Staged implementation of the age extension to the programme commenced on 1 July 2004. In addition to extending eligibility, specific actions relating to coverage of the programme have the potential to reduce breast cancer mortality and therefore warrant immediate action. These include improved coverage for Māori and Pacific women, and increased coverage for North Island women.² Further strategies to improve coverage among Māori, Pacific and North Island women should be identified by the National Screening Unit.

Though not identified as specific actions below, strategies are also needed to ensure the participation of Māori and Pacific women in the National Cervical Screening Programme. These are likely to include work to identify issues of access, including cultural safety for these women. Despite a particular and ongoing effort by the programme to address this issue for over a decade, there remain inequities in coverage as well as in follow-up of women enrolled in the programme (Minister of Health 2003; Hugh Adam Cancer Epidemiology Unit 2004; Centre for Public Health Research 2004). These and other strategic issues relating to the breast and cervical screening programmes should be addressed by the yet-to-be established processes for high-level oversight of these programmes identified below.

² According to Cox and Sneyd 2004:

- extending BreastScreen Aotearoa to women aged 65–69 has the potential for a 28 percent reduction in breast cancer mortality among those aged 70–74 from screening in this age group (resulting in the prevention of 19 breast cancer deaths a year)
- an increase in coverage for Māori women from 45 percent to 70 percent would be expected to produce a 10 percent reduction in breast cancer mortality for Māori women aged 55–74 years
- an increase in coverage from 50 percent to 70 percent should result in an absolute reduction in North Island breast cancer mortality of 8 percent for women aged 55–74 years. (Two-thirds of all breast cancer deaths occur in the North Island: 171 deaths of women aged 55–74 a year.)

Action Table

Goal 2, Objective 1: At a national level, provide a strategic approach to cancer screening and the assessment and surveillance of those with familial risk to ensure quality, acceptability and effectiveness

Outcomes/results	Specific actions	Key stakeholders	Milestones/measures/phasing
36. High-level oversight of existing and potential cancer screening, and of the assessment and surveillance of those with familial risk.	Ensure effective processes for providing high-level strategic oversight of existing and potential cancer screening, and of the assessment and surveillance of those with familial risk.	Cancer Screening and Early Detection Working Group, Chair, NSAC, NSU and other key stakeholders.	Initial meeting of key stakeholders in <i>Phase 1</i> . Process in place by <i>end of Phase 1</i> .
37. Reduction in breast cancer mortality for Māori women aged 55–74 years.*	Identify and implement strategies to increase the coverage of BreastScreen Aotearoa for Māori women.	MOH, NSU, BSA lead providers, Māori health providers and independent service providers.	Strategies identified and implemented. <i>Phase 1</i>
38. Reduction in breast cancer mortality for Pacific women aged 55–74 years.	Identify and implement strategies to increase the coverage of BreastScreen Aotearoa for Pacific women.	MOH, NSU, BSA lead providers, Pacific health providers, independent service providers.	Strategies identified and implemented. <i>Phase 1</i>
39. Reduction in breast cancer mortality for women in the North Island aged 55–74 years.	Identify and implement strategies to increase the coverage of BreastScreen Aotearoa in the North Island.	MOH, NSU, BSA lead providers, Māori and Pacific health providers, independent service providers.	Strategies identified and implemented. <i>Phase 1</i>

* An increase in coverage for Māori women from 45 percent to 70 percent would be expected to produce a 10 percent reduction in breast cancer mortality for Māori women aged 55–74 years (Cox and Sneyd 2004).

Objective 2: Establish a process to assess the value of early detection of cancer other than that obtained through organised screening

Introduction

There is evidence that survival from some cancers (eg, melanoma and certain breast cancers) may be improved by early symptom identification and treatment, and that delays in presentation remain common among some population groups in New Zealand (Lawes et al 1999; Newman et al 1992). Therefore, early cancer detection by individuals and health care workers, coupled with timely referral for specialist assessment and investigation, is an important component of cancer control.

Although some cancers have early warning signs that are easily identified, many do not. Furthermore, diagnosis of a cancer before it appears to have spread does not always lead to an improved outcome. Therefore, early diagnosis efforts should be focused on those cancers where this has been shown to reduce cancer mortality or morbidity.

There has been a suggestion that overall cancer survival rates in New Zealand may be relatively poor and are worse for Māori than for non-Māori (Skegg and McCredie 2002). Currently the extent to which delays in diagnosis are contributing to New Zealand's high cancer mortality rates is unknown, particularly among Māori and Pacific peoples. Also, when promoting early presentation of symptoms and appropriate referral for diagnosis and treatment

of those with cancer, it is unclear which interventions have the potential to improve survival and quality of life.

New Zealand melanoma incidence and death rates are among the highest in the world (Bulliard and Cox 1996). Recent research suggests that interventions to promote the early detection of melanoma may have the potential to reduce deaths from melanoma. Survival decreases with increasing melanoma depth, but with very good prognosis (90 percent five-year disease-free survival) for tumours less than 1 mm thick (Scottish Executive Health Department 2001). In 1998/99 approximately 50 percent of invasive melanomas in New Zealand were diagnosed at <0.75mm. According to a recent analysis, a 10 percent shift in depth distribution from $\geq 0.75\text{mm}$ to <0.75mm depth would result in about 49 deaths prevented per year (Cox and Sneyd 2004).

Action Table

Goal 2, Objective 2: Establish a process to assess the value of early detection of cancer other than that obtained through organised screening

Outcomes/results	Specific actions	Key stakeholders	Timeframes/measures/phasing
40. Identification of those cancers for which early diagnosis is both feasible and is likely to lead to an improved outcome.	Review the literature to identify those cancers for which practicable early diagnosis reduces morbidity and mortality.	MOH, CSNZ and tertiary education institutes.	Literature review. <i>Phase 1</i>
41. Assessment of the extent to which delays in early detection and diagnosis are contributing to New Zealand's high cancer mortality rates, particularly among Māori and Pacific peoples. Identification of reasons for such delays, as a basis for future delay-reduction strategies.	Assess whether delays in early detection and diagnosis of these cancers are occurring in New Zealand, particularly among Māori and Pacific peoples and, if so, the reasons for such delays.	MOH (NZHIS), tertiary education institutes, RNZCGP, Māori and Pacific provider organisations, DHBs.	Research methodology developed. <i>Phase 1</i> Research completed. <i>Phase 2</i>

Outcomes/results	Specific actions	Key stakeholders	Timeframes/measures/phasing
<p>42. Identification of interventions with the potential to improve survival and quality of life.</p> <p>Identification of interventions with the potential to reduce inequalities in cancer mortality and morbidity in New Zealand.</p>	<p>Review the literature to identify and recommend strategies to increase early detection and diagnosis where that has proven to be advantageous.</p>	<p>MOH, CSNZ, tertiary education institutes, RNZCGP Māori and Pacific providers.</p>	<p>Literature review completed.</p> <p><i>Phase 1</i></p>
<p>43. Reduce deaths from melanoma in New Zealand.</p>	<p>Develop a strategic approach, including a literature review and workshop, to the early detection of skin cancer, including melanoma.</p>	<p>MOH, DHBs, CSNZ, HSC, NZDS, RNZCGP, tertiary education institutes and researchers.</p>	<p>Background document, including a survey of literature, developed.</p> <p><i>Phase 1</i></p> <p>Workshop of key stakeholders to develop policy and identify priorities for action.</p> <p><i>Phase 1</i></p>

Goal 3:

Ensure effective diagnosis and treatment of cancer to reduce morbidity and mortality

Objective 1: Provide optimal treatment for those with cancer

Objective 2: Develop defined standards for diagnosis, treatment and care for those with cancer

Introduction

The demand for cancer treatment continues to increase significantly. Between 1996 and 2011 the number of people presenting with cancer each year will increase by almost 50 percent. Alongside this there is the continued development of new treatments, which can extend the care available to many patients. Unfortunately in recent years the increase in resources devoted to cancer treatment has not matched the increase in demand, leading to undesirable and distressing delays in treatment, particularly for radiotherapy and chemotherapy, afflicting many parts of New Zealand. In particular, some studies have shown that delays are significantly worse for Māori.

Such delays will inevitably have a negative impact on the outcome of any treatment. Occasionally, delay may still occur because the patient has not recognised the significance of their symptoms, or has not sought medical advice, or through their perception

of barriers to obtaining such advice. A proportion of those with symptoms who do seek medical advice may not be referred appropriately. This may be due to many causes, which include the lack of referral guidelines for primary care providers.

Commonly there are no clear processes in place by DHBs to acknowledge the letters of referral, grade their urgency and provide timely appointments for consultation and diagnosis. Some clinics provide a rapid service, whereas for others long waits may occur. Increasingly, delays are attributable to workforce or other resource issues, although the organisation of services can vary greatly, and can contribute to some of the delays.

Recently published research suggests that our overall cancer survival may be inferior to that in Australia (Skegg and McCredie 2002). Given that this research surveyed a period when delays in accessing treatment were generally much less entrenched (1996–97 mortality rates), there is significant concern that our current treatment outcomes could be worsening in comparison with similar societies.

For those with suspected or proven cancer a multidisciplinary team approach has been shown to be of major benefit. This approach, plus the use of agreed guidelines and protocols, has improved outcomes. Appropriate standards need to be defined to ensure that all patients receive optimal care through an integrated and patient-centred approach.

The following section outlines mechanisms to address the delays in reaching a diagnosis and treatment, the need to define and implement appropriate quality and service standards for treatment, the establishment of a multidisciplinary team approach, and the requirement that all patients receive optimal standards of care. It defines measures to start to reduce the known inequities in cancer outcomes for certain important groups within our society (such as Māori and Pacific peoples), and the need to maintain our access to modern cancer treatments and to plan for the future.

Action table

Goal 3, Objective 1: Provide optimal treatment for those with cancer

Goal 3, Objective 2: Develop defined standards for diagnosis, treatment and care for those with cancer

Outcomes/results	Specific actions	Key stakeholders	Milestones/measures/phasing
44. Prompt presentation and timely diagnosis and treatment for all patients with suspected cancer.	Establish appropriate timeframes within which those with suspected cancer should be able to see a specialist for diagnosis, or for treatment.	MOH, DHBs, CTWP, professional groups eg, RACS, RANZCOG, RANZCR, NZCOG.	Timeframes established. <i>Phase 1</i>
	Cancer treatment providers review their procedures and checks for receiving and acknowledging referrals and providing timely appointments.	DHBs, cancer treatment providers.	Evidence that waiting times for appointment are being monitored and recorded. <i>Phase 1</i>
Reduction in delays in patients presenting with symptoms suggestive of possible cancer.	Planners and funders of cancer services support and appropriately fund Māori- and Pacific-led initiatives in cancer control to contribute to reducing delays in accessing treatment services. (Note: see also Goal 2, Objective 2.)	MOH, Māori providers, Pacific providers, DHBs, PHOs, clinical and professional groups, training organisations and institutions.	Standards and referral guidelines are developed and monitored to ensure that cancer related inequalities for Māori and Pacific peoples are being addressed. <i>Phase 1</i>
Appropriate referral and timely access for diagnosis and treatment for all those suspected of having cancer.	Better guidance, including referral guidelines for all referrers, GPs, other primary and secondary care Providers) on how to refer those with symptoms suggestive of cancer, and to whom.	DHBs, cancer treatment units, professional groups eg, RACS, RANZCR, RANZCOG, RACGP.	Evidence that DHBs have produced referral guidelines. <i>Phase 1</i>

Outcomes/results	Specific actions	Key stakeholders	Milestones/measures/phasing
	Develop a plan for the provision of diagnostic and treatment services within defined specifications. This plan should include a review of the 2001 report <i>Improving Non-surgical Cancer Treatment Services</i> , plus consideration of surgical and diagnostic limitations to timely cancer treatment.	DHBs, CTWP, professional groups eg. RACS, RANZCR, RANZCOG, RCPA.	Evidence of implementation of plan. <i>By end of phase 1</i>
	Cancer treatment providers monitor waiting times for all cancer treatments (ie, surgery, chemotherapy and radiotherapy).	DHBs, cancer treatment providers.	DHBs to report waiting times on a monthly basis. <i>Phase 1</i>
45. Improve access to diagnosis and treatment for those with recognised disadvantage, such as Māori and Pacific people, who have lower cancer survivals. (Note: see also Goal 5, Objective 2.)	Treatment providers continue to improve access and cultural acceptability of their services.	MOH, DHBs, PHOs, cancer collaboratives and regional networks, NGOs, Māori service providers, cancer service funders and planners, academic and professional groups, Pacific health care providers.	<i>Phases 1 and 2</i>
	Planners and funders of cancer services will prioritise the piloting of new initiatives aimed at reducing cancer related inequalities, particularly for Māori and Pacific peoples.		DHBs with iwi partners, and Māori and Pacific communities, will identify priority areas, incorporate into strategic plans and allocate resources. <i>Phase 1</i>
	Develop tools and high quality resources to assist service providers and health professionals to communicate effectively with Māori about cancer care.		Communication strategies or approaches for Māori are developed and implemented with Māori stakeholders. <i>Phase 1</i>

