

# Budget Initiative Summary Template

This template seeks a high-level summary of the Budget 2016 significant initiatives. Agencies are required to complete the blue fields – your Vote Analyst will complete their assessment in the grey fields. Please also refer to the Guidance document available on CFI\$net, which provides detail on supporting information requirements for your initiatives. This supporting information must be provided to your Vote Analyst.

## Work stream

[Social Sector/  
BGA/Capital  
/Other]

**Vote** Health  
**Responsible Minister** Hon Dr Jonathan Coleman  
**Initiative title** National Bowel Screening Programme  
**Initiative description** People aged 60 – 74 will be offered free screening for bowel cancer.

The bowel screening programme will mail a screening test, an immunochemical faecal occult blood test (iFOBT) to eligible people aged 60-74. The iFOBT detects trace amounts of blood which may indicate the presence of bowel cancer. Those participants who have a positive iFOBT result will be offered a colonoscopy. The colonoscopy can detect polyps and cancers if they are present. Those with bowel cancer will be referred on for treatment. Those who have a negative iFOBT result will be returned to the screening programme and re-invited in two years' time while they remain eligible.

There will also be a requirement for ongoing surveillance colonoscopies for those people who are identified through screening as at increased risk of bowel cancer.

The service delivery model will be based on that of the Bowel Screening Pilot in Waitemata DHB and will be rolled out nationally to cover all DHBs by the end of 2019.

Bowel screening aims to reduce the number of people who develop and die from bowel cancer. The two objectives of bowel screening are:

1. To diagnose and treat bowel cancer at an early curable stage
2. To identify and remove pre-cancerous lesions before they become cancer.

**Ranking**

2

**Responsible Vote Analyst**

[Please provide your name and extension number]

Funding Sought (\$m)	2015/16	2016/17	2017/18	2018/19	2019/20	2020/2021 and outyears
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Operating

Capital

VA Recommendation	2015/16	2016/17	2017/18	2018/19	2019/20 & outyears	TOTAL
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Operating

Capital

9/2/17 (1/1)

Vote Analyst [Support/Do not support/Partial support/Defer]  
 Recommendation [Please provide a short explanation of your recommended funding option]  
 Degree of government commitment [Pre commitment/manifesto commitment/discretionary]

### Supporting Information

Please list the supporting documents provided to your Vote Analyst. A Programme Business Case is being developed in preparation for Budget bid 2016. A Cabinet paper with an update on the outcomes of consultation is provided to SOC for their 02 December 2015 meeting.

Has Cabinet previously considered this initiative? Please provide a Cabinet reference and any supporting material. Cabinet previously considered and approved funding for a bowel screening pilot commencing 2012 to 2015 [CAB Min 10 (12/6B)]. A 2 year extension to the pilot was approved by cabinet as part of Budget 2015. On 1 July 2015 Cabinet agreed that the ministry should consult on a national service delivery model, service configuration and associated workforce and infrastructure needs to inform a business case for the delivery of a national bowel screening programme [SOC Min 9150-14/77].

### Vote Analyst Comment

[Please provide a comment on the quality of the supporting information provided. Have the costs and benefits of this proposal been adequately assessed? Has your agency met the Better Business Case or Regulatory Impact Analysis requirements where relevant? Do you have enough information to provide your assessment? If not, where possible, provide the agency's reason for not providing this information.]

### Strategic Alignment

How does this initiative fit with your agency's strategic intentions and align with the Government's priorities? Bowel screening aligns with the ministerial priorities of making services more accessible, including more care closer to home and improving the quality and safety of health services.

What is intended to be achieved, for whom? Introduce a bowel screening programme to people age 60-74 to reduce mortality from bowel cancer.

The bowel screening programme will mail a screening test - a faecal occult blood test (iFOBT) to eligible people aged 60-74. The iFOBT detects trace amounts of blood which may indicate the presence of bowel cancer. Those participants who have a positive iFOBT result will be offered a colonoscopy. The colonoscopy can detect polyps and cancers if they are present. Those with bowel cancer will be referred on for treatment. Those who have a negative iFOBT result will be returned to the screening programme and re-invited in two years' time while they remain eligible.

