

NEW ZEALAND

Overview: National Cancer Control plan

Cancer incidence is rising in New Zealand, mainly because of population growth and ageing. At present about 16,000 people develop cancer each year; recent forecasts suggest that by 2011 this number will increase to 22,000. Cancer is now a leading cause of death in New Zealand, accounting for 29 percent of deaths from all causes.

Although the standard of cancer services in New Zealand is high by international standards, there are gaps and fragmentation of service provision and delivery. This situation, coupled with limited resources, has resulted in unacceptable waiting times for treatment. It has also resulted in inequitable access to services for socially disadvantaged and geographically isolated groups. Gaps also exist in health promotion activities directed at reducing the number of people who develop the disease. Although many initiatives reflect the close collaboration of agencies and community groups (e.g. in some tobacco control-related activities), more effort and resources are needed to improve overall co-ordination and integration.

The Ministry of Health and the New Zealand Cancer Control Trust – representing the non-government sector – jointly produced the New Zealand Cancer Control Strategy (CCS). The New Zealand CCS is the first phase in the development and implementation of a comprehensive cancer control programme for New Zealand. The areas to be covered by a cancer control strategy encompass all aspects of cancer: prevention, screening (where appropriate), early detection, diagnosis, treatment, rehabilitation and support, and palliative care. It also means addressing problems associated with equity of access to services, workforce development and the need for relevant research, monitoring and evaluation of services, and data collection and analysis.

Additional information on the New Zealand Cancer Control Strategy and Action Plan can be accessed at: <http://www.moh.govt.nz/cancercontrol>

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1. Is it a new plan or is it an updated one? When was the previous plan published and who did it?

This is a new plan. It comprises a strategy and an action plan (2005-2010)

THE FOLLOWING QUESTIONS REFER TO THE PRESENT PLAN:

2. When did you start the planning process? Who decided to do the plan and why?

The planning for the strategy started in 2001. There were several drivers for the plan:

- Pressure from stakeholders (1999 Cancer Control Workshop)
- Increase in cancer incidence and concern over mortality and survival
- Change of government with a new health strategy: of which one population health goal was “reducing the impact and incidence of cancer”(2000)
- General WHO direction promoting cancer control programmes

Note that the plan was a collaborative venture with cancer NGOs from the start.

3. What steps did you take to do the plan and how long did each step take?

For the Strategy:

The NGO representative, the New Zealand Cancer Control Trust, was formed and funded by the Cancer Society of NZ and the Child Cancer Foundation to represent the non-government cancer sector in the strategy development process.

The NZ Cancer Control Trust represents various groups and included external peer reviewers e.g. 1 person was from the UK, 1 from Canada, as well as people from NZ and Australia.

At the start of the process the Ministry contracted the Trust to provide a general overview and scope the plan. Following this a steering group was appointed with members from cancer experts planning of the strategy representing each phase of the cancer control continuum and with Maori representation (to ensure representation from the indigenous people). This took two months to establish.

The Ministry and the NZ Cancer Control Trust signed a Memorandum of Understanding to establish protocols for engagement. The Ministry and Trust also established a joint secretariat to support the work of the steering group and expert working groups. The Trust contributed by funding two of their members to work on the strategy alongside the Ministry and by meeting the travel costs of all six Trust members who were members of the steering group.

Small expert working groups with good sector and research knowledge were set up to inform the steering group in the planning of the strategy. A literature review was undertaken for the primary prevention area. The expert working groups addressed primary prevention, screening and early detection, treatment, support and rehabilitation, and palliative care. Cross cutting themes also considered by each working group were: workforce development, research and how to reduce inequalities in cancer outcomes. The development of the discussion document took 15 months from the establishment of the steering group to the launch of the document.

NZ has a statutory requirement for public consultation on major policy changes. This requirement was met by having a three month consultation period during which the Ministry received written and electronic submissions and undertook 19 consultation workshops including 3 hui (meetings for Maori) 3 fono (meetings for Pacific people) and an Asian forum (facilitated by an interpreter). Where appropriate, the submissions were incorporated into the revised version of the strategy.

The completed New Zealand Cancer Control Strategy was launched 25 August 2003. Total time from the establishment of the Cancer Control Steering Group to the launch of the strategy was 23 months.

For the Action Plan:

Between the launch of the strategy and commencement on the development of the action plan, a two day workshop for stakeholders was held. This provided an opportunity for comments from stakeholders on possible priorities for implementation.

A process similar to that used in developing the strategy was followed for the Action Plan. A Cancer Control Taskforce was appointed to develop an action plan for the implementation of the strategy. Some members had been on the original steering group. New members, with experience of rolling out a strategy, such as District Health Board management, were added to the group. The joint Ministry/NGO secretariat was continued, with the Cancer Control Trust funding the NGO members.

Various members of the taskforce took responsibility for small sub-committees which developed the actions for the implementation of the plan. The development of the action plan took 15 months.