Outcomes/results	Specific actions	Key stakeholders	Milestones/measures/phasing
46. Cancer diagnosis and treatment are provided to defined standards and quality. Care is delivered to agreed standards.	Clinicians will be encouraged to use a case management approach to treatment for Māori and Pacific peoples. (Note: see also Goal 3, Objective 3.)	DHBs, clinicians, NGOs Māori service providers, cancer treatment centres, Pacific health care providers.	A case management approach for Māori and Pacific people is incorporated into service planning and delivery. <i>Phase 1</i>
	There is development of the service and quality standards required to provide high-quality cancer services.	MOH, DHBs, NZCTWP, professional groups (eg, RACS, RANZCR, RANZCOG, RACP, RCPA).	Service and quality standards available for implementation. <i>By end of Phase 1</i>
	Ensure the development of standards and guidelines for the diagnosis, treatment and management of cancer reflect and give priority to those cancers that contribute to the greatest disparities for Māori.		Priorities for Māori appropriately reflected in the developed standards and guidelines. <i>Phase 1</i>
	Ensure that the development of national standards includes a requirement for effective monitoring of cancer-related outcomes, inequalities and service responsiveness for Māori.	MOH, DHBs, PHOs, NGOs, Māori service providers, cancer service funders and planners, academic and professional groups, Pacific health providers.	Requirement for monitoring of specified cancer-related outcomes included in national standards. <i>Phase 1</i>

Outcomes/results	Specific actions	Key stakeholders	Milestones/measures/phasing
Quality of services is defined and able to be monitored.	DHBs develop a schedule for implementing diagnostic and treatment service and quality standards.	DHBs.	Schedule available. <i>Phase 1</i>
	Develop appropriate templates for the accreditation of cancer treatment services (ie. surgical, gynaecological, medical and radiation oncology and haematology services).	MOH, DHBs, NZCTWP, professional groups (eg, RACS, RANZCR, RANZCOG, RACP, RCPA).	Templates available. <i>Phase 1</i>
	Treatment providers establish an accreditation programme for all their cancer treatment services.	DHBs, cancer treatment providers.	Accreditation programme operating. <i>Phase 1</i>
47. Patients have appropriate access to a multidisciplinary team approach throughout their continuum of care.	Cancer treatment providers have documented procedures for the development and operation of a multidisciplinary team approach to diagnosis and treatment.	DHBs, cancer treatment providers.	Documented procedures for multidisciplinary approach. <i>Phase 1</i>
	DHBs, PHOs and cancer service providers will involve Māori and Pacific expertise and the range of relevant Māori service providers in multidisciplinary teams and networks, where possible.		
	Cancer treatment providers ensure that regular multidisciplinary case conferences are established to determine management of treatment and appropriate records are kept of this meeting.	DHBs, cancer treatment providers.	Regular multidisciplinary case conferences held. <i>Phase 1</i>

Outcomes/results	Specific actions	Key stakeholders	Milestones/measures/phasing
	Initially multidisciplinary and, where necessary, inter-regional care to be established for the management of: breast, rectal, head and neck, gynaecological cancers, bone and soft tissue sarcomas, and all cancers requiring multi-modality treatment. Such clinics to be subsequently extended to other appropriate cancers.	DHBs, NZCTWP, cancer treatment providers.	Treatment providers produce evidence that a multidisciplinary team approach is established (at least for those cancers specified). <i>Phase 1</i>
48. There is regional and national consistency of cancer diagnosis and treatment.	Where low patient numbers, rural areas and workforce issues mean it is not feasible to establish multidisciplinary teams, then appropriate referral guidelines and other linkages such as teleconferencing are established to ensure the availability of multidisciplinary input for common cancer sites.	DHBs, NZCTWP, cancer treatment providers.	Referral guidelines developed established. <i>Phase 2</i>
	All diagnostic and treatment providers are required to demonstrate a protocol/guidelines approach in patient diagnosis and management.	DHBs, cancer treatment providers, diagnostic services (pathology, radiology).	DHBs to ensure local/regional guidelines/protocols are in place for all major cancers. <i>Phase 1</i>
	Protocols and guidelines should be developed on both a regional and national basis.	MOH, DHBs, NZCTWP, professional groups (eg, RACS, RANZCR, RANZCOG, RACP, RCPA).	Initial national guidelines available. <i>Phase 2</i>
	A programme for the ongoing development of formal guidelines for cancer care is established.	MOH, DHBs, NZGG.	Plan for guidelines programme developed. <i>Phase 2</i>

Outcomes/results	Specific actions	Key stakeholders	Milestones/measures/phasing
49. There is increased participation in clinical trials.	All cancer treatment providers have an identified policy of supporting clinical trials and ensuring suitable patients are given the opportunity to enrol.	DHBs, cancer treatment providers, NZCOG.	Increased participation and accrual in approved trials. <i>Phase 2</i>
50. Seamless and patient-centred care is provided, avoiding fragmentation and duplication.	Refer Goal 3, Objective 3.		
51. There is appropriate introduction of new treatments, such that New Zealand continues to have access to modern therapies.	Continue to develop mechanisms for the systematic assessment and prompt introduction of proven new pharmaceutical cancer treatments.	MOH, NZCTWP, PHARMAC, DHBs.	Evidence of effective processes in place. <i>Phase 2</i>
	Systems are developed and introduced for the assessment and national introduction of new non-pharmaceutical technologies and techniques of cancer treatment.	MOH, NZCTWP, DHBs professional groups (eg, RANZCR, RACS).	Evidence of effective processes in place. <i>Phase 2</i>
52. There is ongoing advice on, and future planning of, cancer treatment services.	DHBs and the MOH review mechanisms for the ongoing planning of cancer treatment services on a national basis, ³ including the role of the NZCTWP, and agree on a process for obtaining advice on current treatment issues and planning for the provision of services to meet future demand.	MOH, DHBs, NZCTWP.	Treatment advisory group established and functioning. <i>Phase 1</i> Initial national strategic plan for cancer treatment services completed. <i>Phase 1</i>

³ National planning is needed because:

- demand for cancer treatment is predicted to continue to increase
- many services are provided on a regional or supra-regional basis
- the significant cost of provision of some services and capital investment requires national co-ordination to ensure effective utilisation of resources
- present waiting lists for oncology services are due in part to a failure to plan for increasing demand.

Outcomes/results	Specific actions	Key stakeholders	Milestones/measures/phasing
53. Define the need for highly specialised or national units to improve outcomes for those cancers requiring specialised management.	Review the need and feasibility of establishing specialised units for the treatment of specific cancers, or certain patient groups (eg, adolescent cancers, bone and soft tissue sarcoma, upper GIT, low rectal cancers, pancreas and bladder).	Surgical Treatment Working Group, NZCTWP, DHBs, MOH, professional groups.	Report and recommendations produced. <i>Phase 2</i>
	Review the need and feasibility of establishing specialised units for the management of genetically determined cancers, including pre-emptive (prophylactic) surgery for genetically related cancers such as thyroid (children) and stomach.	Surgical Treatment Working Group, NZCTWP, DHBs MOH, professional groups.	Report and recommendations produced. <i>Phase 2</i>
54. Define public entitlement for cancer treatment so there is certainty of treatments available.	There is public consultation to define public expectations of, and entitlement to, cancer treatments in the public health service.	MOH, DHBs.	Consultation document released. <i>Phase 1</i>

Objective 3: Ensure patient-centred and integrated care for those with cancer, their family and whānau

Introduction

After the development of symptoms suggestive of cancer or following screening, a patient is referred to an increasingly complex labyrinth of health services related to diagnosis, treatment of different types, rehabilitation and support, and possibly palliative care. Because many of these services have developed in a piecemeal fashion, service provision is uneven and fragmented. Better co-ordination of the mechanisms of referrals, improved integration of cancer care services and the evaluation of systems for care co-ordination will help to create a seamless and patient-centred service.

Pilot studies are required across different geographical areas and patient groups to map the patient's cancer journey, identify possible gaps and where improvements can be made. Patient-centred co-ordinators have been shown to help patients on their cancer journey. Different systems of patient care co-ordination need to be piloted and assessed and the most appropriate method of ensuring each cancer patient gets to where they need to be – and are supported in doing so – is accomplished. Some patient groups may require specialised advice to achieve this.

Good communication between primary, secondary and tertiary services is essential, and electronic records with computer link-ups between each service will help to achieve this in addition to the established networks. In some centres, such as New South Wales, patients frequently carry a Personal Health Record (PHR) which contains up-to-date information of their cancer diagnosis and care, in order to ensure continuity. The use of PHRs should be explored.

Patients do not always receive information about their cancer, its treatment or the various care options available to them in an appropriate manner and this is seen as a further barrier to effective utilisation of cancer services. Credible and accessible information delivered in a manner that suits each individual, is essential.

With the shift to ambulatory treatment for cancer and recognising that cancer is often a chronic condition, there is a need for well trained, knowledgeable and experienced health care professionals to be available in the community. Access to such professionals and who to contact outside normal working hours is very important for patients and their whānau.

Action Table

Goal 3, Objective 3: Ensure patient-centred and integrated care for those with cancer, their family and whānau

Outcomes/results	Specific actions	Key stakeholders	Milestones/measures/phasing
55. A co-ordinated and seamless cancer journey for the patient.	Ensure initial referral to cancer services is dealt with in a timely and appropriate fashion, with feedback to referring services.	(See Goal 3: Objective 2 and 3.)	
	Pilot studies to map and analyse current cancer patients' journey and clinical pathway across different regions and patient sub-groups to identify gaps and implement areas for improvement. UK tool kit a useful guide. www.nelh.nhs.uk/nsf/cancer/redesign	DHBs, NGOs, regional cancer networks.	Pilot studies commenced. <i>Phase 1</i>
	Pilot studies to evaluate different known systems of patient-care co-ordination to help decide the most appropriate. The Breast Care Nurses model is a common example.	DHBs, NGOs, regional cancer networks.	Pilot studies commenced. <i>Phase 1</i>
	Review the efficiency of existing cancer networks and implement improvements including the sharing of electronic records.	DHBs, NGOs, regional cancer networks, PHOs and other primary care providers.	Reviews commenced. <i>Phase 2</i>

Outcomes/results	Specific actions	Key stakeholders	Milestones/measures/phasing
56. Patients empowered to negotiate their way through the services and to make informed choices.	Review the extent of available information with a view to providing information to patients that is credible, understandable, and delivered in a style suitable for each individual: may be written, audio, video, or face to face. (Overlaps with Goal 4, Objective 4.)	NGOs, DHBs, consumer groups, CSNZ.	Recommendations of the review available. <i>Phase 2</i>
	Ensure information informs patients of their possible choices and respects the right of the individual to pursue complementary and alternative care.	DHBs, NGOs, CSNZ, consumer organisations.	(See Goal 4, Objective 4, Outcome 71)
	Evidence of focus on holistic care to ensure physical, emotional and spiritual needs are met.		<i>Phase 2</i>
57. Improved care in the community setting.	Ensure trained and experienced health professionals available.	(See Goal 5, Objective 1.)	
	Service providers will investigate and report on, the role of Māori and Pacific patient advocates, navigators or interventions to support them through treatment services and ongoing cancer management.	DHBs, NGOs, PHOs and other primary care providers.	Report completed. <i>Phase 1</i>
	Review what information is available to patients and their whānau about who to contact (especially after 5pm).	DHBs, NGOs, PHOs and other primary care providers, CSNZ.	<i>Phase 1</i>
	Identify what practical assistance is required for travel, accommodation, household chores and child care, and seek funding to help with these. (Note: see Goal 4, Objective 2, Outcome 63.)	DHBs, MOH, MSD, CSNZ, PHOs.	<i>Phase 1</i>

Objective 4: Improve the quality of care delivered to adolescents with cancer and their family and whānau

Introduction

Currently, in New Zealand, adolescence is broadly defined as ages 13 to 18 inclusive, although it is recognised that there are both individual patient and clinical considerations that impact on this definition, and that may reduce or extend this range. While it is difficult to be precise, it appears likely that about 100 adolescent patients are diagnosed with cancer each year.

At present paediatric oncology services generally treat patients up to and including age 15, while adult services manage those aged 16 and above. As adolescence straddles the age distinction between paediatric and adult services, there is no consistent, equitable pattern of referral and management for adolescents with cancer in New Zealand. As a result, referral may be ad hoc, depending on the interest of the oncologist, a judgement of maturity of the patient and the nature of the malignancy. Although some cancers are relatively specific to this age group (bone sarcomas), the majority are not, so that adolescents may suffer from paediatric-type or adult-type cancers.

A close positive correlation has been established between patient participation in clinical trials and outcome. While treatment patterns and outcome data for adolescents are not available for New Zealand, it is likely that similar patterns of care to those overseas currently occur in New Zealand. Data from the United States and United Kingdom have shown, for example, that in contrast with paediatric oncology (where clinical trial entry approaches 80 percent), fewer than 10 percent of adolescents benefit from participation in clinical trials. Three retrospective analyses (in France, the Netherlands and the US) have demonstrated significantly superior outcome for adolescents treated on paediatric acute lymphoblastic leukaemia protocols compared with adult protocols. The Adolescent/Young Adult subcommittee of the Children's Oncology Group in the United States is developing a range of clinical trials specific to this age group.

