Regional Public Health
HAUORA Ā IWI KI TE ŪPOKO O TE IKA A MĀUI
Better health for the greater Wellington region

20 September 2019

Committee Secretariat
Māori Affairs Committee
Parliament Buildings
Wellington
ma@parliament.govt.nz

Re: Inquiry into health inequities for Māori

Tēnā koe Mr Tirikatene

Regional Public Health would like to formally register our agreement and support for the submission and recommendations made by Waikato District Health Board (Waikato DHB) on the Māori Affairs Select Committee Inquiry into health inequities for Māori.

Recently government has sought feedback on significant pieces of health policy and legislation, for example, Smoke-free Environments (Prohibiting Smoking in Motor Vehicles Carrying Children) Amendment Bill, Misuse of Drugs Amendment Bill, Kāinga Ora – Homes and Communities Bill, Climate Change Response (Zero Carbon) Amendment Bill, Health and Disability System Review, and the development of the Child and Youth Wellbeing Strategy. The increased consultation has stretched capacity to respond and meant public health units have had to look at new ways of having their voice heard on important health topics. Public health units often collaborate and share ways of working as an efficient way of making good use of the limited resources we have. Regional Public Health has therefore chosen to support the thorough submission made by Waikato DHB

Regional Public Health delivers population and personal health services in the greater Wellington region. Our geographical area of service delivery spans Hutt Valley, Capital & Coast and Wairarapa DHBs. We aim to improve the health of communities; in particular we focus on achieving equitable health outcomes for high needs groups such as Māori, Pacific peoples, child and youth, low income families and other vulnerable groups.

The recommendations suggested by Waikato DHB will help address the inequities for Maori in the greater Wellington region.

We do not wish to speak at the forthcoming hearings.

The contact point for this letter of support is:
Kiri Waldegrave, Senior Public Health Advisor, Regional Public Health
Email: Kiri.Waldegrave@huttvalleydhb.org.nz, Phone: 04 570 9130

Kind regards

Dr Stephen Palmer	**Janice Hemi**
Medical Officer of Health	**Acting Service Manager**

Submission
Inquiry into health inequities for Māori

To: Committee Secretariat
Māori Affairs Committee
Parliament Buildings
Wellington
ma@parliament.govt.nz

Submission due: 20 September 2019

Details of Submitter: Waikato District Health Board

Address for Service: Public Health Unit
Waikato District Health Board
Private Bag 3200
HAMILTON 3240

Contact Person: Dr Nina Scott
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Date: 23 August 2019

The Waikato DHB wishes to be heard

Introduction

1. Waikato District Health Board (Waikato DHB) presents this submission on the Māori Affairs Select Committee's Inquiry into health inequities for Māori with support from the Waikato/Bay of Plenty Division Cancer Society.

2. Waikato DHB has a duty of care and statutory objective under the New Zealand Public Health and Disability Act 2000 to improve, promote and protect the health of people and communities. Additionally, there is a responsibility to promote the reduction of adverse social and environmental effects on the health of people and communities.[1] With nearly 7000 staff, Waikato DHB provides health services to a population of over 400,000 people across the Waikato region, and tertiary-level services to the midland region with a population of over 840,000.[2]

3. Waikato DHB welcomes this inquiry. Māori are a priority group for improved health outcomes because of the unequal health outcomes with respect to cancer and the health determinants. Māori and Pacific peoples have the highest rates of preventable cancers, worse survival, and higher death rates than other New Zealanders. There are stark and unacceptable ethnic differences in cancer survival in Aotearoa.[3]

4. Māori experience inequities across the entire cancer continuum from policy, screening, access to GP services, access to diagnosis, treatment and supportive care.[4]

5. *Te Tiriti o Waitangi* was New Zealand's first health policy. Under the Treaty of Waitangi, the Crown made a commitment to a partnership to improve the participation and health status of Māori. The public health and disability system has a responsibility to improve the health outcomes of Māori people as citizens and the tangata whenua of New Zealand, and make every reasonable effort to eliminate barriers to services that may contribute to inequitable health outcomes. This is reflected in the New Zealand Public Health and Disability Act 2000.[5]

6. In 2006, a key priority was made by the Government and the Ministry of Health to reduce the health inequities that affect Māori. Little if no measurable improvement has been made.[5]

7. In this submission, Waikato DHB defines inequities as differences in health which are unfair, avoidable and remedial.

8. Waikato DHB has reviewed the Māori Affairs Committee Terms of Reference for the Inquiry into health inequities for Māori, and makes the following comments and recommendations for consideration.

9. Waikato DHB has made comment on the Terms of Reference numbers 1 to 5. The appendix section of this submission contains data (graphs) and patient stories.

10. If you have any questions on the comments included in our submission please contact:

    Dr Nina Scott
    Clinical Director
    Māori Public Health
    Te Puna Oranga
    E: nina.scott@waikatodhb.health.nz

Key points

Inequities in cancer

11. In New Zealand, Māori experience a disproportionate burden of cancer. These include:

    - Māori rates of mortality from all types of cancers were twice that of non-Māori.[6]
    - Māori women are approximately twice as likely to die from breast cancer compared with non-Māori, and at least half of the explanation for this is later stage at diagnosis and less breast screening.[4]
    - Māori females had a cervical cancer registration rate twice that of non-Māori; but the mortality rate for Māori females was disproportionately higher at four times that of non-Māori females.[6]
    - Māori females had a lung cancer registration rate four-and-a-half times that of non-Māori females; but Māori females have a mortality rate five times that of non-Māori females.[6]
    - Māori male lung cancer registration and mortality rates were three times those of non-Māori males.[6]
    - For Māori males, the liver cancer registration rate was five-and-a-half times that of non-Māori males.[6]
    - Rates of stomach cancer registration and mortality were almost three times higher for Māori males than for non-Māori males.[6]
    - Prostate cancer registration was lower for Māori males than for non-Māori males; but Māori males had a prostate cancer mortality rate twice that of non-Māori males.[6]
    - Māori are more likely than non-Māori to access services later and to experience serious disorders and/or co-existing conditions.[5]

Screening programmes

12. In New Zealand, there are screening programmes for both breast and cervical cancer. For both these programmes, coverage rates to 31 March 2015 were lower for Māori than for non-Māori.[5]

13. Māori women who have screen detected breast cancers experience over 90% five-year survival rates. Maximising breast screening coverage is an important goal for Māori women, and the mortality benefits for screening Māori women are likely much greater than for the average population given that outside the screening program Māori women do so much worse.[4]

Barriers experienced

14. In 2013/14, compared with non-Māori, Māori children and adults were more likely to report cost as a barrier to seeking health care from a General Practitioner (GP).[5]

15. Lack of transport is more likely to be a barrier to accessing GP, after-hours services[5] medical appointments and treatment for Māori than non-Māori.

16. Adults with low health literacy were more likely to avoid physical visits; were more fatalistic about cancer; had less familiarity and knowledge about cancer screening tests, and were less likely to seek health information from sources other than physicians.[7]

Social determinants of health

17. People living in more socioeconomically deprived areas of New Zealand are more likely to develop cancer and less likely to have their cancer detected early than people living in less deprived areas.[8]

18. Māori health inequalities are not only caused by health issues, but are influenced by a wide range of factors including but not limited to income, employment, education and housing.

Summary of Recommendations

19. Waikato DHB **recommends** the following**:**

- Establish strong Māori governance and leadership within the new Cancer Control Agency.

- Re-establish Te Kete Hauora (national Māori Policy Team) to improve Māori health outcomes by addressing health inequities through Māori-led solutions and with a health bureaucracy responsive to its Treaty obligations.

- Develop a Māori Cancer Control Strategy.

- Improve the health workforce by establishing Māori Cancer Navigation roles to work in Māori Cancer Equity Teams across New Zealand.

- Progress cancer screening programmes for lung, prostate, bowel, stomach and other cancers to improve early access to diagnosis and treatment; with Māori as the first cohort.

- Reduce the cancer screening age for Māori by at least 10 years and provide free screening for women outside the current eligible age requesting screening.

- Improve outcomes in the cancer care pathway through formalised standardisation of care to ensure better and more consistent care management occurs regardless of location.

- A commitment to and focus on studies and research that include the voices of Māori with cancer and their whanau to identify and address factors that inhibit access to and through cancer care services.

- Improve the pathway to diagnosis and treatment by establishing a *Cancer Care Assistance Fund* to provide financial relief for those people at high risk of inequitable cancer outcomes and or undergoing complex cancer treatment or High Suspicion of Cancer (HSCAN) diagnostic pathways. Further, we recommend liaison officers be appointed to comprehensively assist those undergoing complex cancer diagnostics or treatment negotiate an additional funding pathway. If WINZ were to administer such a fund, additional legislative considerations may be required.

- Develop and fund health literacy programmes and provide training for health system personnel to improve patient education and understanding of the cancer care pathway by reducing medical jargon through use of plain language and easy-to-understand written and visual materials.

- Increase the health literacy of the general population by promoting modifiable risk factors and links to cancer such as tobacco smoking, obesity, alcohol consumption, poor nutrition, physical inactivity and other determinants.

Feedback on the terms of reference for the inquiry

Inquiry Terms of Reference 1: Collating existing statistics and evidence regarding Māori cancer health and identifying significant inequalities.

20. Māori health status in the current context is complex because of the overlay of indigeneity.

21. Māori experience longer and slower pathways through health care;[9] hospitalisation rates that are disproportionately low in disease categories where Māori have high death rates, and a health service structure where people without access to transport or resources have more difficulty attending health services for both treatment and prevention.[10]

22. Māori are disproportionately affected by the cancer burden compared to non-Māori, and have a higher rate of cancer registrations both in New Zealand and Midland[1]; particularly Māori women.[11]

23. Midland Māori, have higher levels of cancer mortality in all DHBs than non-Māori and higher rates of avoidable cancer hospitalisations.[11]

24. The proportion of lung cancer mortality for Māori was highest in both New Zealand and Midland. Tobacco smoking is one of the key risk factors in lung cancer and Māori have a much higher daily smoking rate than non-Māori.[11]

25. Within the Waikato DHB, cancer registrations differ between Māori and non-Māori. Lung (19%) and breast (17%) were the top cancers for Māori compared with urological (22%) and lower-gastrointestinal (13%) cancers in non-Māori (Figure 1). (Refer to appendix 1 for all data).

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[1] Midland comprises Bay of Plenty DHB, Lakes DHB, Hauora Tairawhiti, Waikato DHB.

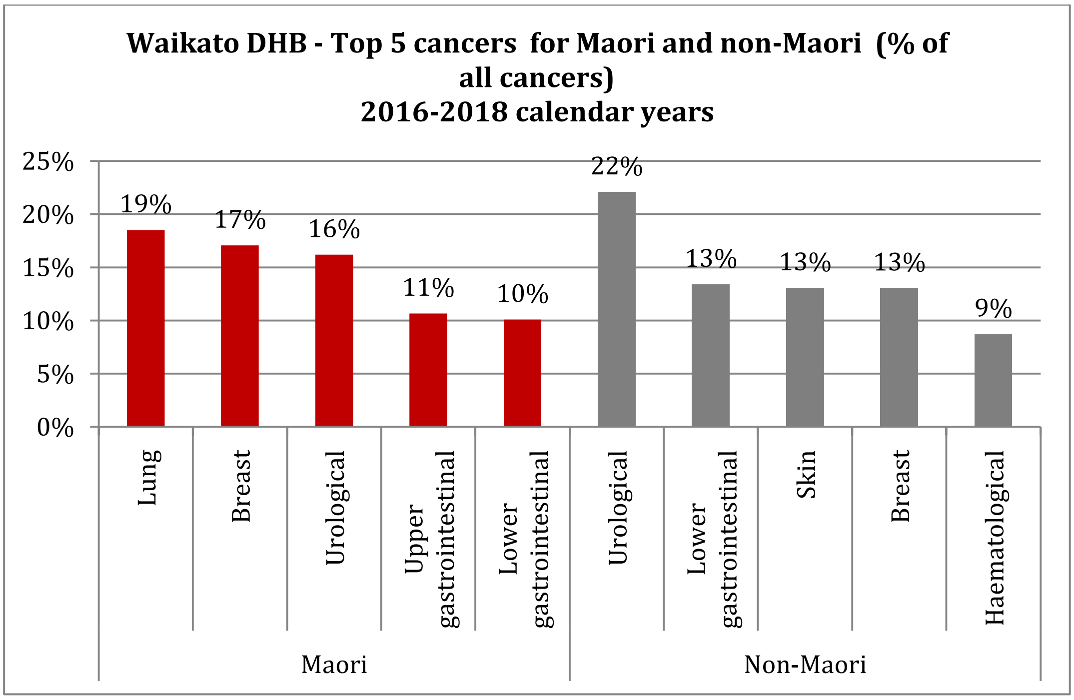

Figure 1: Waikato DHB top 5 cancers for Māori and non-Māori.

