

## **Memorandum to Cabinet Social Policy Committee**

### **A BOWEL CANCER SCREENING PROGRAMME FOR NEW ZEALAND**

#### **PURPOSE**

1. I ask the Cabinet Social Policy Committee to support the implementation of a Bowel Cancer Screening pilot programme to begin by October 2011. This will be funded from time-limited funding and I intend to seek funding in Vote Health's Budget 2010 package. This would be a Budget announcement.

#### **EXECUTIVE SUMMARY**

2. Bowel Cancer is the most frequently diagnosed cancer and the second highest cause of cancer death in New Zealand. New Zealand has the third highest bowel cancer mortality rate in the OECD for women and the sixth highest for men. Internationally there is a move towards adoption of population based screening for bowel cancer. There is strong sector support for a national programme implementation alongside improvement in existing bowel cancer services.
3. The development of bowel cancer is preventable in many cases and highly treatable when identified in the early stages. The objectives of bowel cancer screening are to reduce mortality by the diagnosis and treatment of early stage cancer and to prevent the development of cancer by identifying and removing precancerous tumours. There is a strong association between the stage (extent) of bowel cancer at diagnosis and eventual survival. People detected with localised disease have a 95 percent chance of surviving five years, after which they have the same survival rate as someone who has never had bowel cancer.
4. Evidence from several randomised controlled trials (RCTs) using a guaiac faecal occult blood test (gFOBT) shows that a bowel cancer screening programme reduces deaths from bowel cancer by 16 percent, with a 25 percent reduction for those individuals that participate in at least one round of screening. Based on recent modelling the newer generation immunochemical FOBT (iFOBT), which New Zealand will be using, is expected to improve these benefits with an estimated lifetime reduction in mortality from bowel cancer of 36 percent.
5. A bowel cancer screening programme will significantly increase demand for diagnostic and ongoing surveillance colonoscopies (for those identified with cancer or having an increased risk of developing bowel cancer). There will also be an increase in demand for pathology, surgery and other services, especially in the early stages of the programme. The Ministry has a work programme underway to increase the capacity of colonoscopy services.
6. In 2008 the previous Government committed to fast tracking the implementation of a national bowel cancer screening programme (BCSP) with little preparatory work. A Bowel Cancer Taskforce was established and the first sites were to commence screening by the end of 2009 with a national rollout in 2010. However, no funds were appropriated for the programme and workforce and infrastructure issues to support both existing services and a screening programme had not been addressed.
7. Due to the current workforce, technology and financial pressures, and based on advice from the Ministry and Bowel Cancer Taskforce, I have decided the best way to begin a bowel cancer screening programme is by starting with a pilot

programme. This approach aligns with advice received by the Ministry from the Colorectal Cancer Screening Advisory Group in 2005, the University of Otago in 2008, and the advice of the International Union Against Cancer, which recommends that all new screening programmes are tested first before being nationally rolled out. This is the approach that was taken by Australia and the United Kingdom.

8. My independent advisory committee for cancer, Cancer Control New Zealand (CCNZ) strongly supports the proposed approach to bowel cancer screening in this paper, and believes the consequence of not proceeding with this important work would be immense. CCNZ have prioritised Bowel screening as one of its seven key priority areas.
9. I propose that the pilot programme to test the benefits and costs of bowel cancer screening will begin by October 2011. It will involve two rounds of screening over four years to ensure the processes, outcomes and impacts of screening are well understood in the New Zealand context before considering whether the programme should be rolled out nationally. The Ministry will continue to focus on increasing the capacity and quality of colonoscopy and related services across the country to be able to meet existing demands and increased demand should a national screening programme be approved.
10. Cost estimates for a pilot programme are set-up costs of \$1.2 million for 2010/11, and programme costs of \$4.3–7.6 million per year for 2011/12 to 2014/15, depending on which pilot site/s are chosen. There are additional costs for a small-scale information system to support the screening programme. This is critical to provide adequate safety provisions for individual participants and allow monitoring and evaluation. Ministry officials have advised that initial cost estimates for this system are between \$520,000 to \$1.125 million. I have asked that this cost be carefully scrutinised and my expectation is that the final cost will be lower than this. All costs for the pilot programme will be funded from within available funding in Vote Health as part of Budget 2010.
11. The total estimated annual cost of a fully implemented Bowel Cancer Screening Programme (excluding capital costs) would be between \$24 million (restricted age range 60-69 yrs) and \$53 million (full age range 50-74 yrs). Should a national programme be approved implementation is likely to be phased in, for example starting with a limited age range of 60-69. Costs for the development of the information system for the national programme are currently estimated to be between \$6.5 and \$14.4 million with operational costs of between \$3.6 and \$7.9 million per year in out years. If Cabinet decides to implement a national programme, the operating and capital funding requirements will be considered as part of the Budget 2013 or 2014 process.