Adolescents with cancer have specific psychosocial needs, which are poorly addressed within the current arrangement of services. The diagnosis of cancer in the adolescent threatens to disrupt many of the maturational tasks desirable to attain adulthood. This results in increased dependence on caregivers; reduced peer contact and acceptance; disturbance of physical maturation and appearance; profound effects on developing sexual identity; and interrupted education and career plans. Between 20 and 30 percent of survivors of cancer during adolescence develop symptoms of post-traumatic stress disorder.

Action Table

Goal 3, Objective 4: Improve the quality of care delivered to adolescents with cancer and their family and whānau

Outcomes/results	Specific actions	Key stakeholders	Milestones/ measures/phasing
<p>58. Development of designated regional adolescent oncology services to provide co-ordinated care for adolescents with cancer, ensuring that standards of medical and psychosocial care are met.</p> <p>In particular regional adolescent oncology services will:</p> <ul style="list-style-type: none"> • ensure maximal accrual into age-specific clinical trials • provide multidisciplinary care • encourage the most appropriate medical personnel to treat a designated cancer • address the unique adolescent psychosocial needs • ensure fiscal responsibility • minimise disruption of family dynamics and finances • ensure prospective collection of data on adolescent cancer incidence, treatment and outcome • allow care across more than one site. 	<p>Establish a working group to:</p> <ul style="list-style-type: none"> • design the adolescent oncology services • set minimum standards for medical, nursing and psychosocial care of adolescents with cancer in New Zealand. <p>The working group will include representation from paediatric oncology, adult oncology, adult haematology, Canteen, Child Cancer Foundation, psychology, social work, nursing and appropriate palliative care services.</p> <p>Identify multidisciplinary teams to improve health outcomes through:</p> <ul style="list-style-type: none"> • improved rates of cure • improved compliance and behaviour • shorter duration of stay • reduction in psychosocial morbidity • improved educational outcomes. 	<p>MOH, DHBs, NZCTWP, professional groups.</p>	<p>Working group established. <i>Phase 1</i></p> <p>Working Group report completed. <i>Phase 1</i></p> <p>Regional adolescent oncology services established. <i>Phase 2</i></p>

Goal 4:

Improve the quality of life for those with cancer, their family and whānau through support, rehabilitation and palliative care

Objective 1: Establish integrated programmes of supportive care and rehabilitation with defined leadership

Objective 5: Ensure optimal independence and function for those with cancer through systematic assessment and appropriate multidisciplinary intervention for their social and vocational needs

Introduction

Supportive care and rehabilitation encompasses 'the essential services to meet the physical, emotional, nutritional, informational, psychological, sexual, spiritual and practical needs throughout a person's experience with cancer' (Minister of Health 2003). Needs include those of children, adolescents and adults with cancer, and of their families and whānau. Evidence shows that when people experiencing cancer receive good social, psychological and cultural support, their quality of life improves.

Although there are emerging multidisciplinary professional groups and networks of those involved in supportive care and rehabilitation, there is no existing national leadership and no established body with strategic responsibility or oversight of these areas. Also, despite considerable activity in supportive care and rehabilitation by both government and non-government organisations (some of which receive no government funding), currently across New Zealand there is:

- an absence of consistent service models most likely to lead to high-quality care and services
- fragmentation of services
- an absence of comprehensive needs assessment
- an inability to identify, at a national level, workforce requirements and research priorities.

Across New Zealand there is also inconsistency in the availability of supportive care/rehabilitation for children and adolescents with cancer, their families and whānau. There is also very limited access to specialised educational services for children with learning difficulties as a result of cancer or its treatment.

Guidance on Cancer Services: Improving supportive and palliative care for adults with cancer (National Institute for Clinical Excellence 2004) and the process by which it was developed (see Appendix 4) provide a useful model for improving the quality of care to those with cancer

and their families and whānau in New Zealand. The guidance (as distinct from clinical guidelines) 'aims to provide advice on how services should be configured to provide effective services to people with cancer'. Its purpose is to identify for government and non-government agencies involved in service planning the models most likely to lead to high-quality care and services for people with cancer and their carers. In New Zealand, existing tools (eg, the Health Equity Assessment Tool) should be applied to proposed service models (Te Rōpū Rangahau a Eru Pōmare et al 2003).

Action Table

Goal 4, Objective 1: Establish integrated programmes of supportive care and rehabilitation with defined leadership

Goal 4, Objective 5: Ensure optimal independence and function for those with cancer through systematic assessment and appropriate multidisciplinary intervention for their social and vocational needs

Outcomes/results	Specific actions	Key stakeholders	Milestones/measures/phasing
<p>59. There is ongoing national leadership of supportive care and rehabilitation</p> <p>There is supportive care and rehabilitation recognised at a strategic level as having an integral role in cancer care</p> <p>There is improved implementation of the objectives and actions relating to supportive care and rehabilitation.</p>	<p>Establish a national supportive care committee.</p>	<p>CSNZ, CCF and other NGOs, DHBs, PHOs, professionals involved in services to meet supportive care and rehabilitation needs (see Addendum), MOH.</p>	<p>A national supportive care committee, with appropriate administrative support.</p> <p><i>Phase 1</i></p>

Outcomes/results	Specific actions	Key stakeholders	Milestones/measures/phasing
<p>60. Supportive care and rehabilitation are an integral component of cancer care.</p> <p>Existing services are maximised, and there is consistency in availability of, and access to, services.</p> <p>Effective service models and standards developed to assess the range of services provided.</p> <p>Ability to identify workforce requirements, workforce development needs and research priorities.</p>	<p>Establish a working group to develop guidance* on supportive care and rehabilitation services for adults with cancer, and their carers.</p> <p>(This action incorporates services to address Goal 4, Objective 5: Ensure optimal independence and function for those with cancer through systematic assessment and appropriate multidisciplinary intervention for their social and vocational needs).</p>	<p>MOH, DHBs, PHOs, CSNZ, professionals involved in services to meet supportive care and rehabilitation needs (see Addendum).</p>	<p>A working group with the ability to co-opt expertise established by the National Supportive Care Committee.</p> <p><i>Phase 1</i></p>

*Guidance is advice on how services should be configured to provide effective services to people with cancer.

Outcomes/results	Specific actions	Key stakeholders	Milestones/measures/phasing
<p>61. Supportive care and rehabilitation are an integral component of cancer care and management for children and for adolescents with cancer, their families and whānau.</p> <p>Existing services are maximised, and there is consistency in availability of, and access to, services.</p> <p>Effective service models and standards developed to assess the range of services.</p> <p>Ability to identify workforce requirements, workforce development needs and research priorities.</p>	<p>Establish a working group to develop guidance* on supportive care, rehabilitation and palliative care services for children and adolescents with cancer, and their carers.</p> <p>(This action to be implemented alongside the development of a comprehensive late-effects programme for survivors of childhood cancer specified in Goal 4, Objective 3.)</p>	<p>Paediatric Oncology Steering Group, CCF, Late Effects Working Group of the Paediatric Oncology Steering Group.</p>	<p>A working group with the ability to co-opt expertise established by the national supportive care committee.</p> <p><i>Phase 1</i></p>

*Guidance is advice on how services should be configured to provide effective services to people with cancer.

Addendum: Professionals involved in services to meet supportive care and rehabilitation needs

A wide range of professionals are involved in services to meet supportive care and rehabilitation needs. Although some are part of a dedicated oncology workforce, for most the provision of support for people with cancer forms only a small part of their workload. In addition, friends, family, volunteers and community-based services provide significant care.

Although all those associated with cancer care potentially contribute to the processes and practices of supportive care and rehabilitation, those most likely to be involved can be clustered into the following groupings.

- *Allied health and rehabilitation services* – those who provide services to meet rehabilitation needs (eg, physiotherapists, occupational therapists, dieticians, speech language therapists, Māori health workers, play therapists, educational service providers, ostomy therapists and psychologists).
- *Supportive services* – those whose prime role is to identify practical needs of patients and families and either address and/or refer appropriately, for example for financial assistance, travel and accommodation subsidies, income support and information. Professionals include social workers, Māori health workers, primary health providers, NGO support service staff and oncology information nurses. They may also provide psychosocial services.
- *Psychosocial services* – those whose role it is to provide psychological and social therapeutic interventions to meet the psychosocial needs of patients and their families, including counsellors, psychologists (in both the government and NGO sectors), Māori health workers, peer support groups, and pastoral care workers.
- *Cultural services* – those services whose role is to provide liaison and advocacy to meet the cultural needs of those with cancer and their families. This does not preclude the need for all services to demonstrate a level of cultural competency. Services being delivered to Māori need to reflect an understanding of hauora Māori and approaches that appropriately address Māori health needs.

Objective 2: Ensure people with cancer and their families and whānau are able to access the appropriate resources for support and rehabilitation that they need

Introduction

Information gathered during the development of the Cancer Control Strategy has highlighted the fact that access to necessary resources for support and rehabilitation provided by both the government and non-government sectors is inconsistent throughout the country. In some situations, even within the same region, resource availability may be dependent on the 'local knowledge' of health professionals. There are indications that some people who have repeated difficulty in accessing resources eventually 'give up' as the process is too fraught.

Resources for support and rehabilitation may be required throughout a cancer illness and may be just as necessary for those who are undertaking or have completed treatment as for those receiving palliative care. Resources required may vary across the lifespan and need to ensure quality care and support for all people with cancer, including children, young people and adults. Children and young adults, for example, may have particular resource needs relating to education and employment.

A key issue of concern over many years is the inequitable funding of travel and accommodation costs for those with cancer (and the families of children with cancer) who must travel outside their region for specialist care and support. Another issue concerns the exclusion of people with cancer from centrally provided government funding for disability support services, as they do not meet the definition of a 'person with a disability'. Access to and funding for equipment, household support, home visits by professionals, respite care, carer support and residential care all vary across ages and regions. People also report difficulties accessing the appropriate financial support available through Work and Income New Zealand.

These, along with other issues, illustrate the current lack of an integrated approach to resources for support and rehabilitation, which may well result in less than optimum social outcomes for patients and survivors. Individuals, families and whānau may be financially disadvantaged, which in turn may result in unnecessary or prolonged use of public and other hospital beds when other solutions are available. Also, it is clear that the difficulties relating to access of resources by Māori, Pacific peoples and their families and whānau, as well as those in low socioeconomic groups, are often unacknowledged and, as a consequence, some needs may be largely unmet.

There is a need to assess the current problems relating to access to support and rehabilitation resources, to identify the process by which these could be addressed, and to identify the responsibilities of government and non-government sectors in this process.

A three-tiered approach is proposed to address these issues.

1. A national intersectoral approach: people with cancer and their family and whānau often require resources from several government and non-government agencies. To maximise utilisation and efficacy these ministries and organisations need to work together to identify and address resource needs and to ensure national consistency and co-ordination.
2. A national health sector approach: people with cancer and their family and whānau are affected by current structures within the health sector. Resources are available from different funding sources, including the Ministry of Health, DHBs and the Ministry of Social Development. Consequently, access to resources is often dependent on diagnosis rather than need. Issues of inconsistency, duplication and fragmentation need to be addressed within the health sector.
3. Regional approaches: each cancer network needs to develop a local plan to address the local support and rehabilitation resources needs of people with cancer. This needs to take into account the local population, the resources currently available and future needs.