Patient stories: the impact of cancer inequities

A Māori grandmother with lung cancer is bringing up her mokopuna. She is living in a cold state house and getting recurring chest infections, making it difficult to treat her lung cancer. Each time she goes to a chemo planning appointment she is unable to get any further, and her whanau think she's lying about her cancer. Her eldest mokopuna is struggling and is involving herself with youth crime.
Story provided by Cancer Society with patient consent. (Appendix 2: patient stories)

Another Māori woman with 13 children; nine are living at home and this is causing a lot distress as she needs babysitters whilst she has chemo. Often the kids stay home from school and the husband is struggling also. Cancer is the last thing in their minds. The bare essentials for surviving life and protecting the children as all mothers can relate to are more important. They can't think about the future as just need to find a way they can get to dinner time each day.
Story provided by Cancer Society with patient consent. (Appendix 2: patient stories)

26. Adolescent and Young Adult (AYA) patients have multiple risk factors that are compounded. It is widely recognised internationally and in New Zealand that the AYA cancer population have distinct and unmet needs.[12] Adolescent and young adult cancer incidence and survival in New Zealand (2000–2009) study found five-year relative survival by ethnicity for 15-–24-year-old cancer patients to be significantly lower for Māori (69.5%) and Pacific peoples (71.3%) than it was for non-Māori/non-Pacific peoples (84.2%).[13]

Patient story: adolescent and young adults

Mr I is an 18 year old Māori male with Lymphoma Cancer. He has a partner who is also in the adolescent and young adult (AYA) age group and a young baby. Mr I lives in a rural town approximately 60km away from his tertiary cancer service provider. When treatment is provided at quaternary service he travels approximately 180km, over 2 hours one way trip. At the moment Ms I is looking after baby. Mr I is managing all the logistics such as accommodation and travel to and from appointments. Accommodation in Auckland is scarce at the best of times but very bad at the moment. Dr N needs Mr I to stay a few more days. He is today having Day 22 of Consolidation (VCR & LP MTX). (Motel) was only booked until today. Money is an issue for the couple. I have had conversations and emails with Youth Services, in said rural town) and WINZ personnel, rural town to arrange a travel loan but haven't got very far. It is 180km one way and they have funded most of this themselves and with help from family. It is getting harder to get petrol vouchers from LBF and Canteen although they have been great and have also helped them move hotels as it's not the first time this has happened. As you know, NTA don't provide transport costs from hotel to hospital. Ms I has the NTA claim form completed for rural town to Auckland travel in the last 2 months, she just needs to get a bank generated slip which I am trying to help her with.

Story provided by Waikato DHB Clinical Nurse Specialist with patient consent (Appendix 2: patient stories)

Waikato DHB recommends the following:

- Establish strong Māori governance and leadership within the new Cancer Control Agency.
- Re-establish Te Kete Hauora (national Māori Policy Team) to improve Māori health outcomes by addressing health inequities through Māori-led solutions and with a health bureaucracy responsive to its Treaty obligations.
- Develop a Māori Cancer Control Strategy.

Inquiry Terms of Reference 2: Studying the higher incidence rate Māori experience with specific cancers compared to non-Māori.

Breast cancer

27. New Zealand women from low socio-economic status present with more serious disease; have less optimal treatment, and have suboptimal outcomes. Māori and Pacific disproportionately reside in areas of deprivation. Socio-economic status is an indicator of the inequities present within the NZ health system. There is a strong association between socio-economic status and ethnicity in women with breast cancer; 46% of Māori women and 57% of Pacific women in quintile 5.

28. *Helicobacter pylori*, an infective agent associated with the development of stomach cancer, is thought to be the major driver of ethnic inequities seen in stomach cancer. The prevalence of *H. pylori* is associated with household crowding and poverty, acquired in childhood and passed through families.[14]

29. Māori women who are diagnosed with breast cancer are 76% more likely to die from their cancer than non-Māori women. The most important contributor is late stage at diagnosis, with the additional culmination of multiple inequities along the cancer care pathway. These include differences in neighbourhood deprivation, mode of diagnosis, treatment facility type, and type of loco-regional therapy. These factors reflect inequities in the determinants of health, and access to and quality of health care.[4]

30. New Zealand offers two screening programmes for both breast and cervical cancer. For both these programmes, coverage rates to 31 March 2015 were lower for Māori than for non-Māori.[5]

31. However, Māori and Pacific women diagnosed through the breast screening programme do as well and New Zealand European women.[4]

Waikato DHB recommends the following:

- Progress cancer screening programmes for lung, prostate, bowel, stomach and other cancers to improve early access to diagnosis and treatment; with Māori as the first cohort.

- Reduce the cancer screening age for Māori by at least 10 years and provide free screening for women outside the current eligible age requesting screening.

- Improve outcomes in the cancer care pathway through formalised standardisation of care to ensure better and more consistent care management occurs regardless of location.

Inquiry Terms of Reference 3: Identifying specific sets of issues experienced by Māori health service users.

32. Māori health inequities are not only caused by health issues but are influenced by a wide range of factors including but not limited to income and poverty,

employment, education and housing. These factors are known as the social determinants of health.

33. Access to cancer treatment and treatment outcomes for Māori and Pacific peoples have been persistently poorer compared with the wider population.

34. Barriers to access:
    - Poverty (socioeconomic deprivation)
    - Geographic isolation (rural and remote rural)
    - Mobility of patients (cost and access to affordable transport options)
    - Frailty in older age (comorbidities)
    - Health literacy and education
    - The need to take time off work
    - The need to arrange and pay for childcare.

Access to transport

35. Negotiating access to affordable transport options has been the biggest barrier and frustration identified by patients accessing treatment. This includes access to the National Travel Assistance programme, administered by the Ministry of Health.

36. Waikato DHB is aware that the National Travel Assistance programme (NTA) has recently undergone a review although recommendations are unlikely to be implemented until at least 2020 and beyond. Cancer patients need support now.

37. The National Travel Assistance scheme (NTA) was set up in 2005 to provide financial contribution to the cost of travel and accommodation for people who needed to travel long distances or very frequently to attend specialist hospital appointments. [15]

38. Approximately 1.8 million users access specialist health services per year, but only 33,000 people or 1.8% of those who may need assistance accessing services, access the NTA scheme per year. Twenty-three percent of Māori access the NTA scheme compared with 70% of European. The highest users of the scheme are those taking children aged 0 and 4 years to specialist appointments and treatment; males between the ages of 65 and 74 years, and females between the ages of 65 and 74 years.[15]

39. Figure 2 below suggests that people living in areas of New Zealand with the lowest level of deprivation (decile 1) receive a higher level of funding each, but are funded at a much lower rate than people living in areas of the highest deprivation (decile 10). This suggests the NTA scheme is enabling higher access to people with higher needs, but not assisting them at the same level.[15]

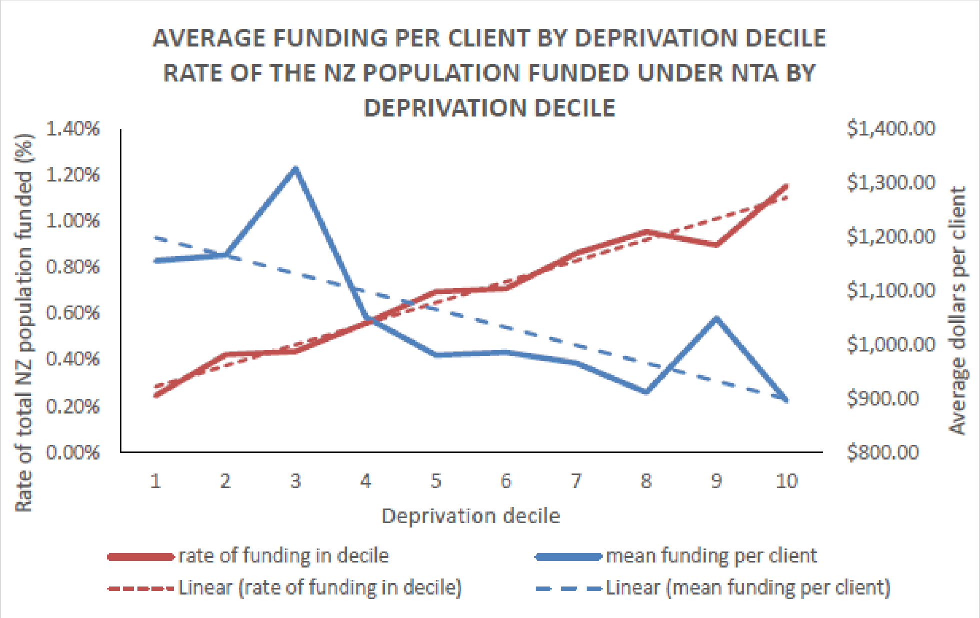

Figure 2: People who use the NTA scheme by socioeconomic deprivation level.

Patient stories: access to affordable transport - the impact

Patient: Mrs K Māori female: 51 Breast Cancer
Barrier in receiving support through National Travel Assistance (NTA). Patient has a Community Services Card (CSC), but lives too close to the treatment centre until near the end of the first cancer curative treatment modalities. Once and if Mrs K gets through her neoadjuvant chemotherapy, surgery, and onto radiation therapy, Mrs K can then back-date for all previous service providers' events. Mrs K enquires if she can claim, currently eligibility status is not met and NTA team are unable/unwilling to register in anticipation.

Story provided by Waikato DHB Cancer Nurse Specialist with patient consent (Appendix 2: patient stories)

Waikato DHB recommends the following:

- Improve the pathway to diagnosis and treatment by establishing a *Cancer Care Assistance Fund* to provide financial relief for those at high risk of inequitable cancer outcomes and or undergoing complex cancer treatment or High Suspicion of Cancer (HSCAN) diagnostic pathways. Further, we recommend liaison officers be appointed to comprehensively assist those undergoing complex cancer diagnostics or treatment negotiate an additional funding pathway. If WINZ were to administer such a fund, additional legislative considerations may be required.

- A commitment to and focus on studies and research that include the voices of Māori with cancer and their whanau to identify and address factors that inhibit access to and through cancer care services.

Health literacy: a barrier to cancer treatment

40. Health literacy is the degree to which individuals have the capacity to obtain, process and understand health information and services needed to make health decisions.[16]

41. Low health literacy is one of the social determinants of health associated with health disparities such as premature mortality rates, lack of adherence to medical recommendations, and higher direct and indirect health costs.[16]

42. Studies have shown that 40%-80% of medical information provided during consultations is forgotten immediately and nearly half of the information retained is incorrect.[17]

43. Engaging people in the development of health literacy cancer prevention and early detection communications can enhance understanding and supports the sharing of information with peer and family members including whānau; children, parents and grandparents.[17]

Waikato DHB recommends the following:

- Develop health literacy programmes and provide training for health system personnel to improve patient education and understanding of the cancer care pathway by reducing medical jargon through use of plain language and easy-to-understand written and visual materials.

- Increase the health literacy of the general population by promoting modifiable risk factors and links to cancer such as tobacco smoking, obesity, alcohol consumption, poor nutrition, physical inactivity and other determinants.

Inquiry Terms of Reference 4: Investigating and critiquing the lower engagement rate for Māori with prevention, early detection, screening programmes, treatment and medication.

44. Māori (and Pacific) are more likely to be exposed to the major risk factors associated with the development of certain cancers; tobacco, alcohol, and obesogenic environments than other population groups in New Zealand. These factors are reflected in the common cancers found in these population groups (Figure 3).