## **BACKGROUND**

12. In New Zealand, bowel cancer is the most frequently diagnosed cancer and the second most common cause of cancer death. It is one of the leading causes of illness and death with approximately 2,750 new cases per year and in 1,222 deaths in 2008. New Zealand has the third highest mortality rate in the OECD for women and the sixth highest for men.
13. An individual's risk of developing bowel cancer rises steeply from 0.6 percent at age 50, to 5.6 percent by the age of 75 years. The number of cases diagnosed each year in New Zealand is therefore expected to increase as our population ages.

14. There is a strong association between the stage (extent) at which bowel cancer is diagnosed and eventual survival. Those with localised disease at diagnosis have a 95 percent chance of a five year survival. Those with distant spread (metastases) have only a 10 percent five year survival rate. There is evidence to suggest that a higher percentage of detected cancers are found at a more advanced stage (greater spread of cancer) in New Zealand than in several countries including Australia, the United States and the United Kingdom.
15. In 2005, New Zealand's Colorectal Cancer Screening Advisory Group (CRCSAG) recommended a feasibility study be undertaken to assess the true impact of screening on participants, service providers and the health care system. It was recommended that colonoscopy capacity be expanded with some urgency to ensure timely provision of diagnostic and surveillance colonoscopy. They also stated that additional significant investment in infrastructure and workforce training would be required to support a screening programme.
16. In 2008 the previous Government committed to fast tracking the development of a national bowel cancer screening programme (BCSP). A Bowel Cancer Taskforce was established and pilot sites were to commence screening by the end of 2009 with a national rollout in 2010. However, no funds were appropriated for the programme and the above workforce and infrastructure issues highlighted by the CRCSAG had not been addressed.

#### **SCREENING FOR BOWEL CANCER**

17. The two objectives of bowel cancer screening are to diagnose and treat bowel cancer at an early curable stage, and to identify and remove pre-cancerous advanced adenomas before they become cancer. International experience shows that between 40 and 60 percent of cancers are detected at a localised stage in a screened population, compared with around 15 percent in a population without a screening programme.
18. Evidence suggests that most bowel cancer develops from adenomatous polyps (adenomas) in the lining of the bowel. Those adenomas which grow to over 10 millimetres after a number of years are more likely to be cancerous or develop into a cancer. The slow development process from adenoma to cancer makes bowel cancer a good example of where a screening intervention with a non-symptomatic population can save lives.
19. A recent Cochrane review evaluating evidence from randomised controlled trials (RCTs) for gFOBT concluded that bowel cancer screening can reduce deaths from bowel cancer and incidence of bowel cancer through the detection and removal of adenomas. The review concluded that screening 50-74 year olds, using a gFOBT is likely to avoid approximately 16 percent of bowel cancer deaths, with a 25 percent reduction for those individuals who participate in at least one round of screening. Recent modelling of the newer generation immunochemical FOBT (iFOBT), which New Zealand will be using, is expected to improve these benefits with an estimated lifetime reduction in mortality from bowel cancer of 36 percent.

#### **ADOPTION OF BOWEL CANCER SCREENING PROGRAMMES**

20. The evidence of mortality benefit shown in the RCTs has driven a strong trend towards the adoption of population based screening for bowel cancer over the last decade. Nineteen of the twenty seven European Union member states already operate either national programmes or pilots for bowel cancer screening. Other countries with population programmes include Australia, Israel, the

Canadian states of Alberta and Ontario, South Korea and Japan. These programmes cover various age ranges from 50 to 74 years.

21. The immunochemical FOBT (iFOBT) is superior to gFOBT in several ways, in particular it has higher detection rates for cancer and adenomas. Internationally, there is a strong move towards their use over gFOBT. Recent modelling concluded that a screening programme based on a biennial iFOBT for 55 to 74 year olds could provide a lifetime reduction in the incidence of, (14.7 per cent) and mortality (36 per cent) from, bowel cancer.

## **COSTS AND COST-EFFECTIVENESS OF A POPULATION BASED BOWEL CANCER SCREENING**

22. Current public hospital (inpatient and outpatient) treatment costs for bowel cancer are approximately \$100 million<sup>1</sup> a year, with an average cost of \$31,000 per person. The Ministry of Health estimates that bowel cancer is responsible for approximately 20 percent of all cancer treatment costs, while accounting for only approximately 14 percent of all registered cancers.
23. Localised cancers are relatively inexpensive to treat, with public hospital costs of approximately \$22,000<sup>2</sup>. More advanced cancers attract between two and four times more outpatient costs than localised cancers and cost approximately \$34,000 for those with distant spread and \$43,000 for those cancers spread to lymph nodes. This is due to higher rates of, and more intensive, non-surgical assessment and treatment. An outcome of a screening programme over time is that it would be possible to detect a greater percentage of cancers at a localised stage reducing the costs of treating advanced cancers.
24. Two critical financial aspects of bowel cancer screening are the increased costs that a programme will engender, and the cost effectiveness of screening compared to non-screening. Economic evaluations of options for bowel cancer screening in average-risk populations have been conducted in a number of countries.
25. Some of the most recent international studies suggest that in addition to being cost-effective a bowel cancer screening programme could ultimately be cost saving. This conclusion is based on the fact that cancers are detected at an earlier stage when treatment is less expensive and that the cost of chemotherapy for advanced cancers is increasing.
26. The most comprehensive recent economic evaluation study was carried out in the Republic of Ireland<sup>3</sup>. The study concluded that
  - A biannual iFOBT population screening programme was cost effective compared with no-screening and with other public health interventions (such as breast and cervical screening) funded in Ireland
  - There would be an initial increase in demand for a range of services but by year ten of a screening programme, the overall requirement for surgery (this includes patients presenting through either screening or as symptomatic) would be lower than with the current policy of not screening.
27. In 2006 the Ministry commissioned a cost-effectiveness study of a Bowel Cancer Screening Programme. Using a model for the age range 50-74 years and based on the Australian FOBT screening scenario, it estimated that a similar