Action Table

Goal 4, Objective 2: Ensure people with cancer and their families and whānau are able to access the appropriate resources for support and rehabilitation that they need

Outcomes/results	Specific actions	Key stakeholders	Milestones/measures/phasing
62. Formalised intersectoral commitment to the provision of support and rehabilitation resources made.	Establish a national intersectoral group with a formal commitment to working in a co-ordinated and collaborative way to identify and address the resource needs of those with cancer and their families and whānau. Membership would include the Ministries of Health, Education and Social Development, together with DHBs and NGOs.	MOH, MOE, MSD, DHBs, CSNZ, CCF, HNZ, PHOs and primary care service providers, Paediatric Oncology Steering Group, NZPHA, consumer groups, regional cancer treatment centres, adult oncology services.	Establishment of group and first meeting. <i>Phase 1</i>

Outcomes/results	Specific actions	Key stakeholders	Milestones/measures/phasing
<p>63. Improved understanding of current policy and practice in the provision of resources relating to support and rehabilitation.</p>	<p>The intersectoral group oversees the collection of information relating to current issues affecting access to support and rehabilitation resources and prepares a scoping document which:</p> <ul style="list-style-type: none"> • defines the scope of resources relating to support and rehabilitation • documents current government and non-government policies and practices regarding provision of and eligibility to these resources (what should be available, from whom, to whom and according to what criteria) • identifies inconsistencies and anomalies in policy and practice • identifies significant variations in practice that need to be addressed • identifies how the above areas impact specifically on people with cancer and their families across the lifespan. 	<p>MOH, MOE, MSD, DHBs, CSNZ, CCF, HNZ, PHOs and primary care service providers, Paediatric Oncology Steering Group, NZPHA, consumer groups, regional cancer treatment centres, adult oncology services.</p>	<p>Scoping document completed. <i>Phase 1</i></p>
<p>64. Reduction in variations in practice in the provision of resources for support and rehabilitation.</p> <p>Support and rehabilitation availability that best targets needs.</p>	<p>The intersectoral group identifies:</p> <ul style="list-style-type: none"> • how significant variations in practice according to current policy can be addressed • the respective roles of government and non-government agencies in addressing these variations • the funding implications of achieving greater consistency and providing the highest level of support. 	<p>MOH, MOE, MSD, DHBs, CSNZ, CCF, HNZ, PHOs and primary care service providers, Paediatric Oncology Steering Group, NZPHA, consumer groups.</p>	<p>Project plan with a commitment to implementation by relevant agencies completed. <i>Phase 1</i></p>

Outcomes/results	Specific actions	Key stakeholders	Milestones/measures/phasing
65. All people with cancer receive resources based on need rather than diagnosis.	Establish a national working party to identify and address issues of fragmentation and dual funding streams within the health sector.	MOH, DHBs, relevant service providers and consumer representatives.	Establishment of national working party. <i>Phase 1</i>
66. All regions will develop and implement a support and rehabilitation resource plan for those with cancer and their families and whānau.	Within each proposed regional cancer network, establish an intersectoral group with a formal commitment to working in a co-ordinated and collaborative way to identify and address the resource needs of those with cancer and their families and whānau within the region. Membership would include representatives of DHBs, NGOs and the Ministries of Social Development and Education.	DHB funding and planning, cancer treatment centres, DHB community services, PHOs, CSNZ, CCF, local hospice/palliative care services, Hospital Palliative Care Association, NZPHA, local representatives of MSD, MOE, consumer organisations, Māori providers, Pacific providers, regional cancer networks.	Establishment of regional intersectoral group. <i>Phase 1</i>
67. Further policy is developed to better meet the resource needs of those with cancer and their families.	Assess current policy and practice in the provision of resources relating to support and rehabilitation.		A document that outlines current policies and practice and sets out current inconsistencies and anomalies developed. <i>Phase 1</i> New and/or amended policy relating to resources for support and rehabilitation developed. <i>Phase 2</i>
68. Easy access to a database of resources available in each network for patients, families and professional staff.	Develop a database of services available in each network. Develop systems to disseminate this information. Develop systems to keep the database current.		Information on available local services easily accessed. <i>Phase 1</i>

Outcomes/results	Specific actions	Key stakeholders	Milestones/measures/phasing
69. Support and rehabilitation resources required by Māori, Pacific and other ethnic groups defined.	Develop reference groups to identify the specific factors that impact on access to support and rehabilitation resources for each group.	DHBs (community services), PHOs, Māori providers, Pacific providers CSNZ, CCF, local hospice/palliative care services, Hospital Palliative Care Association, NZPHA, local representatives of MSD, MOE, consumer organisations.	Document on factors impacting on access completed. <i>Phase 1</i>

Objective 3: Ensure all survivors of childhood and adolescent cancer receive timely and ongoing support and rehabilitation, including the early identification of, and intervention in, late effects

Introduction

Although remarkable improvements in survival rates for malignancies of childhood have been achieved over the last 30 years, many survivors of childhood and adolescent cancer have major physical and psychological sequelae. If these medical and psychological issues are not identified early and addressed there may be a serious loss in quality of life. The impact of such late effects of the disease or its treatment will, without planned intervention, inevitably result in increased utilisation of other social and health services in New Zealand.

The late effects of cancer in childhood and adolescence vary in type and severity according to the specific cancer, the treatment given and the age of the child during therapy. For example, radiation therapy to the whole brain given to a five-year-old child for a brain tumour will inevitably cause impairment of cognitive function and a decline in intellectual and academic ability. Additional medical complications may include infertility, impaired growth, and renal and heart problems. As the young person moves into adulthood they are likely to experience difficulty in

gaining employment, have a higher risk of depression and may be disenfranchised because of their past medical history (Mostow et al 1991; Li et al 1984; Yebby et al 1989). Such discrimination impacts very negatively on their mental wellbeing and their efforts to become independent and productive members of society.

A comprehensive survivorship programme is required to ensure the late effects of childhood and adolescent cancer are assessed and addressed in a systematic and consistent manner in the three Paediatric Oncology Centres and their regional outreach centres. A survivorship programme will also address the multiple transition issues faced by young adults as they progress beyond child and adolescent services into adult primary and secondary care.

Since its establishment in 2003, the Late Effects Working Group of the Paediatric Oncology Steering Group has been designing a comprehensive survivorship programme for the long-term follow-up of children and adolescents with cancer.

The cancer survivorship programme is anticipated to include:

- a comprehensive medical assessment of treatment-related toxicity, including assessment of growth, development and reproductive health
- access to psychological services
- an educational needs assessment (Ministry of Education) and the development of specific programmes to ensure the best long-term educational outcome
- a personalised 'health passport' documenting the diagnosis, its treatment and long-term complications
- a personal health education plan

- a transition plan from paediatric and adolescent oncology services into adult primary and secondary care services.
- access, where appropriate, to work programmes as a transition from the education sector to the workforce
- providing follow-up as close to the patient's home as is possible.

The Paediatric Oncology Steering Group proposes that, once developed, the programme should be piloted for two years in the Paediatric Oncology Centres before being established on an ongoing basis.

Action Table

Goal 4, Objective 3: Ensure all survivors of childhood and adolescent cancer receive timely and ongoing support and rehabilitation, including the early identification of, and intervention in, late effects

Outcomes/results	Specific actions	Key stakeholders	Milestones/measures/phasing
70. Early identification and remedial action of problems in children and adolescents treated for cancer, through a high-quality and long-term surveillance programme.	Implement and evaluate a pilot survivorship programme for the long-term follow-up of children and adolescents with cancer.	Paediatric Oncology Steering Group, CCF, Canteen, adult oncology services, MOH, DHBs, MOE.	<p>Establish pilot programmes in each of the tertiary centres as early as possible.</p> <p><i>Phase 1</i></p> <p>Pilot programme milestones in early Phase 1 include:</p> <ul style="list-style-type: none"> • establishment of late effects clinics • development of a comprehensive medical IT prototype • development of comprehensive psychosocial assessment • development of a comprehensive education assessment package • development of the package of appropriate neuro-psychology tests.

Objective 4: Ensure that those with cancer and their family and whānau have access to high-quality information on treatment and care, including complementary and alternative medicine (CAM)

Introduction

People with cancer, and those who may have cancer, need high-quality and comprehensive information on cancer treatment, care and support, including complementary and alternative approaches, to make well-informed decisions about the course of action that is most appropriate for them. The information needs to be consumer-centred, easily accessible, accurate and up to date, based on the evidence available, and include the range of options relevant to the situation.

The information should also clearly define the benefit or lack of benefit of all therapies associated with cancer treatment including complementary and alternative medicine (CAM) and conventional cancer therapies.

A national information plan is needed to meet consumer's information needs, and to assist health professionals involved in cancer care to provide informed, comprehensive and explicit guidance to their patients. To support the development of a plan there needs to be a national stocktake of current cancer information and cancer information services available (eg, telephone information

services); an analysis of the quality of existing information and the identification of any gaps; a robust process for the development, assessment and updating of information; and a systematic process for disseminating information so it is accessible to consumers in an equitable manner.

Government, non-government and consumer organisations with an involvement and interest in cancer need to work collaboratively to develop a national mechanism for disseminating high-quality information about cancer treatment and care that includes information about effective and ineffective cancer therapies. In an effort to move towards a more integrated approach, it is appropriate that cancer treatment services and cancer care organisations report periodically on progress towards the integration of complementary and conventional therapies in their jurisdictions.

Although there is generic research about information needs, research is required that looks specifically at the information needs of consumers who have been diagnosed with cancer. The Ministerial Advisory Committee on Complementary and Alternative Health (MACCAH) has identified the need to fund research on the needs of consumers for CAM information. This would provide important guidance for the development of appropriate information for consumers with cancer. There will also be benefits in commissioning research to determine the most efficient and effective way for cancer treatment services and organisations to provide comprehensive advice on all therapies that may be of benefit to their cancer patients.

Action Table

Goal 4, Objective 4: Ensure that those with cancer and their family and whānau have access to high-quality information on treatment and care, including complementary and alternative medicine (CAM)

Outcomes/results	Specific actions	Key players	Milestones/measures/phasing
71. Establishment of a national standard for the development, dissemination and review of consumer information across the cancer control continuum.	<p>Identify core principles and criteria to guide the development of a national standard and formal endorsement of consumer information, including:</p> <ul style="list-style-type: none"> • identifying the ideal frequency for reviewing information • ways that consumers will be involved • how cultural aspects and language needs will be addressed • methods of disseminating information • appropriate formats <p>Evaluate the suitability of existing tools for assessing the quality of information suitable for consumers (eg, DISCERN, NICE, AGREE) or identify changes or new tools needed that will be acceptable for the New Zealand setting.</p> <p>Identify particular issues for Māori in determining quality and meaningful consumer information.</p>	MOH, DHBs, CSNZ and other NGOs.	Development and promulgation of a national standard. <i>Phase 1</i>

Outcomes/results	Specific actions	Key players	Milestones/measures/phasing
72. Stocktake, recording and assessment of cancer information resources available and in use in New Zealand.	<p>Gather current cancer information resources in use for inclusion on a national cancer consumer information register by inviting providers and other relevant groups to submit resources provided to patients/consumers.</p> <p>Assess information for endorsement as meeting the national standard.</p> <p>Establish a central national register (database) of all cancer information to provide a clearing house role, enable gaps to be identified and duplication avoided.</p>	MOH, CSNZ and other NGOs, providers and community groups.	<p>Stocktake completed. <i>Phase 1</i></p> <p>Database established. <i>Phase 2</i></p> <p>Process established for assessment and endorsement of information. <i>Phase 2</i></p>
73. Consumers have access to quality cancer-related information that meets the national standard.	<p>Assess and monitor the quality of cancer information for New Zealand consumers.</p> <p>Evaluate existing tools for assessing the quality of information suitable for consumers (eg DISCERN, NICE, AGREE) or identify changes or new tools needed that will be acceptable for the New Zealand setting.</p> <p>Assess overseas information and adapt where appropriate.</p>	MOH, tertiary education institutes.	<p>Mechanism identified to assess and monitor information. <i>Phase 1</i></p> <p>Recommendations for standards published. <i>Phase 1</i></p> <p>Approved standard published. <i>Phase 2</i></p>

Outcomes/results	Specific actions	Key players	Milestones/measures/phasing
74. Information for consumers with cancer will be comprehensive, evidence-based and reflect an integrated approach, combining self-help, CAM, and biomedical information.	<p>Provide a comprehensive range of quality evidence-based information in different formats.</p> <p>This will involve a combination of identifying existing resources and gaps where information needs to be developed.</p>	MOH, CSNZ and other NGOs, DHBs.	<p>Evaluation of approach used, and consumer utilisation.</p> <p><i>Phase 2</i></p> <p>Approved information accessible on-line.</p> <p><i>Phase 2</i></p>
75. Increase provider compliance with Code of Health and Disability Services Consumers' Rights in all health professional settings. Quality information available for consumers within clinical settings.	<p>Emphasise the importance of quality information for consumers, to achieve provider compliance with the Code of Health and Disability Services Consumers' Rights in all health professional education and training programmes.</p> <p>Emphasise the importance of quality information for consumers within the clinical practice integrated care approach.</p> <p>Include a include a focus on consumer information and training in communication skills in professional development and training programmes for health practitioners.</p>	MOH, DHBs, Health and Disability Commissioner, consumer groups, health professional groups, NGOs.	<p>Links established between the development of consumer cancer resources, the education of health practitioners, and the application and use of this information in clinical practice.</p> <p><i>Phase 2</i></p> <p>Training module developed for use in health practitioner education.</p> <p><i>Phase 2</i></p>

Objective 6: Continue to improve access to essential palliative care services that provide appropriate symptom relief and emotional, spiritual, cultural and social support for those with cancer and their family and whānau

Objective 7: Ensure an integrated and comprehensive service is provided to all those with cancer who require palliative care and their family and whānau

Introduction

The WHO (2002) holds that not only should palliative care be a central feature of all good clinical practice, but it should also be given priority status within public health and disease-control programmes. There is now widespread recognition that the principles of palliative care should be applied as early as possible in the course of any chronic, ultimately fatal illness.

In New Zealand, palliative care is provided by a range of health professionals, including primary health care, hospital clinicians and community-based organisations such as hospices. Although community organisations are partially funded by government,

substantial support is derived from public donation, fundraising and voluntary assistance.