45. Early detection of cancer greatly increases the chances for successful treatment of cancer, and improves survival.[18] Early detection is particularly relevant for many of the cancers with commonly diagnosed in Māori, such as breast, cervix, colon, and rectal cancers. However, Māori are more likely to experience difficulties accessing primary care and diagnostic services, and present at later stages of disease.[4]

46. Although screening the numbers of eligible Māori women participating in breast and cervical screening has increased over time, Māori women continue to have lower coverage rates in both screening programmes. [19, 20] For the Waikato,

breast screening of an additional 884 Māori women are required to reach the total population coverage of 70%.[19]

47. In the Waikato, Māori and Pacific women diagnosed through the breast screening programme have outcomes comparable to non-Māori/non Pacific women. For breast cancer specifically, 15% of the disparity in survival seen in Māori women in relation to New Zealand European women was attributable to screening.[4]

48. Cancer treatment pathways are complex and difficult to navigate. Māori are more likely to experience delays to cancer treatment and differences in cancer treatment compared to non-Māori.[21]

49. The figure below demonstrates higher rates of non-attendance (DNA) for Māori patients referred with high suspicion of cancer (HSCAN) compared to non-Māori in the Waikato region. The reasons for these findings are likely to be multifactorial; including many of the key factors reflected in the patient stories presented through the submission and in particular in Appendix 2.

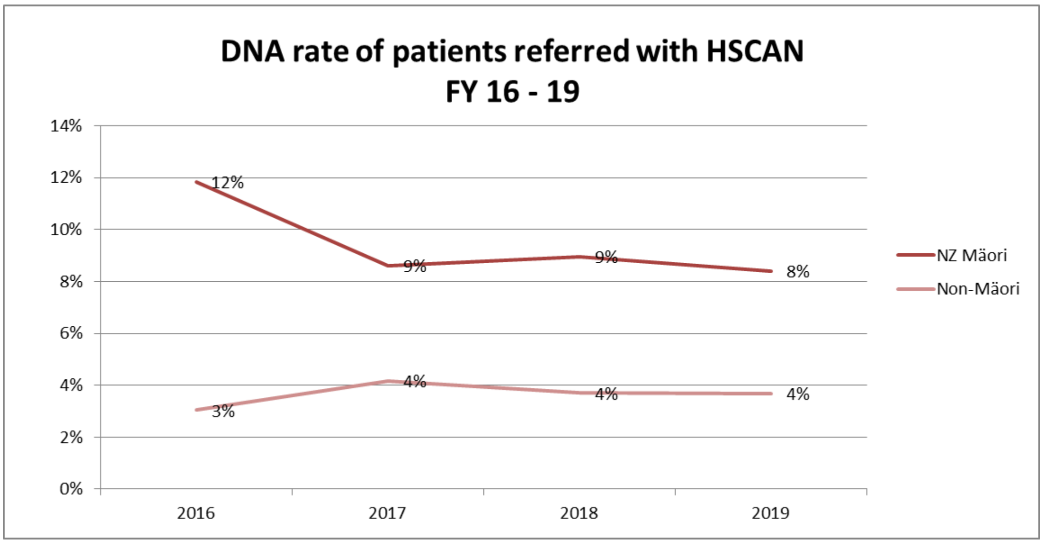

Figure 3: Waikato DNA rate of patients referred with HSCAN

Waikato DHB recommends the following:

- Improve outcomes in the cancer care pathway through formalised standardisation of care to ensure better and more consistent care management occurs regardless of location.
- Improve the health workforce by establishing Māori Cancer Navigation roles to work in Māori Cancer Equity Teams across New Zealand.

Inquiry Terms of Reference 5: Looking at the role primary and health professionals play in improving cancer survival rates for Māori.

50. Access to cancer care is persistently poorer for Māori and Pacific compared to the wider population. Māori are less likely to access primary care, and are more

likely to experience a lack of appropriate and supportive care, impacting on survival.[22]

51. Primary and other health professionals play a significant role in enabling early diagnosis including screening for all cancer patients and facilitating timely treatment that can result in improved cancer survival rates for Māori.

52. Furthermore, these health professionals play a critical role in advocacy for cancer prevention, promoting and providing health literacy, and in addressing the contribution of the social determinants of health to the poorer cancer survival for Māori.[23]

53. Primary and other health professionals can positively influence cancer outcomes through their prioritisation of equity, recognition of inequity processes along the cancer care pathways, and their role in contributing to these inequities. They can act to mitigate these issues in their own practice, including increased cultural awareness, and establishing relationships.

54. Comorbidity is common among cancer patients and impacts the outcomes of people with cancer, including being less likely to receive treatment with curative intent and poorer cancer survival.[24] Māori have a higher prevalence of co-morbidities compared to non-Māori. Through recognising and better managing a patient's co-morbidities, there is a role for primary and health professionals to improve outcomes.

Waikato DHB recommends the following:

- Improve the health workforce by establishing Māori Cancer Navigation roles to work in Māori Cancer Equity Teams across New Zealand.

- Improve outcomes in the cancer care pathway through formalised standardisation of care to ensure better and more consistent care management occurs regardless of location.

- Develop and fund health literacy programmes and provide training for health system personnel to improve patient education and understanding of the cancer care pathway by reducing medical jargon through use of plain language and easy-to-understand written and visual materials.

Conclusion

55. Thank you again for the opportunity to contribute to the Inquiry into Health Inequities for Māori. It is hoped this inquiry will go some way to achieving health equity for Māori across the life course and for the health sector to meet its obligations of te Tiriti o Waitangi. *Mana taurite haurora* (health equity for all).

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Appendices

Appendix 1: Data

All new cancer registrations have increased steadily since 2009, and for Māori numbers peaked in 2018 with 383 new cancer registrations. (Figure 1).

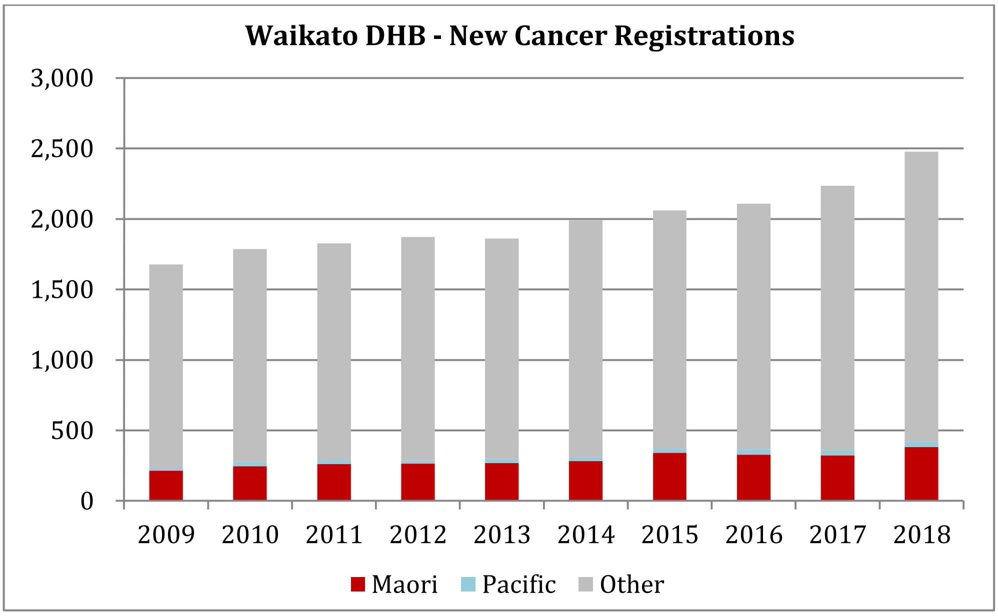

Figure 1: New Waikato DHB Cancer Registrations by ethnicity2009-2018

The top five cancers for Maori are lung, breast, urological, upper gastrointestinal and lower gastrointestinal. These vary from the top five cancers for non-Māori (Figure 2).

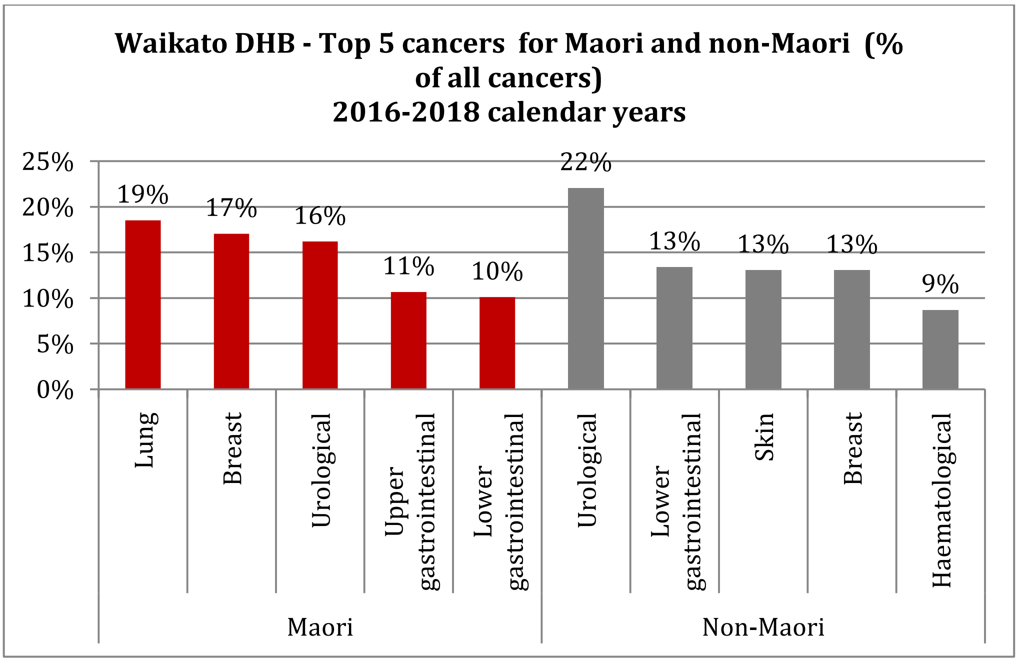

Figure 2: Waikato DHB top five cancers for Māori and non-Māori.

Figure 3 sows there is a higher percentage of Māori women presenting with cancer than non-Māori.

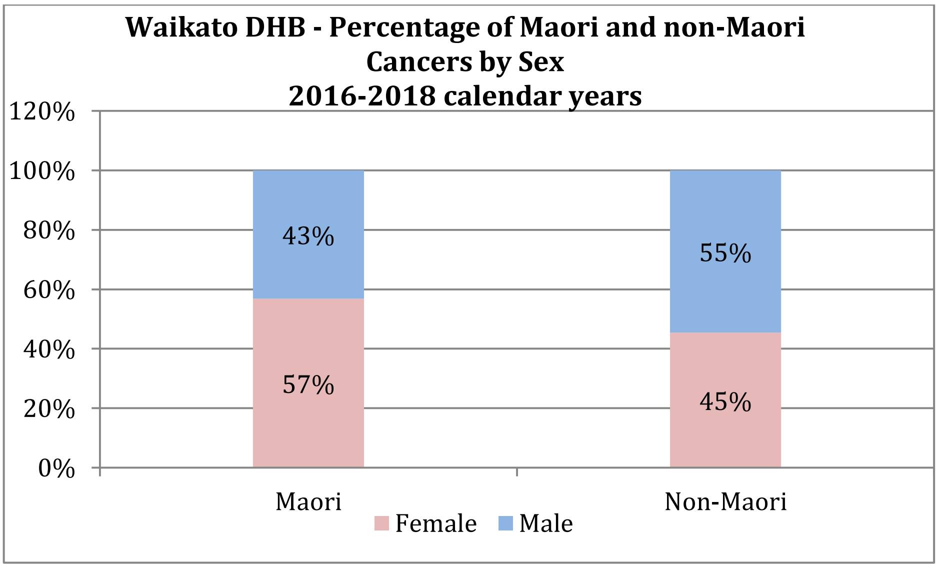

Figure 3: Waikato DHB Percentage of Māori and non-Māori Cancers by Sex

The top five cancers for Māori females include breast, lung, gynaecological, lower gastrointestinal and haematological cancers. For Māori males the top five cancers are urological, lung, upper gastrointestinal and lower gastrointestical (figure 4). These vary compared with the top five cancers for non-Māori females and males as seen in figure 5.