4. Who were the persons involved in each step of the process?**For the Strategy:**

A Cancer Control Steering Group was appointed to oversee the development of the strategy. The Deputy Directors-General of the Public Health Directorate and Clinical Services Directorate were members of the steering group, which was chaired by Dr Colin Tukuitonga, Director of Public Health.

All the New Zealand Cancer Control Trust members were on the steering group: these were Professors Chris Atkinson, John Gavin, Brian Cox, Christopher Cunningham, John Collins and Mrs Betsy Marshall. Betsy Marshall and Professor John Gavin also worked as members of the joint secretariat.

The expert working groups had 6-12 members each (about 40 individuals involved, though there was some overlap between groups).

The joint secretariat had two full time members (Marjan van Waardenberg, Senior Analyst, and Andrea Bland, Administrative Support), and 8 part-time members.

For the Action Plan:

The Cancer Control Taskforce had 13 members. Some had been members of the Cancer Control Steering Group and provided continuity for the next stage of development, the Action Plan. New members included Dr Jan White, CEO of Waikato District Health Board and Judith Strid to provide consumer representation. Dr Kiki Moata provided the Pacific viewpoint. Drs Tony Ruakere and Keri Ratima provided a perspective on Māori issues. The joint secretariat of the Ministry and NZ Cancer Control Trust continued to provide support for the Taskforce.

5. How was the plan done, what resources were used in each step, and what were the results?

Some Ministry staff were dedicated to the project. Many participated on a part-time basis depending on their area of expertise as it related to cancer control. Ministry provided approximately 75% of the funds. This included funding for discrete projects to inform the development of the strategy, and largely came from Ministry's baseline budget.

The New Zealand Cancer Control Trust funded two of their members to participate in the work of the secretariat.

6. When the plan was officially launched? Who and how was the plan disseminated?

The Minister of Health officially launched the New Zealand Cancer Control Strategy on 25 August 2003. The Minister launched the Action Plan on 7 March 2005.

Both documents were disseminated in the same way.

- Appropriate media releases were prepared and aired in the media
- Each Chief Executive Officer, Chair of the Board, and funding and planning manager of each District Health Board received a copy
- A printed copy was sent to key staff members of the six cancer centres in New Zealand; the professional colleges and all Public Health Units.
- All those who had participated in the consultation workshop were notified by email as to how they could order a free copy of the documents, or download it from the website
- NGOs were offered as many copies as required
- The document is available on the Ministry of Health website.

7. What problems were encountered in the planning process? How were they dealt with?

The collaboration between central government and the non-government sector highlighted the fact that there were two very different streams of accountability and prioritization. For central government cancer is but one of many competing priorities. For the non-government cancer sector, cancer is the only priority. In addition to this, both organizations had very different frameworks of accountability in terms of processes for approving expenditure, processes of consultation, obligations to constitutional or other frameworks, and peer review processes.

A concern for the NGO sector was the monitoring of the implementation of the Strategy and Action Plan. The Minister of Health created a Cancer Control Council tasked with

monitoring progress in this area. (Information about the Cancer Control Council can also be found on the Ministry of Health website <http://moh.govt.nz/cancercontrol>).

8. What were the lessons learned from the planning process?

Overcoming any of the above took time. Future planning for a similar process should establish a more detailed Memorandum of Understanding between the partners and allow more time for the project so that the various factors can be dealt with appropriately. It would also be helpful to all parties if the machinery of government is clearly explained at the beginning of the process and equally if the protocols of the participating organizations are also clarified.

9. What are the priorities, target population, main goals, and objectives of the plan?

The overall purposes of the Strategy are to:

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

The main goals and objectives of the plan are:

Goal 1: *Reduce the incidence of cancer through primary prevention.*

Objectives:

- 1 Reduce the number of people who develop cancers due to tobacco use and second hand smoke
- 2 Reduce the number of people developing physical inactivity and obesity related cancers
- 3 Reduce the number of people developing nutrition related cancers
- 4 Reduce the number of people developing skin cancer due to UV radiation exposure
- 5 Reduce the number of people developing infectious disease related cancers
- 6 Reduce the number of people developing alcohol related cancers
- 7 Reduce the number of people developing occupational-related cancers.

Goal 2: *Ensure effective screening and early detection to reduce cancer incidence and mortality.*

Objectives:

- 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
- 2 Establish a process to assess the value of early detection of cancer other than that obtained through organized screening

Goal 3: *Ensure effective diagnosis and treatment of cancer to reduce cancer morbidity and mortality*

Objectives:

- 1 Provide optimal treatment for those with cancer
- 2 Develop defined standards for diagnosis, treatment and care for those with cancer
- 3 Ensure patient centred and integrated care for those with cancer
- 4 Improve the quality of care delivered to adolescents with cancer and their family and whanau (extended family)

Goal 4: *Improve the quality of life for those with cancer, their family and whanau (extended family) through support, rehabilitation and palliative care.*

Objectives:

- 1 Establish integrated programmes of supportive care and rehabilitation with defined leadership (together with objective 5)
- 2 Ensure people with cancer and their families and whanau are able to access the appropriate resources for support and rehabilitation that they need
- 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
- 4 Ensure that those with cancer and their family and whanau have access to high quality information on treatment and care, including complementary and alternative medicine (CAM)
- 5 Ensure optimal independence and function for those with cancer through systematic assessment and appropriate multidisciplinary intervention for their vocational and social needs
- 6 Continue to improve access to essential palliative services that provide appropriate symptom relief and emotional, spiritual, cultural and social support for those with cancer and their family and whanau
- 7 Ensure an integrated and comprehensive service is provided to all those with cancer who require palliative care and their family and whanau.