The New Zealand Palliative Care Strategy (Minister of Health 2001) was developed to establish a systematic and informed approach to funding and providing palliative care in New Zealand. The first stage of the implementation of the strategy has gone some way to increasing access to palliative care services. The New Zealand Cancer Control Strategy identifies palliative care as an integral component of cancer care (Minister of Health 2003). The Expert Working Group on Palliative Care (2003), which provided advice for the development of the Strategy, identified a number of remaining barriers that prevent people receiving appropriate care, including:

- the lack of a palliative care approach by some cancer service providers, leading either to no referral or late referral to palliative care services
- uneven distribution of palliative care services throughout the country, resulting in service gaps, particularly in rural areas
- barriers to access, especially for Māori and Pacific peoples
- a lack of services specifically designed for children and adolescents.

The first priority identified by the Strategy is the need to ensure that essential palliative care services are available for all dying people. However, as yet, not every person in New Zealand can access the level of palliative care they need. Essential palliative care services include:

- assessment (initial and ongoing)
- care co-ordination

- clinical care (community-based nursing and medical management)
- inpatient care
- bereavement and spiritual care
- support care (in the home or in long-term residential care).

Service specifications and a service (costing) model have been developed for some palliative care services (eg, hospices). There are other services, such as hospital palliative care and support care, for which such guidance is yet to be developed. There is a need to develop minimum service levels (eg, the specified number of palliative care beds and trained personnel) for essential and specialist palliative care services within each DHB and within the cancer treatment region. The financial and human resources required to meet these service levels need to be identified.

A review by the Health Funding Authority (1999) identified that there was very little co-ordination and integration of palliative care services. Since the introduction of the New Zealand Palliative Care Strategy, some DHBs and providers have been working to improve this situation, but there is still some way to go.

Lack of co-ordination and inflexibility of services can result in:

- people not being able to access the full range of palliative care services
- inappropriate care (eg, hospital care when hospice or community care may be more appropriate and desirable)
- repeated inappropriate hospital admissions for some people in their last few months of life

- inefficient delivery of services (eg, some people have been visited by more than four providers in a single day (Health Funding Authority 1999)), including fragmentation and duplication of services
- an inability to provide flexible packages of care that are specific to an individual's (or family's and whānau) needs
- older people and people living alone having problems accessing services.

In order to provide a more co-ordinated and effective palliative care service for all New Zealanders, a structure is required to integrate the broad range of professionals and services involved in the care of a person with cancer at all levels. An agreed data collection system is also required to begin a system of benchmarking against critical access and service criteria so that necessary adjustments can be made.

Action Table

Goal 4, Objective 6: Continue to improve access to essential palliative care services that provide appropriate symptom relief and emotional, spiritual, cultural and social support for those with cancer and their family and whānau

Goal 4, Objective 7: Ensure an integrated and comprehensive service is provided to all those with cancer who require palliative care and their family and whānau

Outcomes/results	Specific actions	Key stakeholders	Milestones/measures/phasing
76. The New Zealand Palliative Care Strategy will be implemented.	Ensure palliative care goals and objectives outlined in the Cancer Control Strategy (which reflect those developed in the Palliative Care Strategy) will be incorporated into DHBs' annual plans.	MOH, DHBs, PHOs, HNZ, HPCNZ, NZCTWP, NZPHA, cancer centres.	Palliative care plans developed and implemented in each DHB. <i>Phase 1</i>
77. Access to palliative care for people with cancer from specific underserved populations will increase and will be delivered in an appropriate manner.	<p>Identify and address barriers to access to palliative care services by those with limited or difficult access (eg. Māori and Pacific peoples, children, those living in rural areas).</p> <p>Involve Māori, Pacific and members of other significant ethnic groups in the planning of their local/regional palliative care services.</p> <p>Involve paediatric services and consumers in the planning of local/regional palliative care services. The option of centralised national planning for paediatric and adolescent palliative care to be explored.</p> <p>Involve rural primary health care professionals and consumers in the planning of local/regional services where appropriate.</p> <p>Ensure the public is adequately informed about the extent of palliative care services through local and national information campaigns.</p>	MOH, DHBs, PHOs, HNZ, HPCNZ, NZCTWP, NZPHA, Māori, Pacific and other underserved communities and service providers, Paediatric Society of New Zealand, Paediatric Oncology Steering Group, paediatric palliative care consumers, rural consumers and other community organisations.	<p>Strategy to reduce barriers to access included DHBs /cancer networks plans. <i>Phase 1</i></p> <p>Access rates for those groups identified as having poor access being monitored locally and nationally. <i>Phase 1</i></p> <p>Systems for informing providers and the public about the availability of palliative care services in place in each DHB/cancer network. <i>Phase 1</i></p>

Outcomes/results	Specific actions	Key stakeholders	Milestones/measures/phasing
<p>78. Access to and need for palliative care services will be appropriately monitored.</p> <p>(Note: see also Goal 6, Objective 2, Outcome 112.)</p>	<p>Develop and implement a national minimum palliative care data set.</p>	<p>MOH, DHBNZ and DHBs, HNZ, HPCNZ, NZCTWP, NZPHA, NZHIS.</p>	<p>Data collection to facilitate the building of a national minimum data set on palliative care services completed.</p> <p><i>Phase 1</i></p> <p>The national minimum dataset being used to monitor outcomes in DHBs and cancer networks.</p> <p><i>Phase 2</i></p> <p>Service gaps and prioritisation benchmarking system in place.</p> <p><i>Phase 2</i></p>
<p>79. A system and structure for national leadership in palliative care will be developed for the Cancer Control Strategy.</p>	<p>A group will be formed to ensure the implementation of the New Zealand Palliative Care Strategy and the relevant objectives of the Cancer Control Strategy.</p>	<p>MOH, DHBs and DHBNZ, PHOs, HNZ, HPCNZ, professional groups, NZPHA, NZCTWP, consumer groups.</p>	<p>Group established.</p> <p><i>Phase 1</i></p>

Outcomes/results	Specific actions	Key stakeholders	Milestones/measures/phasing
<p>80. National standards for service provision will be developed and implemented at local and network levels.</p> <p>(See also related Goal 3, Objective 4: Care of children and adolescents, and Goal 4, Objectives 1 and 2 and Goal 5, Objective 1.)</p>	<p>A working group will:</p> <ul style="list-style-type: none"> define specialist palliative care (both direct patient care and education of other health care providers) and determine its appropriate spread across regions and hospitals determine the service capacity and minimum qualification levels of staff working in essential and specialist palliative care determine appropriate levels of service for a given population (ie, specialist and generalist staff, palliative care beds) provide guidance on appropriate referral criteria and systems contribute to and integrate with actions in Goal 4, Objective 2, relating to supportive care. 	<p>MOH, DHBs, PHOs, HNZ, HPCNZ, professional groups (including ANZSPM, palliative care nurses forum, counselling, social work, pastoral care workers, and other national groups), NZPHA, NZCTWP.</p>	<p>Development of national population-based/weighted palliative care service standards. <i>Phase 1</i></p> <p>Implementation of standards. <i>Phase 2</i></p>
<p>81. Palliative care services will be appropriately resourced and delivered.</p>	<p>Review and update the current hospice palliative care service model (costing model) and expand the model to include all palliative care services eg, primary health care, hospital care and support care.</p> <p>Develop and implement service specifications for all palliative care services.</p>	<p>MOH, DHBs and DHBs, PHOs, HNZ, HPCNZ, NZPHA, NZCTWP, residential care and support services.</p>	<p>Recommendations developed and implemented. <i>Phase 1</i></p> <p>Minimum service levels defined (see above). <i>Phase 1</i></p> <p>Minimum service levels monitored. <i>Phase 2</i></p>

Outcomes/results	Specific actions	Key stakeholders	Milestones/measures/phasing
82. Improved communication, integration and co-ordination of cancer services between patients family/whānau and services.	<p>Each DHB will have local and regional palliative care networks in operation which develop and implement:</p> <ul style="list-style-type: none"> • a clear cancer-related palliative care plan • referral system guidance • agreements re a local system of care co-ordination • agreed communication systems • a local service directory • local audit and monitoring activities. <p>Integration with palliative care to be an accreditation requirement for cancer services.</p>	MOH, DHBs, PHOs, local hospice/ palliative care providers, relevant cultural and consumer groups, and cancer treatment services.	<p>Each DHB will have a palliative care network in place.</p> <p><i>Phase 1</i></p> <p>All patients will be able to name a key palliative care worker.</p> <p><i>Phase 1</i></p> <hr/> <p>Eighty percent or more of services accredited.</p> <p><i>Phase 2</i></p>
83. Support care will be easily accessed, no matter where a person lives, or their age.	A palliative care group will be established to contribute to the planning and implementation of actions relating to Goal 4: Objectives 1 and 2 which relate to service guidance and resourcing support care.	CSNZ, MOH, MSD, HNZ, DHBs and DHBNZ, CCF, NZPHA, PHOs and other primary care providers, consumer groups.	First meeting of group. <i>Phase 1</i>

Goal 5:

Improve the delivery of services across the continuum of cancer control, through effective planning, co-ordination and integration of resources and activity, monitoring and evaluation

Objective 1: Develop a co-ordinated national cancer workforce strategy

Introduction

Recruitment, training and retention of the necessary expert cancer control workforce are essential to the delivery of cancer services and to the implementation of the New Zealand Cancer Control Strategy. At present, shortages of specialist professional staff in many areas of cancer care are affecting our ability to provide timely and effective prevention, diagnosis, treatment, support and palliative care for people and their families experiencing cancer. This section of the Action Plan identifies some actions that should be taken promptly in relation to some of those deficiencies where there is strong evidence of need. Shortages in other professional groups also undoubtedly exist. These will be quantified by the proposed stocktake of the cancer control workforce and addressed in the proposed workforce development plan.

There is also a need for balanced cultural representation in the cancer control workforce. Māori and Pacific peoples are substantially under-represented in the health workforce in general, as well as in the various services and activities related to cancer control. It is therefore proposed to increase the intake of Māori and Pacific students into bridging programmes between school

and study for degrees related to health, like those at The University of Auckland.

The demand for cancer control services will continue to increase as the population ages and increases in size. The increasing burden of cancer and inequalities with respect to Māori and Pacific peoples are summarised in the New Zealand Cancer Control Strategy (Minister of Health 2003) and detailed in Cancer in New Zealand: Trends and projections (Ministry of Health 2002).

A variety of ministerial (eg, Health Workforce Advisory Committee), Ministry of Health (eg, Public Health Workforce Action Plan), DHB (eg, Workforce Development Group) and professional organisations (eg, the medical colleges and other professional groups) are currently undertaking surveys of the health workforce to estimate future health workforce needs. The stocktake proposed in this Action Plan will define the current paid and voluntary workforce involved in the various aspects of cancer control. This information on current numbers, recruitment and retention issues will be used, together with agreed international benchmarks, to develop a cancer control workforce development plan. It is important that the proposed stocktake and development plan identify the requirements and incentives to develop the cancer control workforce to better respond to Māori needs. This development needs to occur across both the Māori and mainstream workforce.

There is already evidence that supports early action to remedy deficiencies in several categories of cancer control worker as follows.

- **Oncology pharmacists:** the complexity of storage, preparation, delivery and monitoring of anti-cancer drugs has increased, and will continue to increase. Designated oncology pharmacists are required for each cancer treatment centre and they require ongoing professional development.
- **Anatomic pathologists:** are essential to establish the diagnosis, grade and stage of cancers, and to eliminate cancer as a possibility for patients who do not have cancer. Annual surveys by the Royal Australasian College of Pathologists showed that New Zealand was 24 anatomic pathologists short of parity with Australia. A subsequent report from the Australian Medical Workforce Advisory Committee (2003) concluded that Australia now needs to establish 100 additional training posts for anatomic pathologists.
- **Hospital physicists:** the vacancy rate for hospital physicists has varied from 15 percent to 30 percent since 2000, and New Zealand hospitals have a shortfall of about 50 percent in experienced staff compared to Australia. The Clinical Training Agency has established a new training scheme for hospital physicists and the Genesis Oncology Trust has awarded scholarships to support trainees. DHBs with cancer centres should establish appropriate numbers of physics registrar posts and periodically review physics staff to ensure that Australasian guidelines are met.
- **Medical radiation therapists:** the New Zealand Institute of Medical Radiation Technologists surveys vacancies six monthly against requirements of the New Zealand Radiation Oncology Advisory Committee, and currently 10 percent of posts are vacant. The University of Otago has doubled its intake of radiation therapy students, and some regional divisions of the Cancer Society have awarded scholarships to support such students. DHBs with cancer treatment centres should now define career pathways for radiation therapists and arrange for their continuing education, now expected under the Health Practitioners' Competence Assurance Act 2003.
- **Palliative care workers:** there has been some progress in the postgraduate training of palliative care nurses since publication of the New Zealand Palliative Care Strategy (Minister of Health 2001b), but there is a need for additional postgraduate training of palliative medicine specialists, nurses and social workers, and for roles to be defined for nurse practitioners in palliative care.
- **Cancer nurses:** preliminary results from a National Oncology/Workforce Survey demonstrate that current nursing establishment in most cancer centres is low, and there is acknowledged need for improved training in this field.