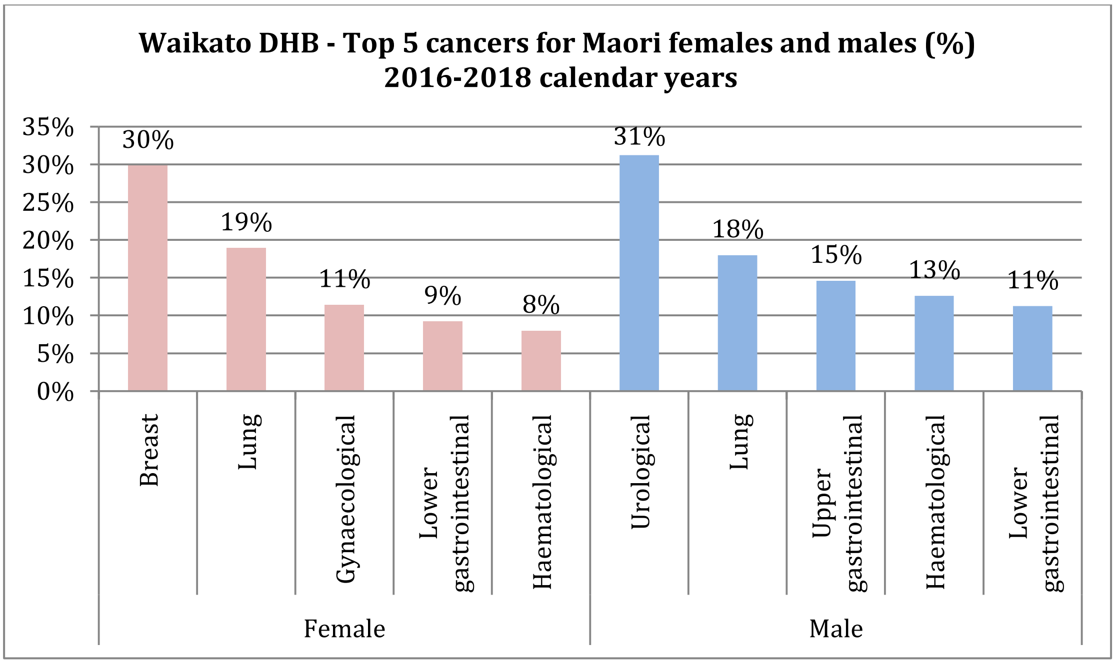

Figure 4: Waikato DHB Top 5 cancers for Māori females and males by percentage

Breast cancer is the leading cancer type for all women; and urological cancer is the leading cancer for all males (figures 4 & 5).

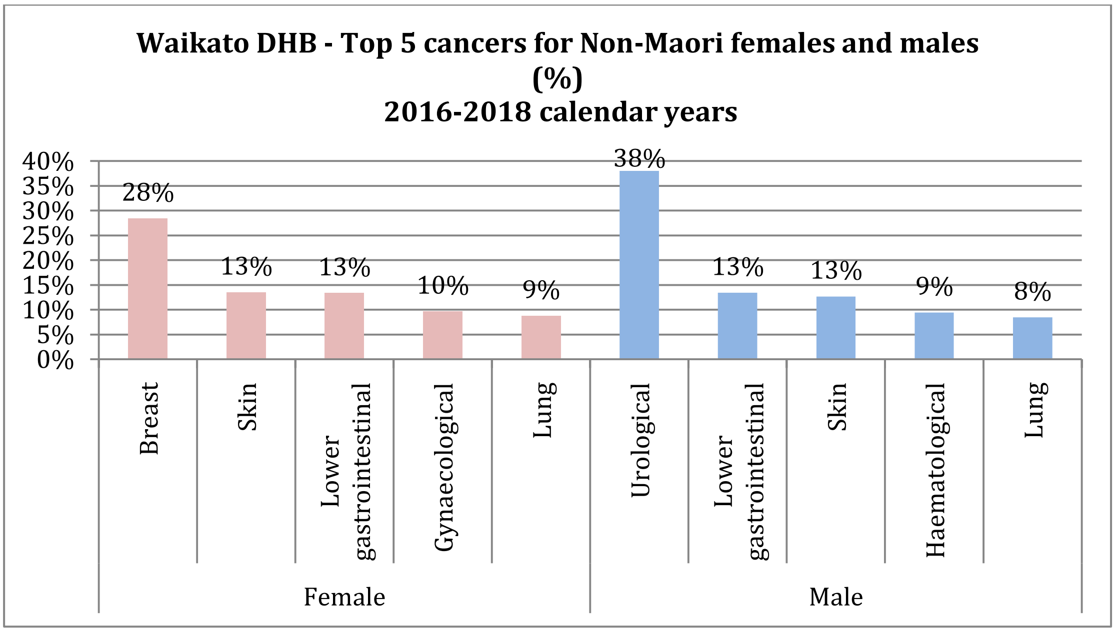

Figure 5: Waikato DHB Top 5 cancers for non-Māori females and males by percentage

Data: High Suspicion of Cancer (HSCAN) did not attend (DNA)

Figure 6 shows the numbers of patients not attending appointments for high suspicion of cancer between 2016 and 2019.

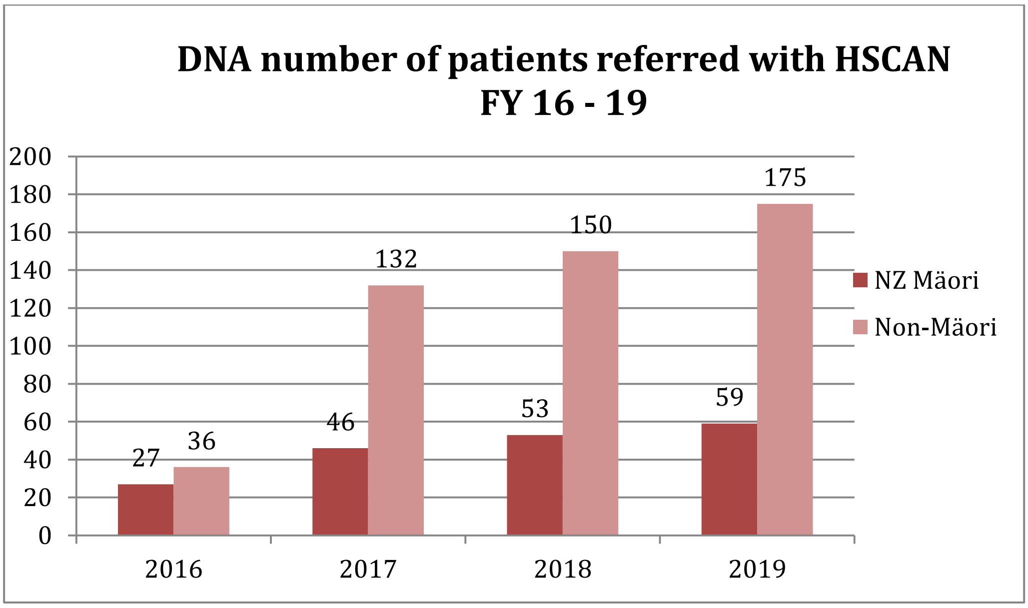

Figure 6: Waikato DHB DNA number of patients referred with HSCAN

Figure 6 shows higher rates of non-attendance for Māori patients referred with a high suspicion of cancer compared to non-Māori.

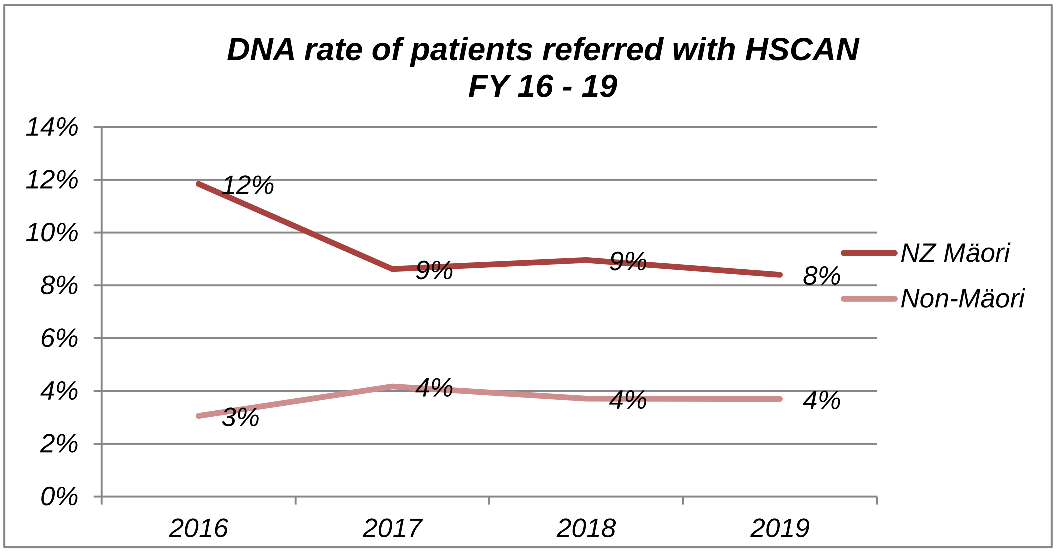

Figure 7: Waikato DHB DNA rate of patients referred with HSCAN

Appendix 2: Patient Stories

Patient story provided by Waikato DHB Cancer Nurse Specialist with patient consent.

Mr I Gender: Male Age: 18 Ethnicity: Maori
Diagnosis: Lymphoma (Cancer) NTA status: Is eligible for NTA including accommodation funding assistance. First cancer treatment pathway: WDHB & ADHB services, curative intent.

The scenario below is loaded with opportunity to mitigate inequity, transport & accommodation being two important components to enabling clinical care and supporting improved outcomes.

Mr I is considered in the Adolescent and Young Adult (AYA) age range. AYA patients have multiple risk factors that are compounding. It is widely recognised internationally and in New Zealand that the AYA cancer population have distinct and unmet needs (AYA Standards of Care MOH 2016).

Ballantine K, Sullivan M. 2013 report adolescent and young adult cancer incidence and survival in New Zealand (2000–2009) study found five-year relative survival by ethnicity for 15-–24-year-old cancer patients to be significantly lower for Māori (69.5%) and Pacific peoples (71.3%) than it was for non-Māori/non-Pacific peoples (84.2%). Mr I is Maori, he has an additional 14.7% risk for five-year relative survival. Mr I experiences the effects of structural barriers to receiving adequate support through NTA. There is a lack of translation of support intention, addressing inequity, compounded by current and strictly applied NTA criteria at Waikato DHB despite additional NGO and social support services involvement.

Mr I lives in a rural town approximately 60km away from his tertiary cancer service provider. When treatment is provided at quaternary service he travels approx. 180km, over 2 hours one way trip. He has a partner in support who is also AYA age group and their baby.

> *Clinical Nurse Specialist (CNS): Mr I & Ms I (partner) have asked if Ms I's brother can come up to Auckland and stay and help with Mr I and baby. He would obviously need accommodation with them while he is here. He isn't working currently so would be available.*
>
> *At the moment Ms I is looking after baby, Mr I and managing all the logistics such as accommodation and travel to and from appointments. Accommodation in Auckland is scarce at the best of times but very bad at the moment. Dr N needs Mr I to stay a few more days. He is today having Day 22 of Consolidation (VCR & LP MTX). (Motel) was only booked until today. So Ms I got up at 6 am to pack up and check out in time to bring Mr I to his appt. The next hotel was booked for Otahuhu so we spent a bit of time arranging for petrol costs, directions etc. Then (motel) had a cancellation so they are going back there now (can't be helped but she despaired at the fact that she packed up for nothing). Ms I had a bit of a moment and said they are just finding it too hard. The moving hotels is the straw that breaks the camel's back. A couple of weeks ago "Daphne", Ms I's mum came up and laid it on the line to all us that this too difficult for a young couple and they need extra support from us. If it wasn't for Waikato NTA we would be in real strife. They have advocated strongly for the family because they can't afford the hotel surcharges in Auckland.*

> *I have to say that I am also struggling. Money is an issue for the couple. I have had conversations and emails with Youth Services, in said rural town) and WINZ personnel, rural town to arrange a travel loan but haven't got very far. It is 180km one way and they have funded most of this themselves and with help from family. It is getting harder to get petrol vouchers from LBF and Canteen although they have been great and have also helped them move hotels as it's not the first time this has happened. As you know, NTA don't provide transport costs from hotel to hospital. Ms I has the NTA claim form completed for rural town to Auckland travel in the last 2 months, she just needs to get a bank generated slip which I am trying to help her with.*
>
> *Consultant Dr has penned a letter to Domain Lodge requesting assistance for our pts asap. However Social Worker tells me they don't accommodate children at all. We are really trying to support this young family with a whanau centred care approach but are quite constrained with what is available. I am worried they will not adhere to the chemo plan, ie the Auckland visits.*
>
> *So, really am asking for the family's request for an additional support person and/or other assistance, ideas. I think the whole family have done really well and tried their best so far.*

Whilst some additional funding was granted in this case, once it had been fervently argued, the response was symptomatic of a lack of ability (because criteria was being strictly applied to or not able to be met) or a lack of understanding of the social determinants of care and their effects on health care outcome. The additional funding for this case was argued on the basis of clinical decision-making, client well-being and providing emotional/physical support. It is likely without this care and support from his partner he will not complete treatment for this life threatening cancer.