Participants in the programme are likely to have their cancers detected at an earlier stage than those not detected in the programme. Funding is also included for those people who are identified at increased risk of bowel cancer requiring ongoing surveillance colonoscopies.

How does this initiative relate to current activity(s) undertaken by your agency and/or by others across the State Sector This initiative will build on the bowel screening pilot currently underway in the Waitemata DHB region. Results from the first screening round in the pilot are positive and show that the programme is safe, effective and acceptable. In addition, there has been significant investment (around \$11 million) in colonoscopy service provision over the past three years which has seen a

Please list the agencies or non-government organisations that you have consulted in the process of developing this initiative.

65% reduction in the number of people waiting longer than the target time for a colonoscopy.

District health boards, NGOs, private endoscopy providers, primary care providers and Maori and Pacific health providers were part of the sector consultation in late 2015. In December 2015 the Ministry will consult with Te Puni Kokiri, Ministry of Pacific Island Affairs, Treasury, Ministry of Social Development and Department of Corrections.

### Vote Analyst Comment

[Please rate this initiative's alignment with Government priorities on a scale from 0-5. Please also provide a short comment on the answers provided by your agency – does this initiative align with the strategic intentions of the agency as outlined in their Four-year Plan? Is the strategic intent of this initiative clear? Has the agency clearly outlined who this initiative will target and what it is intended to achieve? Has your agency worked with other agencies where relevant in developing this initiative? Do they have a clear understanding of how this initiative will fit in with existing activity across the State Sector?]

### Impact Analysis

Provide a summary of the costs and benefits of this proposal.

#### Costs

- Cost to implement a national bowel screening programme
- Additional burden on colonoscopy and pathology related capacity including workforce and theatre capacity
- Adverse events following colonoscopy
- Additional retirees, more people survive longer
- Mental health considerations as people waiting for a colonoscopy following a positive test may become anxious if wait times are too long.

#### Benefits

- Bowel screening will produce a pronounced shift in the proportion of patients being diagnosed with cancers at an earlier stage (ie the cancer is less advanced). In the unscreened population only 13% of all cancers are found at Stage 1, in the screened population 39% of cancers are found at Stage 1.
- International publications estimate a reduction in the mortality rate of between 16% and 22% (for the cohort screened) 8-10 years following the implementation of a screening programme. Based on current mortality rates in the target population we could expect between 70 and 100 fewer deaths from colorectal cancer each year after eight years of a national bowel screening programme.
- A recent study from Ireland estimated 0.0237 QALYs saved per person screened over and above the option of not screening. The price of a QALY is currently estimated as \$38,110.

#### Other benefits include

- A reduction in the incidence of bowel cancer by locating and removing pre-cancerous lesions prior to them becoming cancers

- Fewer Emergency Department (ED) admissions required as patients are diagnosed earlier through screening
- Decrease in hospice/palliative care requirements through higher survival rates
- Increase in workforce as people are more likely to be retained in the workforce if diagnosed with bowel cancer early
- Identification of known genetic cancers in more families
- Raising awareness. National advertising campaigns will encourage awareness of bowel symptoms which may encourage earlier detection in the unscreened population
- The halo effect. Symptomatic, surveillance, pathology and cancer services may improve in quality and timeliness due to the imposed rigor of the new screening programme
- Improving our standing with other OECD countries which currently shows New Zealand having the fifth highest rate of bowel cancer mortality
- Improvements in data collection and data sharing. Better information collection will support benchmarking and evaluating service delivery and outcomes leading to improved quality outcomes.

What alternative options did you consider? Why did you choose your preferred option?

#### Option 1 – Do nothing

The pilot would discontinue and people would only have access to colonoscopy if they had symptoms or are at increased risk of bowel cancer. This option was discarded because New Zealand has one of the highest rates of bowel cancer in the developed world and the benefits of a national bowel screening programme would not be realised.