Action Table

Goal 5, Objective 1: Develop a co-ordinated national cancer workforce strategy

Outcomes/results	Specific actions	Key stakeholders	Milestones/measures/phasing
84. Appropriate levels of recruitment, training, professional development, and retention of the paid and voluntary workforce required for effective cancer control.	Undertake a comprehensive stocktake of the present cancer control workforce and define future workforce requirements across the continuum of cancer control. The stocktake should include a review of training, recruitment and retention rates for each professional group.	HWAC, MOH, DHBs employers of the health workforce, educators of the health workforce.	Plan and initiate stocktake. <i>Phase 1</i> Analyse and publish stocktake. <i>End of Phase 1</i>
85. A comprehensive workforce development plan to direct future training and recruitment needs for cancer control.	Develop a cancer control workforce development plan aimed at correcting current deficits and meeting future workforce needs. The plan should include strategies to improve staff retention rates. The plan should define the responsibilities of the key stakeholders in meeting the workforce needs of cancer control.	HWAC, MOH, Tertiary Education Commission, educators of the health workforce, employers of the health workforce, DHBs.	International benchmarks are agreed. <i>Phase 1</i> Cancer control workforce development plan completed. <i>End of Phase 1</i> Annual monitoring of the cancer control workforce. <i>Phase 2</i>

Outcomes/results	Specific actions	Key stakeholders	Milestones/measures/phasing
86. Increased involvement of Māori and Pacific health professionals in cancer control.	<p>Expand Ministry of Health support for bridging programmes between school and study for degrees in health.</p> <p>Develop and expand postgraduate support for Māori and Pacific staff involved in cancer control.</p> <p>Annually monitor the proportions of Māori and Pacific cancer control workers from 2005.</p>	MOH, DHBs, health workforce educators, health workforce employers, CTA.	<p>Increase the number of Māori and Pacific students entering bridging programmes for health studies by 10 percent per year. <i>Phases 1 and 2</i></p> <p>Increase the number of Māori and Pacific peoples entering the cancer control workforce by 10 percent per year. <i>Phases 1 and 2</i></p>
87. Oncology pharmacists are appointed to DHBs with cancer treatment centres to improve the management and safety of chemotherapy.	<p>DHBs with cancer treatment centres appoint designated oncology pharmacist(s) and make provision for their ongoing professional development.</p> <p>The Ministry of Health will work with the Clinical Training Agency to identify cancer treatment centre(s) as a training centre for initial training and on going professional development of oncology pharmacists.</p>	MOH, DHBs, CTA.	<p>One cancer treatment centre or centres identified as the training centre for oncology pharmacists. <i>Phase 1</i></p> <p>Appointment of oncology pharmacists identified in DHB district annual plans. <i>Phase 1</i></p> <p>One cancer treatment centre identified as a training centre for oncology pharmacists. <i>Phase 1</i></p>

Outcomes/results	Specific actions	Key stakeholders	Milestones/measures/phasing
88. Increased training and retention of anatomic pathologists to meet the growing needs for cancer diagnosis.	Work towards the establishment and resourcing of 10 additional training posts in anatomic pathology.	CTA, DHBs, RCPA.	Additional posts established and filled. <i>Phase 1</i>
89. Increased training and retention of hospital physicists to meet the growing needs for radiotherapy.	Continue the newly established training scheme and review the intake to ensure the national requirement for new staff is met. Establish appropriate numbers of physics registrar posts and regularly review physics staff to ensure Australasian guidelines are met.	CTA, DHBs with cancer treatment centres.	Recruitment and retention of hospital physicists monitored annually. <i>Phase 2</i>
90. Increased training, and retention of radiation therapists to meet the growing needs for radiotherapy.	Continue the expanded intake of radiation therapy students. Define career pathways for radiation therapists and support their continuing professional development.	The University of Otago, CTA, NZ Institute of Medical Radiation Technology, DHBs.	The expanded training scheme for radiation therapists continues. <i>Phases 1 and 2</i> Continue current monitoring recruitment and retention of radiation therapists.
91. Improved capacity and capability of the cancer nursing workforce.	Agree on appropriate establishments for oncology/haematology nurses for cancer centres and for ambulatory care. Define the scope of a senior oncology nurse. Establish and resource training posts for 12 nurses annually to complete post-graduate certificates or diplomas related to cancer nursing.	DHBs with cancer treatment centres, CTA, NZCTWP, professional groups, tertiary education institutes, Cancer Nurses Section of New Zealand Nurses Organisation.	Establishments for cancer nurses agreed. <i>Phase 1</i> Criteria and scope of practice for senior oncology nurses defined. <i>Phase 1</i> First postgraduate programme for oncology/haematology nurses commenced. <i>Phase 2</i>

Outcomes/results	Specific actions	Key stakeholders	Milestones/measures/phasing
92. The cancer control research workforce is expanded to provide skills and expertise across the continuum of cancer control including behavioural, social and psychological research.	Expansion of doctoral and postdoctoral research awards to include fields associated with the priorities of the New Zealand Cancer Control Strategy.	HRC, cancer research funding agencies, tertiary education institutes, DHBs.	Training awards related to cancer control awarded. <i>Phase 1</i> Identify need for additional training in cancer control research. <i>Phase 2</i>
93. Increased recruitment and retention of palliative care workers to provide an integrated and comprehensive service throughout New Zealand.	Increase recruitment and funding for positions in palliative care, including Māori and Pacific workers in rural areas; the development of undergraduate and postgraduate programmes for doctors and nurses; additional vocational training posts in palliative care medicine and the development of new roles for nurse practitioners in palliative care. Support and encourage continuous professional education for all groups of palliative care workers.	NZCTWP, CTA, educators of the health workforce, employers of the health workforce, Māori and Pacific health service providers, HNZ, ANZSPM and other professional groups.	Two additional vocational training posts in palliative medicine established. <i>Phase 2</i> Recruitment and retention of the palliative care workforce monitored annually. <i>Phase 1</i>
94. A workforce is available to meet the needs of rehabilitation and support services for cancer patients and their whānau.	Identify workforce requirements and workforce development needs to meet the (yet to be developed) 'guidance' on supportive care and rehabilitation services for adults, children and adolescents (see Goal 4, Objective 1).	Employers of staff involved in the rehabilitation and support of cancer patients, NGOs, health workforce educators.	Recruitment and retention of workforce involved in rehabilitation and support aspects of cancer monitored annually. <i>Phase 2</i>

Objective 2: Ensure programmes and services are accessible to Māori across the cancer control continuum

Cancer is a leading cause of morbidity and mortality among Māori and there are significant disparities between Māori and non-Māori in relation to the incidence of cancer, cancer mortality rates and utilisation of cancer services. Differential access to health services is a primary concern; it has had a profound effect on health outcomes for Māori and contributes to the disparities in health status between Māori and non-Māori.

Recent research into access to cancer services for Māori (Cormack et al 2004) has identified three broad categories of factors with the potential to influence Māori access, which are:

- health-system level factors – which include the failure to respond to Māori needs at both the cancer-specific service level and across more generic health care systems (eg, service organisation, funding, resources, waiting times)
- health-care process factors – which include the way service providers relate to and communicate with each other, and the composition and characteristics of clinicians and providers delivering services to Māori across the cancer control continuum (an important issue is the perceptions and stereotypical beliefs providers form about Māori service 'preferences', which then affect the type and range of options provided to Māori and their whānau; these factors affect not only the initial consultation but can permeate the ongoing relationships and perceptions Māori form for cancer services)

- patient-level factors – which include those associated with socioeconomic position, location, access to transportation, knowledge and beliefs, and patient resources. These factors are likely to reflect the cumulative effects of disadvantage for Māori.

Discussions about access have historically tended to focus on patient- or population-level factors with little or no regard to the additional effects of health care systems and processes in creating barriers of access to cancer-related services for Māori.

Improving cancer care for Māori and reducing cancer-related inequalities in health requires a commitment to addressing the wider socioeconomic and ethnic disparities in New Zealand, which provide the context in which services are delivered to, and accessed by, Māori.

Services being delivered to Māori need to reflect an understanding of hauora Māori and approaches that appropriately address Māori health needs. Māori-provided services are being increasingly integrated into the mix of health and disability services in New Zealand. Māori health services are those that are planned and delivered by Māori health workers and professionals using cultural concepts and values. While the target audience for these services is Māori and their whānau, they are also used by other members of the community at large. In addition to services specifically developed within a Māori cultural framework, there is a need to ensure that all services delivered to Māori demonstrate a level of cultural competency or capacity of health workers to improve health status by integrating culture into the clinical context.

Whakatātaka: Māori Health Action Plan 2002–2005, identifies a range of activities for the Ministry of Health, DHBs and service providers to improve health and disability services for Māori.

All cancer-related activities to address the needs of Māori should apply the pathways from He Korowai Oranga (Minister of Health and Associate Minister of Health 2002), the reducing inequalities intervention framework and Health Equity Assessment Tool (Te Rōpū Rangahau Hauora a Eru Pōmare et al 2003). He Korowai Oranga: The Māori Health Strategy provides a framework and specific priority action areas to improve Māori health outcomes. It identifies four pathways that need to be addressed:

- development of whānau, iwi and Māori communities
- Māori participation in the health and disability sector – active participation by Māori at all levels of the health and disability sector
- effective health and disability services – timely, high-quality, effective and culturally appropriate services to improve health and reduce inequalities
- intersectoral collaboration – with the health and disability sector taking a leadership role across government sectors and government agencies to achieve whānau ora by addressing the broader determinants of health.

Action Table

Goal 5, Objective 2: Ensure appropriate programmes and services are accessible to Māori across the cancer control continuum

Outcomes/results	Specific actions	Key stakeholders	Milestones/measures/phasing
95. Appropriate and effective governance models are developed to address Māori inequalities in access and outcomes.	<p>Ensure Māori are actively involved in identifying Māori priorities across the cancer control continuum.</p> <p>Evaluate the extent to which Māori inequalities are being addressed in the implementation of the Cancer Control Strategy.</p> <p>Ensure appropriate resourcing and support for improving Māori capacity and involvement in the implementation of the Strategy.</p>	MOH, iwi, hapū and Māori communities, Māori providers, DHBs, PHOs, NGOs.	Reporting on implementation of the strategy will identify how it has engaged with Māori communities, and how cancer-related inequalities are being addressed for Māori. <i>Phases 1 and 2</i>
96. Services across the cancer control continuum are appropriately focused towards Māori priorities and reducing cancer-related inequalities.	<p>DHBs, PHOs and cancer service providers will involve Māori expertise and the range of relevant Māori service providers in multidisciplinary teams and networks.</p> <p>Planners and funders of cancer services will consider the needs of Māori in the piloting of new initiatives aimed at reducing cancer related inequalities.</p> <p>Service providers will investigate the role of Māori patient advocates, navigators or interventions to enhance the patient journey for Māori and their whānau.</p> <p>Planners and funders of cancer services will support and appropriately fund Māori-led initiatives in cancer control.</p>	MOH, DHBs, PHOs, cancer collaboratives and regional networks, NGOs, Māori service providers, cancer service funders and planners.	DHBs with iwi partners and Māori communities will identify priority areas and incorporate into strategic plans and allocate resources. <i>Phases 1 and 2</i>

Outcomes/results	Specific actions	Key stakeholders	Milestones/measures/phasing
97. A case management approach is in place for Māori patients from commencement of treatment (overlaps with Goal 3, Objective 3).	Clinicians will be encouraged to use a case management approach to assist Māori at all levels of the continuum, with a primary health care professional identified at the start.	DHBs, PHOs, academic and professional groups, Māori providers, NGOs.	Case management approach for Māori is incorporated into service planning and delivery. <i>Phases 1 and 2</i>
98. Decisions about policy and funding address inequalities and Māori priorities in cancer control.	<p>Strengthen the inequalities focus of cancer control policies and reflect the dual purpose of the Strategy to reduce the impact, incidence and inequalities with respect to cancer.</p> <p>Assess the extent to which policy and funding decisions contribute to differential effect discrimination for Māori (including use of the HEAT tool).</p> <p>Ensure a strategic approach to the development of interventions to address access to cancer services for Māori.</p>	MOH, CCC, iwi, hapū and Māori communities, Māori providers, DHBs, PHOs and NGOs.	<p>Reporting on implementation of the Strategy will identify how policies and funding decisions address cancer-related inequalities for Māori.</p> <p>DHBs and health providers will identify what activities they are planning to reduce cancer related inequalities for Māori annual plans and service reports.</p> <p><i>Phases 1 and 2</i></p>