The response was as follows:

> *Consideration can be given to funding travel between accommodation and the treatment facility based on the clinical need to do so as supplied by the treating specialist, but the need expressed here appears to be social rather than clinical. Therefore consideration of NTA funding over and above what Policy allows is dependent on some further information being supplied.*

It also concluded

> *The accommodation surcharge for AYA patient's brother to stay in the same room with them. Waikato DHB will not fund an extra room for his brother*
> *Taxi travel between accommodation and Auckland City Hospital. This will be limited to one return trip for AYA patient and his supporters for each appointment he has i.e. supporters must travel with AYA patient to and from the hospital. I'll ask (name), NTA Co-ordinator, to set this up with the cab company normally used for hospital appointments given there is already a robust booking process in place*
> *AYA patient's brother must travel to and from (small rural town) with AYA patient and AYA partner i.e. Waikato DHB will not fund him to travel separately, as per the clinical reasons given for him to be second supporter*
> *Waikato DHB will not fund any other whanau travel or accommodation costs*

There was an effort to

> *…try to get an email to RMCDH asking if they would consider accommodation, but quite frankly given that I now have a number of things to put in place and limited time to do so, I can't guarantee being able to provide an answer until 2018.*
>
> *I need to note here too that approval given for extra funding for AYA patient does not set a precedent for all Waikato DHB patients, but rather that all requests will be considered on a case-by-case basis.*

The patient does not get the opportunity to exit out of their health event, i.e. they do not get to go on holiday. They are bound by the care they need, the social determinants of health, and the outcomes of history. This one scenario distressed the patient, his partner, his whanau and his care team across two DHB's. The degree of work required for all parties was significant – particularly for clinicians who are better utilised on delivery of clinical information or clinical duties and are instead in front of the distressed patient and whanau, or pleading via an administrative mechanism, for help for this young man. This is surely an uneconomical use of clinicians' time. That saving alone would mitigate the upfront cost of a more comprehensive NTA care package, given we know what this and other similar AYA patients' pathways such as Mr I's will involve.

This does and should set a precedent not for just this AYA patient but every AYA patient who is required to be away from their family/whanau, who are accessing lifesaving, significant complex (cancer) treatments in specialist hubs of excellence because every DHB and the Ministry are mandated to address inequity and improve cancer outcomes, particularly for Maori. It is documented in nearly every DHB's strategic imperative, every service plan locally and regionally.

In the next treatment round for Mr I and whanau the same issues are repeated:

> *Motelier: Just letting you know (Mr I and family) checked out this morning. As much as we want to help them, they chop and change so much it's quite hard to manage our bookings around them. Should we look at any other options for them? Not sure what options there are? I don't think Mr I stayed in the room so it was his Mum and Dad and the 8 yr old as far we could tell…*
>
> *NTA: If (motel) decline to provide further accommodation for Mr I's whanau because it's too problematic for them then we are in real trouble. Does anyone have any ideas as to how we can better manage the bookings, and the family themselves, so we don't run this risk?*
>
> *CNS AYA: requested clarification to who "they" is directed at "they chop and change". They this family or they the health care providers.*
>
> *CNS ADHB: Reflects no other ideas (for solution), but open to suggestions. We always tried to err on the side of caution by booking beyond expected discharge because of the accommodation issues in Auckland. If something doesn't go right for Mr I and he ends up staying longer in hospital – (perhaps the consultants can talk to that one). It wasn't that long ago we were packing them up and moving them to another hotel – these are the things that made it hard for the family and became a deal-breaker.*
>
> *I'm a bit offended by the remarks in that email from (motel). Multidisciplinary team have managed the logistics of travel because it is far too complex for our social work*

> *team, let alone Mrs I with a baby and managing Mr I's care. So to say they are chopping and changing is wrong, but also we had organised for whanau to stay while Mr I is an inpatient and they don't need to comment on that.*
>
> *Consultant: I think unfortunately it is us chopping and changing which of course is with very good reason!! Almost think (motel) need to see the protocol and see how prescriptive it is. We have been lucky that he wasn't on trial as that would have been even more difficult to manage. Patient's Consultant cannot absolutely predict when he will clear the Methotrexate and when his (blood work) will be good enough to come in for chemo. We have to overestimate to ensure they are not left without any accommodation. The room during this bit of treatment was never going to be for Mr I but in (chemo regime a) and interim maintenance (chemo regime b), then we are done. He will be in the room with the family unless he gets admitted as an emergency. I am predicting that he will start (chemo b) in 2 weeks time but that will depend on his counts over the next 2 weeks. I will book him for the day 1 chemo regime) on xx/xx/xxxx and hopefully he can see (Dr) that same day or the day before. I think he should stay until his day 4 (chemo) and then wondered if the rest of the (chemo) could be given at Waikato ie day 8 and day 15. Then day 29 with us and the rest of (chemo regime b) with Waikato (happy to do (chemo) on day 36?). (Chemo regime c) should be given up here but there are 8-9 days in between each chemo and the single days could be given and he could go home. When there are 2 consecutive days he would need 1 night of accommodation.*
>
> *NTA: Thanks for all your comments. (Motelier) has said subsequently that they will continue to accept their bookings, but (motel) is a business, run to make a profit, as well as providing a service to patients/supporters, and we must be cognisant of chopping and changing start dates making it harder for them to manage keeping their occupancy at 100%.*
>
> *Please also remember that if the room is booked and Mr I (and whanau) don't check in without due warning then potentially a room is left vacant when it could have gone to another family. (Moteliers) are at the coalface so they are aware of how this impacts others needing accommodation.*

The example above is but one small aspect of care that has a major impact on the ability of this young man to achieve his treatment requirements and exemplifies degrees of implicit and explicit bias. Mr I will have an additional cost burden, this will amplify the effect on the family and whanau and community. What message are we conveying to his community in terms of accessing health care and changing cancer outcomes, prevention and early access to simple cancer treatments ("when we treated him like that" as voiced by his mother in law). What would this mean to a young child?, to grow up without a father, what of the cost of psychological impact on Mr I and his partner for the sake of a few hundred health dollars spent well?

Whilst there is a drive for better, sooner, faster health care delivered closer to home there are identifiable care pathways such as transplant services and specialist hubs/ centres of excellence for complex secondary or tertiary care. Access to clinical trials, which are often only provided at specialist hubs, are known to improve cancer outcomes.

These care pathways are supported by Standards of Service Provision for Cancer (specific) Patients in New Zealand and the Adolescent and Young Adult (AYA) standards which all specify equity related good practice points and an equity statement. Barriers to health care are recognised as multidimensional, and include health system and health care factors (e.g., institutional values, workforce composition, service configuration and location), as well as patient factors (e.g., socioeconomic position, transportation and patient values). Addressing these factors requires a population health approach that takes account of all the influences on health and how they can be tackled to improve health outcomes.

Key components of successful cancer management include early recognition and reporting of symptoms, expertise in identifying patients requiring prompt referral and rapid access to investigations and treatment, this includes upfront support to treatment centres. NTA can have a significant impact here, as an enabler. Alternatively it can contribute to a systemic failure to spend limited health dollars responsibly and effectively in the curative phase of a cancer health pathway. When cancer recurs there are second phase treatments required. These incur more expense, more complex treatments and have significant associated morbidity cost (failure to cure) along with expensive non-curative cancer disease maintenance therapies and palliation costs. This significantly adds to the burden of health care spend. This of course does not reflect any patient or social cost.

Guidance for Improving Supportive Care for Adults with Cancer in New Zealand mandates patients with a cancer diagnosis and their family/whānau have equitable and coordinated access to appropriate medical, allied health and supportive care services (Ministry of Health 2010a).

NTA needs to be timely and responsive and acknowledge the complexity of the care pathway while responding proactively in the context of the person and whanau unit in order to support mitigating the factors that detrimentally affect health for individuals and our services ability to provide it. NTA administration needs to support the process, not hinder it, staff and managers needs to be fully educated about the role NTA plays in supporting equity.

Cancer care may be grouped with chronic conditions however, first cancer treatments are often time sensitive (supported by health targets) and is the most opportune juncture to resource and mitigate the inequity factors that prevent curative cancer outcomes (of which, when achieved have a significant societal and health dollar benefit).

NTA could be an ideal mechanism to extend that effort as an enabler, an equity driver and in doing so supports the crown, DHB's, doctors, nurses, allied health teams and communities who are striving to mitigate the effects of social determinants of health and improve health equity and the patients who are trying to survive. For patients in the now, this may not come soon enough.

The New Zealand State Services Commission describes structural discrimination as occurring "when an entire network of rules and practices disadvantages less empowered groups while serving at the same time to advantage the dominant group". This leads to socio-economic disadvantage and political isolation for people who are marginalised by this system. Structural discrimination can be unintentional and includes practices that are embedded in everyday organisational life and are part of the system. The NTA policy review must protect against implicit (subconscious) bias, the attitudes or stereotypes that affect our understanding, actions and decisions in an unconscious manner. These biases, which encompass both favourable and unfavourable assessments, are activated involuntarily and without an individual's awareness or intentional control.

Whilst it is proper to administer the scheme by the criteria set, it may benefit some team members to undergo further training on the social determinants of health and its impact. Accountability or funding silos should not derail the overall intent of the scheme or create further health disparity or the influence of unconscious bias. Current NTA criteria may be administered fairly (equally) but not equitably.

The effects of social determinants are particularly evident in prevalence and cancer outcomes as they conspire to exaggerate disparity by binding a population into lifestyles forced by resources limitations. This also serves to compound the difficulties of timely access to care. It is widely accepted that socially disadvantage people are more likely to experience precarious domicile security, insecure work and less accessibility to basic health care services. The impact of socio-political policy and resource availability all have a significant influence in prevention and the early identification of cancer. Access to curative cancer treatments regimes are highly influenced by cost, where geographically the service is provided and how acceptable it is to the population it endeavours to serve. Reducing health inequities is important because health is a fundamental human right. Good health is of social and economic value to individuals, society and the economy.

Auckland Gynae Surgical Patients

Patient stories provided by Waikato DHB Cancer Nurse Specialist with patient consent.

Waikato DHB patients requiring the above surgery are at a distinct disadvantage from those in other DHB's and it is costing them on average a return trip, a nights accommodation, at the very least.

Waikato refers them to Auckland for surgery.

1. Required to travel to Auckland at own expense – *There is a shuttle from Rotorua that calls into our lodge and carries onto Auckland that I feel we could utilise. Return travel could utilise the same service….or is there another way*
   Often clients are older and driving to Auckland is not an option for them.

2. Often need to report early in am which requires them to stay a night in Auckland at their own expense. They often take a support person who pays to stay in a motel for the 3 days that they have surgery. *Alternative would be to have the CNS at Auckland hospital refer them to Domain or have an understanding between us and Auckland. We do have people from other DHB's stay for free although this isn't frequent. Given our DHB pays for lodge stays with us I wonder if they would consider part funding these patients in Auckland*

3. If they have booked into the Domain Lodge they are $600, maybe discounted but not sure – Patient(1 night prior to early morning admission) and support person(3 nights) which is above what most patients/family can afford

4. I feel the Cancer Society would like to improve people and their family's cancer journey, and therefore could we not work together to improve the present situation for these patients as it's not their fault they have to travel to another DHB for their surgery.