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*

Objectives:

- 1 Develop a co-ordinated national cancer workforce strategy
- 2 Ensure programmes and services are accessible to Maori across the cancer control continuum
- 3 Ensure active involvement of consumer representatives across the spectrum of cancer control

Goal 6: *Improve the effectiveness of cancer control in New Zealand through research and surveillance.*

Objectives:

- 1 Extend and enhance research across the continuum of cancer control
- 2 Improve the use, efficiency and scope of national data collection and reporting.

Each of the objectives is supported by a range of actions to achieve the outcome.

10. Is monitoring and evaluation included in the plan? Briefly describe

As described in Goal 6. In addition to that, monitoring plans and projects have been developed for Phases 1 and 2 of the Action Plan.

A Cancer Control Council has been established to monitor the implementation of the whole plan against the objectives and timeframes set out in the plan.

11. What are the resources allocated and the timeframe to carry out the implementation of the plan?

The Action Plan has a timeframe of 5 years after which it will be reviewed. In 2004, \$22 million NZD was allocated to commence the implementation of the Action Plan. Further allocation is subject to the budget process.

12. Has the plan been implemented? If NO, Why not?

Implementation has started on a number of objectives. Objectives that were already in train before the plan was completed are being enhanced where required to conform to the goals and objective of the plan.

A Principal Adviser Cancer has been appointed to drive the process within the Ministry and to work closely with the health sector and the NGO sector to achieve this.

The implementation phase of the plan started in 2005-2010. The New Zealand Cancer Control Strategy Action Plan 2005 – 2010.

13. If YES, When did the implementation phase start?

The implementation phase started in March 2004. However as this strategy builds closely on work already in progress, and as the cancer sector were closely involved with the development of the Strategy and Action Plan, many objectives were already in progress before the official implementation phase began.

14. What has been implemented so far, when and where?

The following actions to support the goals and objectives of the strategy are already underway:

Goal 1 –

- An extensive Tobacco control plan and programme encompassing, smokefree legislation, cessation programmes and health promotion have been under way for some years. Further programmes targeting youth and high needs groups are being developed.
- A Healthy Eating – Healthy Action Strategy has been developed and an accelerated implementation is being undertaken. This objective covers improved nutrition, increased physical activity and reducing obesity. Part of this outcome is the implementation of a fruit in schools programme.
- Work has begun on aspects of Objective 4- reducing cancer incidence related to UV exposure.
- Hepatitis B vaccination programmes are in place and will in the long term reduce the incidence of primary liver cancer.

Goal 2 –

- New Zealand had a cervical screening programme and a breast cancer screening programme in place prior to the cancer control strategy development project. Improvements in terms of database function are planned. The age range for breast cancer screening has been extended to include women between the ages of 45 and 50.
- The establishment of a pilot programme for colorectal cancer screening is currently under consideration.

Goal 3, 4 and 5 –

- Planning for managed cancer services networks, and consistent multidisciplinary care approaches is underway.
- An implementation fund has funded 23 different projects for the various health boards, NGOs, and the primary care sector to undertake ‘one off’ projects to, for example, establish networks, improve streamlining of services, map patient pathways, improve information available to patients.
- A needs assessment of cancer workforce capacity has commenced
- Producing a common definition of specialist and generalist palliative care and producing a revised palliative care service specification covering both specialist and generalist requirements
- Implemented a pilot late assessment effects programme for survivors of childhood and adolescent cancer
- Work is underway to develop a national specialized adolescent cancer service through a new service specification
- Planning a programme of guidance development and protocol sharing.

Goal 6 –

- Project planning is underway for a comprehensive cancer treatment management database to complement the compulsory incidence and mortality registration that has been in place for 12 years.

- The Ministry is negotiating a contract for research in to the primary prevention of cancer with a research provider. A research forum for treatment and palliation will occur later this year.

15. What problems have you encountered during the implementation phase?

One of the key issues in a collaborative process such as this is the need to reconcile different viewpoints such as the cancer providers being focused on one disease and a constituency that supports that view, and a government position that has to continually consider the competing priorities of a publicly funded health service, including a commitment to reduce inequalities in health outcomes.

Misunderstandings also occurred from time to time due to lack of understanding of government process and accountabilities.

16. What are the lessons learned from the implementation phase so far?

Collaboration between government and non-government organizations requires that more time needs to be invested into the process.

Perhaps the first step in the process should be some facilitated sessions that inform participants of the various processes and accountabilities that each organization has to accommodate.

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