Outcomes/results	Specific actions	Key stakeholders	Milestones/measures/phasing
<p>99. The development of national standards and guidelines reflect priorities for Māori.</p> <p>(Note: see also Goal 3, Objectives 1 and 2.)</p>	<p>Ensure the development of standards and guidelines for the prevention, screening, diagnosis, treatment and management of cancer are reflective of, and give priority to, those cancers that contribute to the greatest disparities for Māori.</p> <p>Ensure that the development of national standards includes a requirement for effective monitoring of cancer-related outcomes, inequalities and service responsiveness for Māori.</p> <p>Develop tools to assist service providers and health professionals to communicate effectively with Māori about cancer and cancer care.</p>	<p>MOH, Māori providers, DHBs, PHOs, NGOs, clinical and professional groups, training organisations and institutions.</p>	<p>Standards and referral guidelines are developed and monitored to ensure that cancer-related inequalities for Māori are being addressed.</p> <p><i>Phases 1 and 2</i></p>
<p>100. Improved information for, and communication with, Māori communities.</p>	<p>Ensure effective communication with, and development of high-quality resources for, Māori communities to:</p> <ul style="list-style-type: none"> • keep them informed of cancer and cancer service options, and engage Māori in new developments • incorporate messages regarding the extent of the problem for Māori • encourage Māori to access cancer treatment services at the earliest time. • improve the availability of appropriate information to ensure cultural acceptability • involve the marae/community in communicating with Māori • identify and utilise positive role models. 	<p>MOH, DHBs, NGOs, Māori providers, iwi, hapū, and Māori communities.</p>	<p>Communication strategies or approaches for Māori are developed and implemented with Māori stakeholders.</p> <p><i>Phases 1 and 2</i></p>

Outcomes/results	Specific actions	Key stakeholders	Milestones/measures/phasing
101. Ongoing monitoring and evaluation that provides ongoing information about Māori access to cancer services and cancer-related inequalities for Māori will be undertaken.	<p>Institute systems for the routine monitoring and reporting on equity of access to cancer services for Māori across the cancer control continuum.</p> <p>Routinely collect and publish data by ethnicity to reflect the goal of reducing inequalities and to allow for monitoring of ethnic inequalities.</p>	MOH, DHBs, PHOs and cancer control service providers and networks.	Monitoring and data collection processes are developed to report on Māori access to cancer control services and activities and cancer related inequalities. <i>Phases 1 and 2</i>
102. Research will inform the planning, development, and delivery of cancer services for Māori across the cancer control continuum.	<p>Develop and implement a research agenda for Māori, and in particular to consider with appropriate responses to address:</p> <ul style="list-style-type: none"> • prioritising cancer research for Māori with cancer, their whānau and communities • investigating cases in which cancer stage is unrecorded, including reasons for this • exploring the extent to which delays contribute to inequalities in cancer outcomes for Māori, including delays in diagnosis and treatment • investigating the existence of, extent and reasons for, differential treatment for Māori and non-Māori which may contribute to cancer-related inequalities. 	MOH, CCC, tertiary education institutes, research bodies, Māori researchers, NGOs, DHBs.	A research agenda is developed for Māori cancer research. <i>Phase 1</i>

Objective 3: Ensure active involvement of consumer representatives across the spectrum of cancer control

Introduction

The active involvement of consumers and communities at all levels is a fundamental principle of the New Zealand Health Strategy (Minister of Health 2000). Other national strategies also identify the importance of addressing consumer needs by consulting with consumers and communities. The focus on participation is seen as an essential way to provide a voice to consumers generally, as well as specifically to Māori and also to Pacific peoples to address inequalities that impact on health and wellbeing.

The involvement of consumers will include identifying ways to increase community access to information about cancer control as well as ways to become actively involved in the provision of cancer control services and programmes. The engagement of consumers in an ongoing manner so they are an integral part of cancer control planning and decision-making will contribute to an increased knowledge and understanding of the significance of the Cancer Control Strategy within the wider community. There will also be a greater sense of community ownership of cancer control activities.

Action Table

Goal 5, Objective 3: Ensure active involvement of consumer representatives across the spectrum of cancer control

Outcomes/results	Specific actions	Key stakeholders	Milestones/measures/phasing
103. Increased consumer participation and opportunities for consumer representatives to be actively involved in cancer control activities at local, regional and national levels.	Establish a well-resourced and organised initiative to facilitate consumer participation by those most affected by cancer, and to provide opportunities for consumer representatives to be involved in cancer control activities.	Regional cancer networks, Collaborative, MOH, DHBs, NGOs, PHOs, and all other groups and agencies involved with any cancer control activity.	Initiative established. <i>Phase 1</i>
	Establish a process to determine the most appropriate way for organisations involved in Cancer Control activities to: <ul style="list-style-type: none"> • ensure people most represented in the health statistics have ongoing input into identifying key issues and appropriate strategies. • establish formal links, and enable the active involvement of consumer organisations that have an interest in cancer control. 		Liaison with the regional networks to provide assistance and guidance to enable consumers to be actively involved in regional and local cancer control activities. <i>Phase 2</i>

Outcomes/results	Specific actions	Key stakeholders	Milestones/measures/phasing
104. Increased opportunity for organisations to seek consumer involvement.	<p>Establish a register of community organisations, consumer groups, Māori and Pacific groups as a mechanism for contacting and informing consumers about cancer control initiatives and opportunities for active engagement and participation.</p> <p>Establish a process to determine the most appropriate way for Māori to have opportunities to be actively involved in all cancer control activities.</p> <p>Establish a process to determine the most appropriate way Pacific peoples will be provided with the opportunity to be actively involved in all cancer control activities.</p>	Regional cancer networks Collaborative, MOH, DHBs, NGOs, PHOs, and all other groups and agencies involved with any cancer control activity.	<p>A register of consumer organisations and key consumer contacts established. <i>Phase 2</i></p> <p>Formal links established with relevant consumer, Māori and Pacific peoples organisations and appropriate initial processes put in place. <i>Phase 2</i></p>
105. All groups involved with cancer control and related work are committed to working with consumers and are able to demonstrate this in practice. They will also have Māori and Pacific expertise that is appropriately supported.	Develop a policy and/or terms of reference that include the active involvement of consumer representatives (including Māori and Pacific people) as working group members.	Regional cancer networks Collaborative, MOH, DHBs, NGOs, PHOs, and all other groups and agencies involved with any cancer control activity.	<p>All cancer control groups will be able to demonstrate they have a policy and/or terms of reference that include the active involvement of consumer representatives. <i>Phase 1</i></p> <p>All groups involved with cancer control activities involve consumers. <i>Phase 2</i></p>

Outcomes/results	Specific actions	Key stakeholders	Milestones/measures/phasing
106. All consumer representatives involved with cancer control groups and related activities have the appropriate experience and/or training so they are well prepared to be effective and knowledgeable representatives.	Assess whether existing training is appropriate for consumer representatives in cancer control – if not, develop training to meet needs.	MOH, CSNZ, consumer groups, regional cancer networks.	<p>All potential and aspiring consumer representatives able to access appropriate training. <i>Phase 1</i></p> <p>All cancer control groups and related activities will have informed consumer representatives and linked to a consumer organisation or network. <i>Phase 2</i></p>
107. Consumer involvement will be based on a consumer-centred model.	Involve consumer organisations in the review of existing consumer guidelines, identification of any gaps, and the provision of advice.	MOH, CSNZ, consumer groups.	<p>Existing guidelines used and updated. <i>Phase 1</i></p> <p>The consumer participation policy and terms of reference completed. <i>Phase 1</i></p>

Goal 6:

To improve the effectiveness of cancer control in New Zealand through research and surveillance

Objective 1: Extend and enhance research across the continuum of cancer control

Introduction

Cancer control research seeks to identify and evaluate ways to reduce cancer morbidity and mortality and to improve the quality of life of people living with, recovering from or dying from cancer (Minister of Health 2003). Research directly related to cancer control in New Zealand is essential to improving the quality and cost–benefit ratio of cancer control services and activities.

The national cancer plans of Canada, England, France, Ireland and Norway include additional research activities among their priorities. Australia has established, and the Commonwealth government funds, the National Cancer Control Initiative, which undertakes an ongoing programme of research to inform and improve their initiatives in cancer control. The Taskforce believes that the New Zealand health sector needs to invest more in research. Research should become a core activity of the health services, and involvement in research a recognised and respected activity of health professionals.

A survey by the Treatment Expert Working Group of current expenditure on cancer research by the major research funding agencies showed that investment is very unevenly distributed across the spectrum of cancer control.⁴ Whereas biomedical research is relatively well supported and of good quality, and there is some clinical and epidemiological research,

there is almost no investment in behavioural, psychological, cultural, environmental and health services research. The Cancer Control Taskforce agrees that it is important to substantially and urgently increase social and behavioural research related to cancer control in New Zealand. This could be managed by the Health Research Council through its request-for-proposals programme.

The other actions arise from the broad areas for action defined in the Cancer Control Strategy (p53). These are the need for a strategic and regular process for facilitating research related to cancer control to ensure that all aspects of the cancer control spectrum are continually informed by new knowledge, and the development and maintenance of Māori research capacity.

The strategic approach will be developed by a forum involving all major government and non-government supporters of cancer research and the development of a five-year rolling plan for cancer control research. This proposal is in line with actions undertaken in England following the introduction of *The NHS Cancer Plan: A plan for investment, a plan for reform* (Department of Health [London] 2000).

There is a need for an expanded Māori cancer control research workforce to obtain the knowledge necessary to more effectively reduce and eliminate the major ethnic disparities in cancer incidence and mortality (Minister of Health 2003). This proposal is based on an expansion of existing programmes of the Health Research Council by awarding additional Māori PhD scholarships and postdoctoral fellowships linked to cancer control research.

⁴ See: <http://www.cancercontrol.org.nz/pdf/ewg3.pdf>

Action Table

Goal 6, Objective 1: Extend and enhance research across the continuum of cancer control

Outcomes/results	Specific actions	Key stakeholders	Milestones/measures/phasing
108. A strategic and regular process for facilitating research relevant to cancer control in New Zealand.	Convene a cancer research funders forum to define priorities in cancer research and to negotiate co-operative research activities in those fields.	HRC, MOH, DHBs, CSNZ, CCF, Genesis Oncology Trust, Leukaemia and Blood Foundation, other organisations that fund or participate in research related to cancer control.	A cancer research funders forum convened, which will meet biennially. <i>Phases 1 and 2</i>
	Develop and maintain a five-year rolling research plan for cancer control.		A five-year rolling plan for cancer control research adopted and reviewed two-yearly thereafter. <i>Phases 1 and 2</i>
109. The development and maintenance of Māori research capacity.	Increase recruitment and training of Māori cancer control research workers.	HRC, MOH.	<i>Phase 1</i>
	Increase the number of doctoral and postdoctoral awards to Māori engaged in cancer control research from 2006.		<i>Phase 2</i>
	Use the request for research proposal process to establish cancer control research projects of particular relevance to Māori by 2007.		<i>Phase 2</i>

Outcomes/results	Specific actions	Key stakeholders	Milestones/measures/phasing
110. Development of research capacity in the behavioural, social, cultural and psychosocial aspects of cancer control.	The cancer research funders forum and Health Research Council initiate research programmes into aspects of cancer control, which are at present under researched.	HRC, MOH, CSNZ, other funders of cancer research.	<p>Research proposals in the behavioural, social, cultural and/or psychosocial aspects of cancer invited.</p> <p><i>Phase 1</i></p> <p>Two research projects commenced.</p> <p><i>Phase 2</i></p>

Objective 2: Improve the use, efficiency and scope of national data collection and reporting

Introduction

Determining the effectiveness of the actions required to implement this Cancer Control Strategy will require collecting, analysing and reporting on additional national cancer data related to each of these actions. Such information is also essential evidence for the periodic review and modification of the Strategy's objectives. Together with improved collaboration among the various stakeholders in cancer control, this will significantly increase the range of data collected and provide an increased emphasis on the analysis and interpretation of cancer-related information.

Essential to this objective is the development of an agreed, nationally consistent minimum data set and the efficient and collaborative management of cancer data. This requires the effective use of information technology, including using standard data sets, agreed data definitions and appropriate networking mechanisms to link databases and health record systems across New Zealand. A more comprehensive national cancer data set would enhance surveillance at both the population and individual levels. Population cancer trends could be monitored and the information linked to treatments provided, allowing comparisons and reporting on patterns of care and outcomes.

Standardised collection of ethnicity data is necessary to form an accurate picture of the cancer situation in New Zealand's various sub-populations. Ethnicity data tend to be poorly collected, inaccurate or not collected at all in the health sector. The plan proposes improved and more consistent ethnicity data to improve the accuracy of the picture of the differences between Māori and non-Māori. Additional data on ethnicity would also identify important differences that may exist with respect to the growing Pacific and Asian populations.