Other issues probably not associated with Domain Lodge but part of our patients facing extra adversity are:

1. Cancellation of surgery – *See client 1*
2. Post op recovery – Clients getting same surgery in Auckland get physio and ours get told they are not entitled to this.
3. Some clients would be entitled to the wrap around service if surgery was done at Waikato DHB, but get nothing on return and are in the community for 6/52 before seeing anyone – *I think the Waikato Bay of Plenty Cancer Society would be happy to pick these patients up for Physcosocial care and liaising across the health services but we are often unaware of this and I think there is confusion, as in Auckland everyone with a cancer diagnosis is referred to the cancer society Liaison Nurses automatically at diagnosis.*
4. Patients told to see GP if worried, but this had ended in Patients paying $75/dressing when they should have been referred to the district nursing for

follow up*. If there was community referral system we could liaise around this as we know the systems and where clients need to go for appropriate treatment*

Client 1

Client received her letter informing her of scheduled OT in Auckland
Her 81 year old sister planned to arrive from Nelson (her son in the UK booked her flight up for her online) to be her support person and had booked accommodation
They went up the night before the operation and stayed in a motel – which the sister had her niece in Invercargill book online for them and the sister was stating there for 5-7 days
They caught a taxi to the hospital, for 6.30am reporting time. They arrived at the hospital to be told that the bladder team was unavailable and her surgery would be the following week
Client had been told not to take valuables/money to the hospital so had no way of ringing/paying for transport back.

81 year old sister had a card (but no phone) which the Nurse kindly booked transport over the phone and the hospital kindly gave them a taxi to the bus stop

The above led to:

- having to cancel their accommodation
- trying to rebook for the following week(but there was a concert on and they couldn't find any accommodation –although there was accommodation which was very expensive due to the high demand from concert goers,-so the 81 year old stayed with a grandson in a flatting situation with university students. This subsequently unfortunately strained family relationships and as yet has not been able to be fully repaired)
- The sister has now wasted one week of her support role and then had to return to Nelson at the original time meaning the client was short of help/support for a week as everything had been put back a week
- The family relations were very strained (due to the accommodation debacle)and so the niece going to pick client up to return her to Hamilton, suddenly refused to do this
- Client had to ask a 70 year old friend, who is not use to driving in Auckland to come and pick her up
- She told "Penny" CNS in Auckland about the transport home issue, as she had remained in hospital for 10 days, but because she didn't have a community service card she couldn't catch the shuttle

She attended her preadmission clinic, left home at 0800 and didn't get home until 6.oopm. Had a conversation with another person attending the clinic who advised them they got discounted parking which they were totally unaware of and no-one had mentioned this, so was relieved to pay only $3.50 instead of $16.50.She arrived home to a phone call from the hospital asking her why she hadn't kept her appointment, but she was actually still in Auckland hospital.

Client 2

Client returned from Auckland Gynae Oncol surgery. Got an infection. Was advised to see her GP if concerned. She had to go to the GP for dressings every other day and paid $75/time to have a dressing done unaware that District nursing should have been an option.

Client 3

Lives alone in Hamilton
Only relative (son) is living in Tauranga
Son took an annual leave (A/L) to take his mother to her surgery
It got cancelled and so he returned her home and then he travelled onto Tauranga
He took a 2nd day of A/L for the second date given and the same happened
Her surgery got cancelled
She went up a third time and this time her surgery went ahead
Her son visited one day and they suddenly said she could go home
The son and client had not anticipated this and the son would have liked to stay in Hamilton with his Mum for the first couple of nights home, however he had a dog at home and had not made arrangements for this as he assumed he would be coming straight home
This lead to distress as the son had to return to Tauranga and his Mum stayed for the first night by herself.

Patient story provided by Waikato DHB Cancer Nurse Specialist with patient consent.

We have had several problems recently getting patients to Auckland, we have discussed. Specifically a patient (NZ European) that Sarah was supporting whom I phoned last Wednesday and she will be putting in a complaint about the lack of transport. For this patient who was not eligible for NTA, the logistics of getting a bus to Greenlane for a consultation and then Auckland city hospital for her surgery was a huge stressor and she got a lift home from a friend after surgery but was very unhappy about doing so.
The other recent example was a Maori patient who outright refused to go to Auckland from the start not due to the financial burden but because of the pressure of travelling there. She had no car or whanau with a car to get her there and getting a bus was too onerous and stressful for her. We did her surgery in Waikato in the end but it was a hugely stressful time for her - and us as supporters!
I have repeatedly, over the years, advocated for a supported system, I.e. a shuttle/car to take patients with a support person to their consultation appointment in Greenlane on a Thursday. It is an appointment that lasts about 5 hours as they see surgeons, nurses and anaesthetic teams and patients and whanau are exhausted after the day when they have to deal with rush hour traffic elevating stress levels more!
Patients also have to go up for their surgery the day before, as they have to be on the ward at 07.00hrs. Recently a patient from Te Kuiti set off from home at 04.00hrs to be there as she had no funding for accommodation through NTA.
I hear many times that patients are very happy with their Auckland Hospital experience and the surveys I have done tell us this, but the transport issue is a recurring problem for them.

Patient story provided by Waikato DHB Cancer Nurse Specialist

A Māori lady distressed because for the financial implications and the real probability of this fragile balance disrupting her ability to attend for curative treatment. – Breast cancer – radiotherapy 3 week, rural. She works in a factory she has adult children in her home, and grandchildren. She has managed thus far with using annual leave and a great deal of care coordination from our Breast cancer CNS with strategic appointments management but she is very stressed as the house hold bills keep coming in, WINZ has declined her, (and others) advocacy attempts to seek some financial relief. As I understand because there are other working adult in the home.

Patient story provided by Waikato DHB Cancer Nurse Specialist

A Māori grandmother with lung cancer is bringing up her mokopuna. She is living in a cold state house and getting recurring chest infections, making it difficult to treat her lung cancer. Each time she goes to a chemo planning appointment she is unable to get any further, and her whanau think she's lying about her cancer. Her eldest mokopuna is struggling and is involving herself with youth crime.

Patient story provided by Waikato DHB Cancer Nurse Specialist

A Māori lady distressed because for the financial implications and the real probability of this fragile balance disrupting her ability to attend for curative treatment. – Breast cancer – radiotherapy 3 week, rural. She works in a factory she has adult children in her home, and grandchildren. She has managed thus far with using annual leave and a great deal of care coordination from our Breast cancer CNS with strategic appointments management but she is very stressed as the house hold bills keep coming in, WINZ has declined her, (and others) advocacy attempts to seek some financial relief. As I understand because there are other working adult in the home.

"Harry"

Harry was a sixty year old Maori male, he had multiple comorbidities, he was a current smoker, he was noted to be memory impaired, had high alcohol and cannabis consumption and complexity with simple communication strategies. There was evidence he had inability to afford GP services, to fill prescriptions and he lived with his immediate family in a precarious domicile situation (*Pae taumata, Oranga)*.

Harry was referred by his GP to the Respiratory service as a High Suspicion of Cancer (HSCAN) in April 2016 following a Chest x-ray which demonstrated a 9.5cm spiculated mass – likely a life limiting lung cancer *(Whanaketanga, Pae taumata).*

Harry had a long history of Did Not Attend events (DNA's) noted on IPM (Oranga flag).

The heath care service delivery team's inability to simply contact Harry by phone proved to set up several DNA's including his CT scan and First Specialist Appointment (FSA). There were multiple mix ups with appointments and multiple services interactions required, who were also all at capacity.

There was a recognition that this scenario was loaded with equity risk and doing the same thing would set up the same result. Referral was made to the Equity & Access Clinical Nurse Specialist (CNS) to help mitigate the inequity factors and provide some effective and efficient health interventions and economies *(Ratonga a iwi, Haumaru).*

Several home visits and door knocks finally resulted in a communication with Harrys trusted friend rather than immediate whanau. It was this support person who was key in helping Harry manage his health care engagements (with Harry's direction and permission) along with communication with wider whanau and with building on health literacy needs *(Oranga, Haumaru).*

Because of known service constraints and an "all patient" obligation consideration of Harry's scenario was discussed via the Chest Conference, this included service management and it was decided collectively that no further HSCAN FSA opportunity was to be afforded via the designated clinic process *(Ratonga a iwi, Manaaki, Haumaru).*

With collaboration, the Lung Cancer CNS, CNS Equity & Access and Lead Respiratory Clinician prepared for an alternative solution to enable the inequity factors to be mitigated. The plan was if we could support patient to attend we would bring him in as an acute via the emergency department and complete diagnostics (FSA, bronchoscopy, lung functions, blood work and assessment of capacity and social support), all on the same day *(Kotahitanga, Mauri Pai).*

The CNS Equity & Access had developed an initial relationship to enable Harry and his supporter to attend ED at a mutually agreed day/time. The Respiratory team very quickly were able to engage, assess, and discuss Harry current status from what was already known, including the result of the CT scan, what they would recommend and how that might look from Harrys perspective and how to proceed in accordance with Harry's wishes.

Harry agreed to complete his diagnostics (which had been pre booked for that day). He now understood the gravity of his situation and allowed us to contact his sisters who were unaware of the unfolding situation. His sister attended later that day and we had a frank conversation about the scenario Harry found himself in. Knowing there would be the need for continued communication of results and recommended plan of care, Harry confirmed he would like this to be coordinated via his trusted friend (*Whanaketanga, Pae taumata, Oranga, Ratonga a iwi, Haumaru, Manaaki, Whakamana, Whakarongo, Mauri Pai, Whakapakari, and Kotahitanga)*.

Post diagnostics the usual processes occurred with discussion at Chest Conference (MDM) and the concluding outcome recommendation was to offer chemotherapy or best supportive care as treatment options. Harry and his supporter came back to clinic for the confirmed diagnosis and recommendation discussion. Harry chose to have the medical oncology discussion and attended with whanau and his friends support. Harry's goal was to see his next birthday in December 2016, which was met.

Harry proceeded through chemotherapy treatment with just the odd glitch. Harry's CT in Sept showed a very impressive response to chemotherapy. The tumour now 1.5cm, nodal disease had effectively disappeared and he was now offered consolidative local radiation therapy *(Ratonga a iwi, Manaaki).*

In October Harry was scheduled to start radiation therapy but had not attended, the radiation therapy team have been unable to get hold of him. When they tried to contact Harry on his home number, they were greeted by verbal abuse by someone other than Harry.

A chance corridor passing with the service provider and the CNS Equity & Access was quickly followed by a direct referral email and because there was an existing trusted relationship this communication breakdown was easily mitigated with a quick phone call to see Harry back on track. Harry completed his radiotherapy in November.

The Faster Cancer Treatment target was a tool and key driver for identifying this high risk patient. The reporting database was used a mechanism for identifying high risk patients. Although Harry case breached the 62 Day Target at 81/62 days he did met the 31 Day Target at 8/31 days. This was most definitely an addressing inequity success and indeed a cancer outcome success and a statement was added to the MOH reporting commentary *(Pae taumata, Haumaru, Oranga).*

For Harry's stage of lung cancer the average survival would be 13 months. Harry lived well for most of his 16 months post GP referral. In April the following year Harry's disease had progressed and he was referred early to hospice services. Harry died at the end of June having had chemotherapy, radiotherapy and hospice care input. May he rest in peace.

The very predictable alternative scenario for Harry could likely have been palliative care as first treatment. The FCT 31 Day Target would reflect as 0/31 days. He would likely have presented distressed, coughing up blood with untreatable disease as an acute ED admission with perhaps weeks or days to live. The equity interventions, the team and service flex and the accommodation of the inequity factors this man's life circumstances held were effectively mitigated where they were able to be to effectively support his engagement with health services and access care.

We believe this story demonstrates one example of our ongoing commitment and ability to address inequity in our small part of this man's life where his health care and our care delivery intersected. It reflects the Waikato DHB core values and strategic imperatives that are fundamental to our professional, ethically and moral responsibilities in providing excellent health care services.

Patient story provided by People at heart – Te iwi Ngakaunui.
Leeann Shaw CNS Lung Cancer, Mary-Ann Hamilton CNS Equity & Access

National Travel Assistance: patient examples:

Mrs K Gender: Female Age: 51 Ethnicity: Maori Diagnosis: Breast Cancer

NTA status: not yet eligible for NTA but will meet twenty two or more visits in two consecutive months criteria when at the end of 1st cancer curative intent treatment pathway suite.