**Option 2 – Basic:** Screening to people aged 60-74, no primary care involvement in results management and no funding for surveillance colonoscopies.

Introduce a screening programme to people age 60-74 but only fund the basic screening pathway. This option was seen as being achievable given the current workforce capacity and the screening programme would generate an additional 9300 colonoscopies in the first full year.

This option was discounted as it did not include primary care involvement and did not include ongoing surveillance colonoscopies. Surveillance colonoscopies are currently undertaken and funded by DHBs many of whom struggle to keep up with referrals. Therefore it is unlikely that DHBs could undertake the additional surveillance colonoscopies if they were not funded. The recent gains made with additional funding to DHBs to reduce wait times for colonoscopies would be lost. Because the referral to surveillance was as a result of screening, there is a duty of care to that patient to have the complete

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screening process funded.

This option did not involve primary care in positive results management, which has been shown to be beneficial to promoting equity and engagement in bowel screening. By not involving primary care a bowel screening programme would be less aligned with the principles of the New Zealand Health Strategy.

**Option 3 – Integrated:** Screening to people aged 60-74, primary care involved in results management, but no funding for surveillance colonoscopies.

Introduce a screening programme to people age 60-74 and enable positive iFOBT results to be managed by the patient's primary care provider, which is more in line with the principles of the New Zealand Health Strategy. The programme would be funded for a more integrated screening pathway but not for ongoing surveillance colonoscopies.

This option was discounted as it did not include ongoing surveillance colonoscopies. As mentioned in Option 2, surveillance colonoscopies are currently undertaken and funded by DHBs, many of whom struggle to keep up with referrals. Therefore it is unlikely that DHBs could undertake the additional surveillance colonoscopies if they were not funded. The recent gains made with additional funding to DHBs to reduce wait times for colonoscopies would be lost. Because the referral to surveillance was as a result of screening, there is a duty of care to that patient to have the complete screening process funded.

#### **The preferred option**

**Option 4 – Complete:** Screening to people aged 60-74, primary care involved in results management, and funding for surveillance colonoscopies.

This option was chosen as it is achievable in terms of capacity and is supported by the sector. It is more in line with the principles of the New Zealand Health Strategy, and more likely to ensure DHBs are able to safely manage surveillance colonoscopy demand as a result of screening. Analysis of the pilot data shows that an age range of 60-74 years, with an increased positivity threshold (ie the level at which blood is detected in the sample) compared with the pilot (which is similar to levels used in other OECD countries):

- will detect the most cancers possible within an achievable number of colonoscopies.
- will minimise the risk of adverse events from colonoscopy when compared to the number of cancers detected
- is the most cost effective age range.

### Vote Analyst Comment

[Please rate this initiative on a scale from 0-5 reflecting the benefits relative to the costs. Please explain your rating and provide a short comment on the quality of the cost-benefit analysis and the reliability of the inputs.]

### Legislative and Regulatory Implications

Please detail any legislative implications and whether the RIA requirements apply. N/A

### Vote Analyst Comment

[Please use this space to insert the QA statement if applicable. See page 21 of the guidance for information on QA - contact the RIA team if you have any questions.]

### Affordability

What strategic trade-offs would be required to fund this initiative from baselines?

There is no opportunity in the current Ministry of Health work programme that could be stopped or scaled down to fund this initiative from baselines. This initiative could not be implemented without additional funding.

Provide an option for scaling, phasing and/or deferring this initiative.

Options include deferring implementation for another year/s or implementation could be phased over a longer period. Current implementation is planned to be complete by the end of 2019 but could be extended over a longer period.

Describe the implications on service delivery if this funding is not approved or deferred.

There is a risk that not only momentum, but also workforce capacity and capability from current investment will be lost.

Each year that the start of the programme is delayed will result in:

- a whole cohort of people aged 74 years (over 36,000 people) not being offered bowel screening in their lifetime
- 81 cancers not detected in year one of the phased roll out
- a delay in detecting an estimated 700 cancers across the whole country by the time full roll out is achieved
- continuing services in Waitemata in the interim will cost \$6 million per annum.