Action Table

Goal 6, Objective 2: Improve the use, efficiency and scope of national data collection and reporting

Outcomes/results	Specific actions	Key stakeholders	Milestones/measures/phasing
111. A national cancer information set that provides up to date and meaningful information for monitoring the effective implementation of the Cancer Control Strategy.	Refine the role of the Cancer Registry and identify the essential links it needs to collect the information most effective for cancer control.	MOH, DHBs, public and private providers, PHOs and primary care providers.	Phase 1
	Continue work on producing a core clinical cancer data set.	Cancer Registry, NZCTWP, professional groups.	Clinical cancer dataset developed. Phase 1
	Consult with other interested parties (e.g. research, screening, specialised treatment providers etc) to expand the core data set to incorporate other requirements.	NZCTWP, MOH (NSU), DHBs.	Phase 2
	Ensure that the refined Cancer Registry links with the appropriate clinical, pathology and palliative care databases.	DHBs, NZHIS, providers of cancer treatment services.	Phase 1
112. Improved and consistent collection of ethnicity data.	Expand and standardise the collection of ethnicity data.	NZHIS, MOH, DHBs, all providers.	That all ethnicity data is collected. Phase 1
	Training on ethnicity data collection is undertaken at provider level.		Number of training seminars undertaken at provider level. Phase 1

Appendix 1: Cancer Control Taskforce Membership

Chair

Associate Professor Chris Atkinson (Oncologist, Christchurch)

Deputy Chair

Dr Jan White (Chief Executive, Waikato DHB)

Members

Audrey Aumua, (CEO Ta Pasifika PHO to December 2003)
(resigned December 2003)

Associate Professor Brian Cox (Director, Hugh Adam Cancer
Epidemiology Centre, Otago) (resigned May 2004)

Associate Professor John Collins
(Head of Breast Cancer Services, Middlemore Hospital to July 2004;
currently Dean of Education, RACS)

Dr Garry Forgeson (Medical Oncologist, Palmerston North
Hospital)

Dr Mona Jeffreys, Post-doctoral Research Fellow, Centre for Public
Health Research, Massey University (commenced August 2004)

Mr Kiki Maoate (Paediatric Urologist, Canterbury DHB)
(commenced February 2004)

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Jan Nichols (Executive Manager, St Joseph's Mercy Hospice)

Iain Potter (Director, Health Sponsorship Council)

Dr Tony Ruakere (GP, Te Atiawa Medical Services)

Judi Strid (Consumer Representative)

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Mary-Louise Hannah (Senior Advisor Nutrition/Surveys, Public Health Policy, Ministry of Health)

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Marjan van Waardenberg (Senior Analyst, Project Leader Cancer Control Strategy, Public Health Policy, Ministry of Health)

Appendix 3: Ministry of Health Documents and Strategies to Consider

All of the following references can be accessed on the Ministry of Health's website www.moh.govt.nz

Cancer in New Zealand: Trends and projections

Clearing the Smoke: A five-year plan for tobacco control 2004–2009

Decades of Disparity: Ethnic mortality trends in New Zealand 1980–1999

Food and Nutrition Guidelines for Healthy Adults: A background paper

He Korowai Oranga: The Māori Health Strategy

Healthy Eating – Healthy Action: Oranga Kai – Oranga Pumau: A strategic framework

Health of Older People Strategy

Improving Non-Surgical Cancer Treatment Services in New Zealand

Improving Quality: A systems approach for the New Zealand health and disability sector

Improving Quality Action Plan: Supporting the improving quality approach

Pacific Health and Disability Action Plan

The New Zealand Health Strategy

The New Zealand Health Workforce: Framing future directions (Discussion document)

The New Zealand Palliative Care Strategy

The New Zealand Primary Health Care Strategy

Screening to Improve Health in New Zealand: Criteria to assess screening programmes

Travel and Accommodation Assistance Policy (in preparation)

Whakatātaka: Māori Health Action Plan 2002–2005

Appendix 4: Guidance Development Process

Appendix 4 relates to the actions under Goal 4, Objective 1. The guidance (as distinct from clinical guidelines) 'aims to provide advice on how services should be configured to provide effective services to people with cancer'. The guidance development process (which will form the basis of milestones) should include:

- a needs assessment involving consumers and service providers
- identification of key areas of need through analysis of the needs assessment
- an evidence review for key areas of need
- development of service model proposals
- application of existing tools (eg, inequalities and Whakatātaka) to proposed service models
- consultation on service model proposals
- development of final guidance
- adoption of guidance by providers
- identification of gaps in services
- identification of workforce requirements
- identification of training/workforce development requirements
- identification of research priorities.

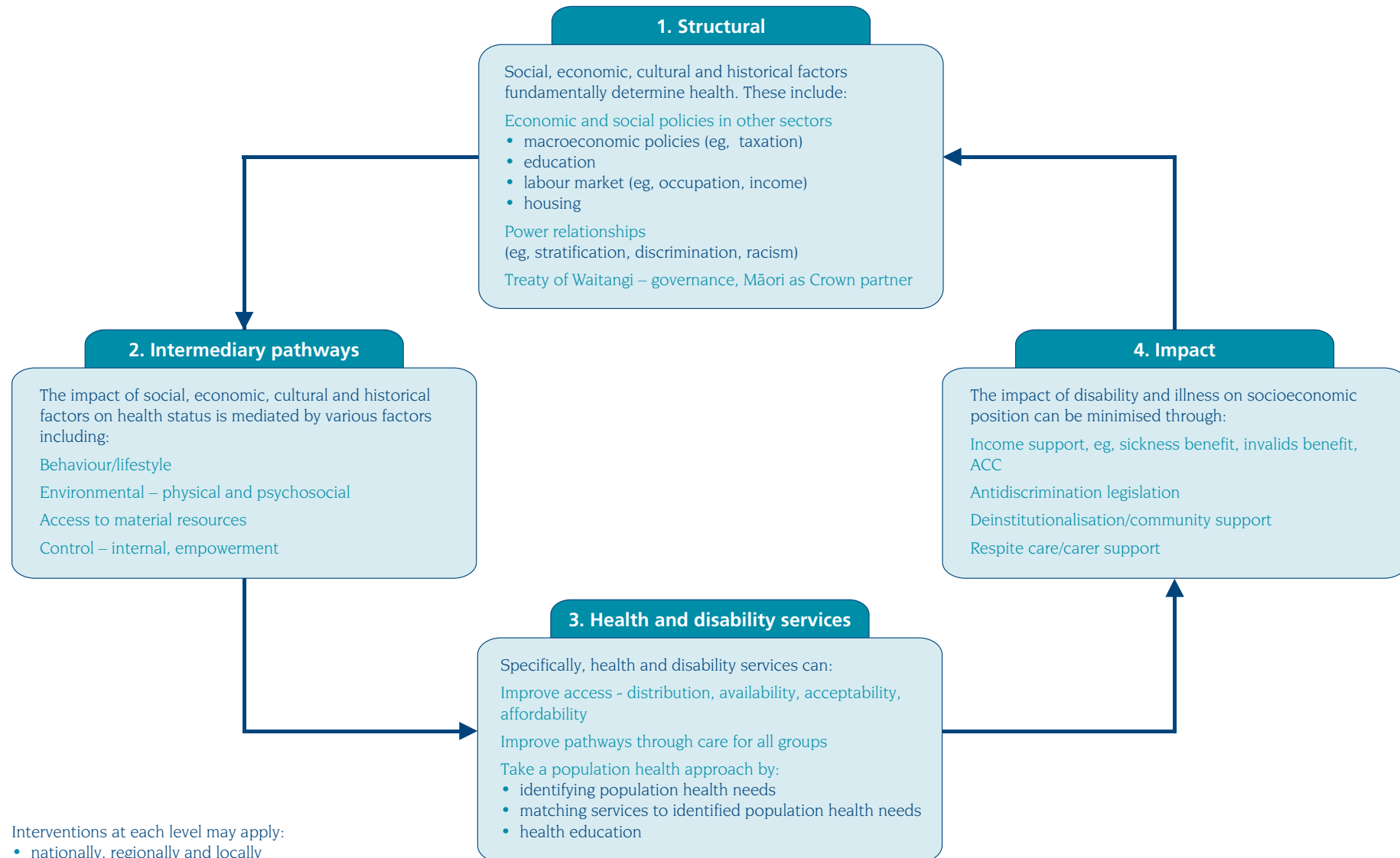
Actions to ensure integrated programmes of supportive care and rehabilitation for Māori and Pacific peoples should be included within this process. Each of the steps outlined above and the outcomes/milestones below should specifically address issues for Māori and Pacific peoples.

Outcomes/results for this action include:

- maximisation of existing services
- improvement in the experience of care of those with cancer and their family and whānau by involving them in needs identification
- development of effective service models to meet the needs of those with cancer and their carers
- development of standards to assess the range of services provided
- identification of workforce requirements and workforce development needs
- improved organisation, co-ordination and integration of services (eg, through the development of regional service directories, unified checklists/tools to assess care needs and a clear understanding of the services to which patients and carers should be referred).

Appendix 5: Equity Tools

Intervention framework to improve health and reduce inequalities



Interventions at each level may apply:

- nationally, regionally and locally
- taking population and individual approaches

Source: Ministry of Health. 2002. *Reducing Inequalities in Health*. Wellington: Ministry of Health.

A Health Equity Assessment Tool (Equity Lens) for Tackling Inequalities in Health

There is considerable evidence, both internationally and in New Zealand, of significant inequalities in health between socioeconomic groups, ethnic groups, people living in different geographical regions and males and females (Acheson 1998; Howden-Chapman and Tobias 2000). Research indicates that the poorer you are, the worse your health. In some countries with a colonial history, indigenous people have poorer health than others. Reducing inequalities is a priority for government. The New Zealand Health Strategy acknowledges the need to address health inequalities as 'a major priority requiring ongoing commitment across the sector' (Minister of Health 2000).

Inequalities in health are unfair and unjust. They are also not natural; they are the result of social and economic policy and practices. Therefore, inequalities in health are avoidable (Woodward and Kawachi 2000).

The following set of questions has been developed to assist you to consider how particular inequalities in health have come about, and where the effective intervention points are to tackle them. They should be used in conjunction with the Ministry of Health's Intervention Framework (Ministry of Health 2002).

1. What health issue is the policy/programme trying to address?
2. What inequalities exist in this health area?
3. Who is most advantaged and how?

4. How did the inequality occur? (What are the mechanisms by which this inequality was created, is maintained or increased?)
5. What are the determinants of this inequality?
6. How will you address the Treaty of Waitangi in the context of the New Zealand Public Health and Disability Act 2000?
7. Where/how will you intervene to tackle this issue? Use the Ministry of Health Intervention Framework to guide your thinking.
8. How could this intervention affect health inequalities?
9. Who will benefit most?
10. What might the unintended consequences be?
11. What will you do to make sure it does reduce/eliminate inequalities?
12. How will you know if inequalities have been reduced/eliminated?

(Adapted from Bro Taf Authority. 2000. *Planning for Positive Impact: Health inequalities impact assessment tool*. Cardiff: Bro Taf Authority.)

Amended by Ministry of Health. May 2004.

Source: Te Rōpū Rangahau a Erū Pomare, Ministry of Health and Public Health Consultancy. 2003. *A Health Equity Assessment Tool*. Wellington: Public Health Consultancy, Wellington School of Medicine and Health Sciences.

Appendix 6: Abbreviations

ALAC	Alcohol Liquor Advisory Council	HPV	Human papillomavirus
ANA	Agencies for Nutrition Action	HTANZ	Health Teachers Association New Zealand
ANZSPM	Australia and New Zealand Society of Palliative Medicine	HWAC	Health Workforce Advisory Committee
ASH	Action Against Smoking, New Zealand	MACCAH	Ministerial Advisory Committee on Complementary and Alternative Health
ATAK	Aparangi Tautoko Auahi Kore	MFE	Ministry for the Environment
BSA	BreastScreen Aotearoa	MOE	Ministry of Education
CAM	Complementary and Alternative Medicines	MOH	Ministry of Health
CCF	Child Cancer Foundation	MORST	Ministry of Research, Science and Technology
CPHR	Centre for Public Health Research, Massey University	MSD	Ministry of Social Development
CSNZ	Cancer Society of New Zealand	NGO	Non-governmental Organisation
CTA	Clinical Training Agency	NHF	National Heart Foundation
DAP	District Annual Plans	NSAC	National Screening Advisory Committee
DHB	District Health Board	NSU	National Screening Unit
DHBNZ	District Health Boards New Zealand	NZCOG	New Zealand Clinical Oncology Group
ERMA	Environmental Risk Management Authority	NZDS	New Zealand Dermatological Society
GP	General Practitioner	NZEI	New Zealand Educational Institute
HPS	Health Promoting Schools	NZPF	New Zealand Principals Federation
HRC	Health Research Council	NZPHA	New Zealand Private Hospitals Association
HSC	Health Sponsorship Council	PHO	Primary Health Organisation
HNZ	Hospice New Zealand	PHU	Public Health Unit
HPCNZ	Hospital Palliative Care New Zealand	PPTA	Post Primary Teachers Association

OSH	Occupational Safety and Health Service
NOHSAC	National Occupational Health and Safety Advisory Committee
NZCTWP	New Zealand Cancer Treatment Working Party
NZHIS	New Zealand Health Information Service
PHO	Primary Health Organisations
PHR	Personal health record
RACS	Royal Australasian College of Surgeons
RANZCOG	Royal Australia New Zealand College of Obstetrics and Gynaecology
RANZCR	Royal Australia New Zealand College of Radiologists
RCPA	Royal Australasian College of Pathologists
RNZCGP	Royal New Zealand College of General Practitioners
SPANZ	Secondary Principals Association New Zealand
SPARC	Sport and Recreation New Zealand
STA	School Trustees Association
TCRSSG	Tobacco Control Research Strategy Steering Group
TLA	Territorial Local Authority
UVR	Ultra violet radiation
WHO	World Health Organization

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