Barrier in receiving support through NTA: Mrs K has a Community Services Card (CSC) but lives too close to the treatment centre until near the end of the first cancer curative treatment modalities. Current criteria where CSC and distance criteria are applied add to maintaining and creating further inequity for low socio-economic patients. The current criterion does not support access to curative treatment in high inequity risk patients. Once (if) Mrs K gets through neoadjuvant chemotherapy, surgery and onto radiotherapy Mrs K can then claim back last 12 months events. It is difficult for any one service to identify when eligibility starts and then back-date for all previous service providers' events. Mrs K enquires if she can claim; currently eligibility status is not meet, NTA team are unable/unwilling to register in anticipation.

Administrative burden lies on patient at time of high stress and change of health status. The NTA administrative process is not conducive to supporting treatment adherence i.e. creates further inequity due to strictly applying current criteria where there is a known treatment pathway. Mrs K would benefit from claim at beginning of treatment pathway.

Significant opportunity cost for health service whilst patient is on treatment and maximising curative intent with adherence to treatments. This significantly reduces potential recurrence and metastatic disease related cost to person and health services, the opportunity (future) costs are predictably high.

Recommend: Remove distance criteria for patients with Maori or Pacific Island ethnicity. Remove distance criteria for those with a community services card. Provide packages of care, NTA criteria for disease specific pathways.

Ms R Gender: Female Age: 38 Ethnicity: Maori Diagnosis: Breast Cancer

NTA status: became eligible for NTA on twenty two or more visits in two consecutive months criteria, when at end of 1st cancer curative intent treatment pathway suite – Radiotherapy more than 12 months post initial referral. Date: December 2016

Barrier in receiving support through NTA: Ms R would have benefited from NTA scheme support from the beginning of her breast cancer treatment regime which spanned over 14 months. This included diagnostics, neo-adjuvant chemotherapy, and breast cancer surgery and adjuvant radiotherapy. Ms R is predictably at high risk of an inequitable cancer outcome given the identified inequity factors that would disrupt her ability to complete her curative breast cancer treatment regime.

Transportation was one of many factors. Ms R lived too close for NTA eligibility at the beginning of her pathway, she did have a CSC. Ms R did not attend several appointments including an Oncology First Specialist Appointment (FSA). She had a high risk breast cancer.

Although eventually Ms R was registered and claimed, the administration burden of claiming all appointments from many different systems took a clinical nurse specialist to advocate on her behalf across the whole pathway, as the NTA team could not see the entire appointment burden and therefore claim her entire entitlements once she became did become eligible. The statute of ability to claim 12 months prior meant some appointments were no longer within the timeframe.

This lady lived in a house with several boarded up broken windows and she suffered a house fire relating to loss of sensation in her hands (secondary to the chemotherapy side effects) whilst trying to cook for her family. Simple communication, access to a functioning mobile phone, had to be supported by a WINZ grant, to enable purchase of a phone and credit, meaning further indebtedness with debt repayments via her benefit, further diminishing her weekly income.

There appears to be a degree of implicit bias. Implicit bias can operate in conjunction with structural racialization. Together these two powerful forces create barriers that impede access to opportunity across many critical life domains such as housing, education, health. This is set up by current criteria where the perceived social aspects of care are excluded from current NTA policy when it is the social determinants that have contributed to the inequity in the first place (the social, cultural, political, economic, commercial and environmental factors that shape the conditions in which people are born, grow, live, work and age). These factors directly translate to inequitable cancer/health outcomes.

Mr & Mrs A Gender: Female, Male Ages: 57, 61 Ethnicity: Maori
Diagnosis: Breast Cancer, Lung Cancer

Mrs & Mrs A are a Maori couple who live 20km from treatment centre. Their immediate (household) whanau group include two school aged grandchildren. Mrs A is mid-fifties and diagnosed with breast cancer. She has a community services card and is not eligible for NTA because she lives too close until the time she is prescribed Radiotherapy (twenty one daily treatments over three-four weeks) at the end of the acute part of her breast cancer treatment pathway. She then became eligible for NTA under the twenty two or more visits in two consecutive months criteria. She is then eligible to claim retrospectively for all of the preceding health contacts relating to her breast cancer diagnostic pathway and treatments numbering 38 events.

Before she was diagnosed with breast cancer she had been referred by the emergency department to General Medicine; to Geriatric AT&R; to Echocardiography Department; to Active Rehab; to Neurology having been diagnosed with a stroke noted to be likely have been contributed to by high family stresses, her history of diabetes and two other comorbidities. Mrs A had significant family stresses leading up to her stroke. She was supporting all her children significantly. She also had OPA physio assessment/treatment and then occupational therapy assessment. These events are <u>not</u> reflected in the NTA eligibility as they are not part of the same health event.

Mrs A is part of a whanau group with a burden of ill-health and limited financial resource.

Mr A lives with Mrs A and whanau and obviously operates in the same social circumstances. He has cardiac and respiratory comorbidities. He has been diagnosed with a surgically treatable lung cancer with curative intent. He is not eligible for NTA assistance as he lives too close. Mr A is busy in secondary health services too. Mr A “does not attend” or “cannot attend” several important post surgery monitoring diagnostics i.e. to see if there is any residual cancer in his lungs. At the request of a clinical nurse specialist (CNS) A, CNS B became involved in care and as part of that care assessed Mrs & Mrs A’s NTA eligibility and requested registration and back dated claims for Mrs A. Mr A’s events from GP to secondary care (eligibility criteria) numbered 14. Mr A lived too close and did not meet the NTA criteria by current measures on distance for frequency criteria. This whanau’s health burden was significant in number of events (requirements to present at hospital) when just looking at the same event episode, let alone the other comorbidity care. Comorbidity further escalates risk for inequitable health and cancer outcomes by reducing treatment options.

By having “same health event” criteria it further compounds the effects of the social determinants on health outcomes, and further disadvantages those who already bare the greatest burden of poorest health.

Ms W Gender: Female Age: 43 Ethnicity: Maori
Diagnosis: Breast Cancer and synchronous metastatic thyroid cancer (to lung).

Ms W lives approximately 30 km from hospital and she does not have a community service card. Ms W was diagnosed with breast and what was thought to be a lung cancer at the same time – both to be treated with curative intent. Ms W was not eligible for NTA until she was prescribed her radiotherapy for her breast cancer. This was over a period of June 2016 – May 2017 after Ms W had attended 16 radiological diagnostics, 31 outpatient appointments relating to breast cancer diagnosis and surgery with two specialities, 9 inpatient episodes (totalling 30 days), 43 attendances for chemotherapy for her breast cancer and 25 attendances for Breast radiotherapy before she was able to be registered for NTA. We were informed that NTA had “a good look” and this client does not qualify for NTA assistance as the only criteria she would be eligible to claim for is the 22x2 when she hit the radiotherapy part of her treatment, more than 12 months following initial diagnosis.

She then went on to have her thyroid (metastatic to lung) cancer treated by Left VATS converted to thoracotomy and upper lobe wedge resection and is continued to be treated with adjuvant oncology treatments which finished Nov 2017.

It is unreasonable to have NTA criteria constricted to application to one health event, it is one person’s health and can not be compartmentalised. When the additional cost of being treated for cancer(s) is built in (emotionally, loss of work/income, pharmacy costs…), the health burden this wahine and her whanau are manging physically and financially, is indeed very high.

Ms F Gender: Female Age: 56 Ethnicity: Not Stated
Diagnosis: Basal Cell Carcinoma –nose/ face

Special circumstance process – need for consultant sign off process cumbersome. Consider designated nurse, social worker or others signoff to reduce administrative burden.

Nurse email- Nurse required to have confirmation by consultant of nurse led information to put forward for special circumstance request.

> *S: NTA require a letter from the treating specialist to enable NTA special circumstance funding for transport to enable Mrs F to attend for her surgery (tentatively XX/XX/XX) i.e. next week. Recurrent BCC face/nose.*
> *B: Waitlisted under your service 16 Jun 201X -Excision of lesion(s) of skin and subcutaneous tissue of other site and full thickness skin graft of other site –Dr A – Said Hospital – expected date 12 Jul 201X*
> *A: History of very traumatic time last time she had treatment, so will be having the procedure under general anaesthetic. We have booked her in to stay at the Lodge the night before and the night after, i.e. XXth and XXth July. The problem is around getting her to said town and then getting her home afterwards. These are the issues she is dealing with are:*
> *1) She lives 6kms outside rural town where the Health Shuttle leaves from. She has had a leg amputated, has a prosthetic leg and uses crutches.*
> *2) Her only mode of transport is a 3 wheeled motorbike, which she won't be able to use as she won't be able to wear her helmet post procedure. She would normally come for appointments on her motor bike.*
> *3) She dislikes using the Health Shuttle as no-one to help her get on and very uncomfortable for the 2 hours plus journey and she does not meet the shuttles criteria for being able to get on / off shuttle independently.*
> *4) There is no taxi service in rural town and she says she has no-one who can give her a lift to catch the Health Shuttle. The community bus that could pick her up and take her to the Health Shuttle, doesn't start till 9am and the Health Shuttle leaves at 8am.*
> *5) She is getting very anxious about this whole situation.*
> *6) No other cancer society volunteers available to drive Mrs K up here.*
> *7) Transport people in rural town, very helpful, but nothing more they can do.*
> *8) Local Medical Centre -any other volunteer organisations who have drivers, but nothing else available as far as they know.*
> *9) Cancer Society Lions Lodge accommodation support pre and post surgery in place to assist with logistics and has the ongoing support of Cancer Society Liaison Nurses.*
> *10) There is medical and psychological clinical need.*
> *R: Require confirmation of clinical need to put case to NTA/funding managers to approve special circumstance funding to enable transport option for Mrs F to attend for her surgery.*
> *R: Would you be so kind as to respond urgently (bearing the diminishing timeframe) with your endorsement as to clinical need in this situation (directly to NTA or to myself, email or dictated note)…*

Email response to nurse, who had assessed the situation and determined special circumstance was required to enable patient access to treatment for cancer.

> *…I can confirm that Mrs F requires treatment and that she requires support and this is a special circumstance that requires her to have additional transport support as outlined in the email trail below to allow her to achieve her required medical treatment.*
> *Consultant Plastic and Reconstructive Surgeon, said DHB*

NTA as enabler of access to treatment for patient with complex health need but simple treatment and transport barrier.

Mr G **Gender: Male** **Age: 18** **Ethnicity: Maori**
Diagnosis: Lymphoma (Cancer)

NTA status: Is eligible for NTA including accommodation, 1st cancer curative intent treatment pathway WDHB & ADHB services. Date: 2017 - currently

Barrier in receiving support through NTA: Lack of translation of support intention and addressing inequity compounded by current strictly applied criteria.

This scenario loaded with opportunity to mitigate inequity, transport & accommodation being two important components of provision of care.

Mr G is considered in the Adolescent and Young Adult (AYA) age range. AYA patients have multiple risk factors that are compounding. It is widely recognised internationally and in New Zealand that the AYA cancer population have distinct and unmet needs (AYA Standards of Care MOH 2016).

Ballantine K, Sullivan M. 2013 report adolescent and young adult cancer incidence and survival in New Zealand (2000–2009) study found five-year relative survival by ethnicity for 15-–24-year-old cancer patients to be significantly lower for Māori (69.5%) and Pacific peoples (71.3%) than it was for non-Māori/non-Pacific peoples (84.2%). Mr G is Maori.

Mr G lives in a rural town approximately 60km away from his tertiary cancer service provider. When treatment is provided at quaternary service he travels approx. 180km, over 2 hours one way trip. He has a partner in support who is also AYA age group and their baby.