### Vote Analyst Comment

[Please provide a brief comment on the quality of the agency's Four-year Plan and discussion of strategic trade-offs. Do you agree with the agency's assessment of the impact of not approving this initiative?]

### Delivery and Risk Management

What are the risks to delivering this initiative? How will these risks be mitigated?

Risks and mitigations

- The establishment of a national IT system in the roll out timeframe. The risk will be mitigated by extending the Pilot IT system to accommodate a national programme, either for first tranche DHBs or whole programme. Adequate CAPEX funding needs to be secured to fund the delivery of high quality IT support

- Inequalities in participation will further exacerbate inequalities of outcomes. This will be mitigated by ensuring KPI reporting for participation along the pathway broken down by various groups. Also need to ensure good engagement with Māori and Pacific stakeholders at governance (and all) levels. The ability to monitor quality/consistency/safety along the pathway. This will be mitigated by ensuring there is budget provision and adequate services available for adequate IT reporting systems
- The additional burden of surveillance colonoscopies on the workforce. The risk will be mitigated by ensuring adequate funding is available for additional surveillance colonoscopies; good workforce modelling and ongoing implementation of workforce initiatives such as nurse endoscopy.
- The pilot is already generating demand for ongoing surveillance colonoscopies. The DHB is responsible for follow-up of these individuals and ensures people who are identified through the screening programme are receiving appropriate care. This risk is mitigated by monthly monitoring of DHB wait times for colonoscopy. A review of current Surveillance Guidelines will also be undertaken informed by current international standards
- The sector is not adequately prepared and ready in time. This will be mitigated by ensuring adequate lead in time (at least a year) and implementation funding. DHBs will also be assessed for readiness prior to commencing screening.

What capability is required to deliver this initiative? Does this capability exist or will it need to be built?

The capability to undertake this initiative exists in the Ministry and the health sector. There will be capital requirements in terms of theatres and IT system development. In addition, Health Workforce NZ will work with professional bodies and DHBs to support adequate training and increased numbers, in particular for endoscopists and pathologists.

#### Vote Analyst Comment

[Please rate this initiative red, amber or green according to your assessment of risks associated with the delivery of this initiative. Consider the size of the proposal relative to the agency's activity, any cross agency impacts, and impacts to front-line service delivery.]

#### Implementation and Evaluation

How will this initiative be managed and implemented?

Implementation will be overseen by a dedicated team at the Ministry of Health, with advice from a bowel screening advisory group. The Ministry will continue to work closely with the sector to support increased colonoscopy volumes and lessons learned from the pilot will continue to inform a national roll out. Governance arrangements will continue to include both sector and pilot expertise.

Bowel screening will be rolled out in three implementation tranches. DHBs each require different amounts of time to prepare for bowel screening depending on their state of readiness. The provisional configuration of those tranches are:

1. 2017 - An additional screening site will be added to the pilot in early

2017. Tranche 1 will also include setting up a national coordination centre and further development of the bowel screening IT system ready for the remaining DHBs. The pilot will be transitioned to the national programme in late 2017.

2. 2018: Implementation of bowel screening in nine further DHBs. Tranche 2 will also include set up of regional bowel screening centres.

3. 2019: Implementation of bowel screening to the final nine DHBs. Funding will be made available up to one year in advance (or longer for the small number of DHBs with capital requirements) to support the required implementation planning and development of service providers prior to commencement.

**When will this initiative be evaluated and how will performance be assessed?**

This bid includes funding for a post implementation evaluation in year 2020/21. The bowel screening programme will have quality standards along the bowel screening pathway. Ongoing monitoring will be undertaken at national, regional and local levels. Key performance indicators will be monitored at a national level by the Ministry. Regular six monthly monitoring reports will be published. Regional bowel screening centres will manage quality across the region to ensure service providers are meeting national quality standards. Providers will have continuing quality assurance processes in place. An accreditation programme will be established.

**Vote Analyst Comment**

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