> *Clinical Nurse Specialist (CNS): Mr G & Ms G (partner) have asked if Ms G's brother can come up to Auckland and stay and help with Mr G and baby. He would obviously need accommodation with them while he is here. He isn't working currently so would be available.*
>
> *At the moment Ms G is looking after baby, Mr G and managing all the logistics such as accommodation and travel to and from appointments. Accommodation in Auckland is scarce at the best of times but very bad at the moment. Dr N needs Mr G to stay a few more days. He is today having Day 22 of Consolidation (VCR & LP MTX). (Motel) was only booked until today. So Ms G got up at 6 am to pack up and check out in time to bring Mr G to his appt. The next hotel was booked for Otahuhu so we spent a bit of time arranging for petrol costs, directions etc. Then (motel) had a cancellation so they are going back there now (can't be helped but she despaired at the fact that she packed up for nothing). Ms G had a bit of a moment and said they are just finding it too hard. The moving hotels is the straw that breaks the camel's back. A couple of weeks ago "Daphne", Ms G's mum came up and laid it on the line to all us that this too difficult for a young couple and they need extra support from us. If it wasn't for Waikato NTA we would be in real strife. They have advocated strongly for the family because they can't afford the hotel surcharges in Auckland.*
>
> *I have to say that I am also struggling. Money is an issue for the couple. I have had conversations and emails with Youth Services, in said rural town) and WINZ personnel, rural town to arrange a travel loan but haven't got very far. It is 180km one way and they have funded most of this themselves and with help from family. It is getting harder to get petrol vouchers from LBF and Canteen although they have*

> *been great and have also helped them move hotels as it's not the first time this has happened. As you know, NTA don't provide transport costs from hotel to hospital. Ms G has the NTA claim form completed for rural town to Auckland travel in the last 2 months, she just needs to get a bank generated slip which I am trying to help her with.*
>
> *Consultant Dr has penned a letter to Domain Lodge requesting assistance for our pts asap. However Social Worker tells me they don't accommodate children at all. We are really trying to support this young family with a whanau centred care approach but are quite constrained with what is available. I am worried they will not adhere to the chemo plan, ie the Auckland visits.*
>
> *So, really am asking for the family's request for an additional support person and/or other assistance, ideas. I think the whole family have done really well and tried their best so far.*

Whilst some additional funding was granted in this case, once it had been fervently argued, the response was symptomatic of a lack of ability (because criteria was being strictly applied to or not able to be met) or a lack of understanding of the social determinants of care and their effects on health care outcome. The additional funding for this case was argued on the basis of clinical decision-making, client well-being and providing emotional/physical support. It is likely without this care and support from his partner he <u>will not complete treatment for this life threatening cancer</u>.

The response was as follows:

> *Consideration can be given to funding travel between accommodation and the treatment facility based on the clinical need to do so as supplied by the treating specialist, but the need expressed here appears to be social rather than clinical. Therefore consideration of NTA funding over and above what Policy allows is dependent on some further information being supplied.*

It also concluded

> *The accommodation surcharge for AYA patient's brother to stay in the same room with them. Waikato DHB will not fund an extra room for his brother*
> *Taxi travel between accommodation and Auckland City Hospital. This will be limited to one return trip for AYA patient and his supporters for each appointment he has i.e. supporters must travel with AYA patient to and from the hospital. I'll ask (name), NTA Co-ordinator, to set this up with the cab company normally used for hospital appointments given there is already a robust booking process in place*
> *AYA patient's brother must travel to and from a rural town with AYA patient and AYA partner i.e. Waikato DHB will not fund him to travel separately, as per the clinical reasons given for him to be second supporter*
> *Waikato DHB will not fund any other whanau travel or accommodation costs*

There was an effort to

> *…try to get an email to RMCDH asking if they would consider accommodation, but quite frankly given that I now have a number of things to put in place and limited time to do so, I can't guarantee being able to provide an answer until 2018.*

> *I need to note here too that approval given for extra funding for AYA patient does not set a precedent for all Waikato DHB patients, but rather that all requests will be considered on a case-by-case basis.*

The patient does not get the opportunity to exit out of their health event, i.e. they do not get to go on holiday. They are bound by the care they need, the social determinants of health, and the outcomes of history. This one scenario distressed the patient, his partner, his whanau and his care team across two DHB's. The degree of work required for all parties was significant – particularly for clinicians who are better utilised on delivery of clinical information or clinical duties are instead in front of the distressed patient and whanau, or pleading via an administrative mechanism, for help for this young man. This is surely an uneconomical use of clinicians' time. That saving alone would mitigate the upfront cost of a more comprehensive NTA care package, given we know what this and other similar AYA patients' pathway will involve.

This does and should set a precedent not for just this AYA patient but every AYA patient who is required to be away from their family/whanau, who are accessing lifesaving, significant complex (cancer) treatments in specialist hubs of excellence because every DHB and the ministry is mandated to address inequity and improve cancer outcomes, particularly for Maori. It is documented in nearly every DHB's strategic imperative, every service plan locally and regionally.

In the next treatment round for Mr G and whanau the same issues are reflected:

> *Motelier: Just letting you know (Mr G and family) checked out this morning. As much as we want to help them, they chop and change so much it's quite hard to manage our bookings around them. Should we look at any other options for them? Not sure what options there are? I don't think Mr G stayed in the room so it was his Mum and Dad and the 8 yr old as far we could tell…*
>
> *NTA: If (motel) decline to provide further accommodation for Mr G's whanau because it's too problematic for them then we are in real trouble.Does anyone have any ideas as to how we can better manage the bookings, and the family themselves, so we don't run this risk?*
>
> *CNS AYA: requested clarification to who "they" is directed at "they chop and change". They this family or they the health care providers.*
>
> *CNS ADHB: Reflects no other ideas, but open to suggestions. We always tried to err on the side of caution by booking beyond expected discharge because of the accommodation issues in Auckland. If something doesn't go right for Mr G and he ends up staying longer in hospital – (perhaps the consultants can talk to that one). It wasn't that long ago we were packing them up and moving them to another hotel – these are the things that made it hard for the family and became a deal-breaker.*
>
> *I'm a bit offended by the remarks in that email from (motel). Multidisciplinary team have managed the logistics of travel because it is far too complex for our social work team, let alone Mrs G with a baby and managing Mr G's care. So to say they are chopping and changing is wrong, but also we had organised for whanau to stay while Mr G is an inpatient and they don't need to comment on that.*

> *Consultant: I think unfortunately it is us chopping and changing which of course is with very good reason!! Almost think (motel) need to see the protocol and see how prescriptive it is. We have been lucky that he wasn't on trial as that would have been even more difficult to manage. Patient's Consultant cannot absolutely predict when he will clear the Methotrexate and when his (blood work) will be good enough to come in for chemo. We have to overestimate to ensure they are not left without any accommodation. The room during this bit of treatment was never going to be for Mr G but in (chemo regime a) and interim maintenance (chemo regime b), then we are done. He will be in the room with the family unless he gets admitted as an emergency. I am predicting that he will start (chemo b) in 2 weeks time but that will depend on his counts over the next 2 weeks. I will book him for the day 1 chemo regime) on xx/xx/xxxx and hopefully he can see (Dr) that same day or the day before. I think he should stay until his day 4 (chemo) and then wondered if the rest of the (chemo) could be given at Waikato ie day 8 and day 15. Then day 29 with us and the rest of (chemo regime b) with Waikato (happy to do (chemo) on day 36?). (Chemo regime c) should be given up here but there are 8-9 days in between each chemo and the single days could be given and he could go home. When there are 2 consecutive days he would need 1 night of accommodation.*
>
> *NTA: Thanks for all your comments. (Motelier) has said subsequently that they will continue to accept their bookings, but (motel) is a business, run to make a profit, as well as providing a service to patients/supporters, and we must be cognisant of chopping and changing start dates making it harder for them to manage keeping their occupancy at 100%.*
>
> *Please also remember that if the room is booked and Mr G (and whanau) don't check in without due warning then potentially a room is left vacant when it could have gone to another family. (Moteliers) are at the coalface so they are aware of how this impacts others needing accommodation.*

The example above is but one small aspect of care that has a major impact on the ability of this young man to achieve his treatment requirements and degrees of explicit bias. He will have an additional cost burden, this will amplify the effect on the family and whanau and community. What message are we conveying to his community in terms of accessing health care and changing cancer outcomes, prevention and early access to simple cancer treatments ("when we treated him like that"). What would this mean to a young child?, to grow up without a father, the psychological impact on Mr G and his partner for the sake of a few hundred health dollars spent well?

Whilst there is a drive for better, sooner, faster health care delivered closer to home there are identifiable care pathways such as transplant services and specialist hubs/ centres of excellence for complex secondary or tertiary care. Access to clinical trials, which are often only provided at specialist hubs, are known to improve cancer outcomes.

These care pathways are supported by Standards of Service Provision for Cancer (specific) Patients
in New Zealand and these national guidance documents all specify equity related good practice points and an equity statement. Barriers to health care are recognised as multidimensional, and include health system and health care factors (e.g., institutional values, workforce composition, service configuration and location), as well as patient factors (e.g., socioeconomic position, transportation and patient values). Addressing these factors

requires a population health approach that takes account of all the influences on health and how they can be tackled to improve health outcomes.

Key components of successful cancer management include early recognition and reporting of symptoms, expertise in identifying patients requiring prompt referral and rapid access to investigations and treatment, this includes upfront support to treatment centres. NTA can have a significant impact here, as an enabler. Alternatively it can contribute to a systemic failure to spend health dollar responsibly and proactively in curative phase of health pathway with predictable consequence of significant health dollar spend. When cancer recurs there are second phase treatments required. These are more expensive, more complex and have significant associated morbidity cost (failure to cure) and expensive metastatic cancer disease maintenance therapies and palliation costs. This significantly adds to the burden of health care spend. This of course does not reflect any patient or social cost.

Guidance for Improving Supportive Care for Adults with Cancer in New Zealand mandates patients with a cancer diagnosis and their family/whānau have equitable and coordinated access to appropriate medical, allied health and supportive care services (Ministry of Health 2010a).

NTA needs to be timely and responsive and acknowledge the complexity of the care pathway while responding proactively in the context of the person and whanau unit in order to support mitigating the factors that detrimentally affect health for individuals and our services ability to provide it. NTA admin needs to support process, not hinder it, staff and managers needs to be fully educated about the role NTA plays in supporting equity.

Cancer care may be grouped with chronic conditions however, first cancer treatments are often time sensitive (supported by health targets) and is the most opportune juncture to resource and mitigate the inequity factors that prevent curative cancer outcomes (of which, when achieved have a significant societal and health dollar benefit).

NTA could be an ideal mechanism to extend that effort as an enabler, an equity driver and in doing so supports the crown, DHB's, doctors, nurses, allied health teams and communities who are striving to mitigate the effects of social determinants of health and improve health equity and the patients who are trying to survive.

The New Zealand State Services Commission describes structural discrimination as occurring "when an entire network of rules and practices disadvantages less empowered groups while serving at the same time to advantage the dominant group". This leads to socio-economic disadvantage and political isolation for people who are marginalised by this system. Structural discrimination can be unintentional and includes practices that are embedded in everyday organisational life and are part of the system. The NTA policy review must protect against implicit (subconscious) bias, the attitudes or stereotypes that affect our understanding, actions and decisions in an unconscious manner. These biases, which encompass both favourable and unfavourable assessments, are activated involuntarily and without an individual's awareness or intentional control.

Whilst it is proper to administer the scheme by the criteria set, it may benefit some team members to undergo further training on the social determinants of health and its impact. Accountability or funding silos should not derail the overall intent of the scheme or create further health disparity or the influence of unconscious bias.

Aspects of the current criteria deliver explicit bias where distance and CSC criteria are combined. If you have miniscule financial resource and live 10km from hospital and your appointment is on Monday and your benefit is on Thursday, it can be the difference between being able to attend or not.

Ministry of Health (2013) note that **breast cancer was the third leading** (all) cause of premature death for both Māori and non-Māori females and lung cancer was the leading cause of premature death for Māori females and the top leading causes of premature death for Māori male and non-Māori. The Maori breast cancer registration rate was 1.4 times that of non-Māori women and **Māori women were around 1.5 times as likely to die from breast cancer as non-Māori women**. Māori women had lung cancer registration rates over four times that of non-Māori. **The lung cancer mortality in Maori women was over 4 times that of non-Māori** (Ministry of Health 2015).

The effects of social determinants are particularly evident in prevalence and cancer outcomes as they conspire to exaggerate disparity by binding a population into lifestyles forced by resources limitations. This also serves to compound the difficulties of timely access to care. It is widely accepted that socially disadvantage people are more likely to experience precarious domicile security, insecure work and less accessibility to basic health care services. The impact of socio-political policy and resource availability all have a significant influence in prevention and the early identification of cancer. Access to curative cancer treatments regimes are highly influenced by cost, where geographically the service is provided and how acceptable it is to the population it endeavours to serve.

Reducing health inequities is important because health is a fundamental human right and its progressive realization will eliminate inequalities that result from differences in health status, such as disease or disability (WHO). Good health is of social and economic value to individuals, society and the economy.