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<sup>1</sup> This excludes community drug costs, community support services, hospice palliative care, GP visits, community laboratory and radiology costs and all privately-funded hospital services.

<sup>2</sup> *ibid*

<sup>3</sup> Ireland has a lower bowel cancer incidence than New Zealand. This would suggest that New Zealand would at least match the results predicted in Ireland.

programme in New Zealand would cost between \$25 and \$32 million per year. The study concluded that each life year saved would cost approximately \$35,000 (in 2006 dollars). The Ministry has advised me that the total estimated annual cost of a fully implemented Bowel Cancer Screening Programme (including surveillance and information system operating costs, but excluding capital costs) would be between \$27.6 million (restricted age range 60-69 yrs) and \$61.9 million (full age range 50-74 yrs), in 2010 dollars.

#### **PROPOSED BOWEL CANCER SCREENING IN NEW ZEALAND**

28. A population-based programme for bowel cancer screening in New Zealand would invite a defined population who are at average risk for bowel cancer (that is, do not have a pre-existing condition or family history that would put them at higher risk) to participate in the programme. Over time it is likely that everyone aged 50-74 will be invited to participate.
29. People will receive an FOBT kit in the mail. They will complete this test in the privacy of their own home and mail it back to a screening centre. This test detects occult (non-visible) blood in the faeces. A positive test indicates that the person has an increased risk of having bowel cancer. These people will be referred for a diagnostic test, usually involving a direct examination of the bowel by colonoscopy.
30. There is strong sector support for both a National Bowel Cancer Screening Programme implementation and the improvement of existing bowel cancer services. The Bowel Cancer Taskforce, whose members are clinical leaders in gastroenterology, colorectal surgery, oncology, general practice and primary health care, public health and gastroenterology nursing, endorse the implementation of the bowel cancer screening programme in tandem with increasing colonoscopy capacity. This approach is supported by Cancer Control New Zealand, the New Zealand Society of Gastroenterology, the New Zealand Association of General Surgeons, the Colorectal Surgical Society of Australia and New Zealand (NZ branch), the Royal New Zealand College of General Practitioners and the Cancer Society of New Zealand.

#### **IMPLEMENTATION OF A BOWEL CANCER SCREENING PROGRAMME IN NEW ZEALAND**

31. The Ministry has provided several options for a phased roll-out. I have selected an option with the following two components:
  - a. The Ministry will continue to focus on increasing the capacity of colonoscopy and related services to meet existing demand and to be able to meet demand for a national screening programme.
  - b. A four year pilot programme to assess benefits and costs of bowel cancer screening, to commence by October 2011. The final decision whether to proceed with a national programme will be made following evaluation of the pilot site. If the programme is successful the operating and capital funding requirements for the national programme will be made under a separate bid as part of the Budget 2013 or 2014 process.

##### **a) Improving Colonoscopy Capacity and Quality**

32. Colonoscopies are already required for people with symptoms of, those who have had, and those that have been treated for bowel cancer, as well as, those at ongoing greater risk, in particular those with pre-existing or familial risk. The ability of DHBs to provide these services is variable. Reasons include a shortage of colonoscopists and endoscopy nurses; inadequate data to plan services and

assess need; inappropriate referral to colonoscopy and shortage of theatre space for colonoscopies.

33. A successful and equitable screening programme will require the development of additional colonoscopy services and quality improvements to meet both the increased demand from people requiring diagnostic services as well as treatment services for those with confirmed bowel cancer.
34. There is evidence to suggest that the expectation or existence of, a bowel cancer screening programme will act an impetus to improve the quality and efficiency of colonoscopy services. For example the introduction of organised breast screening programmes has been reported to have led to measurable system improvements in diagnostic and treatment services for breast cancer. There is evidence from international bowel cancer screening programmes to suggest similar improvements will be seen in colonoscopy services.
35. The knowledge that a national bowel cancer screening programme is imminent would focus the attention of DHBs on improving the colonoscopy and related services they provide. Without the commitment to a national programme this focus could be diminished and DHBs are less likely to focus on colonoscopy capacity amongst their many competing demands. However, the Ministry has a comprehensive work programme to ensure DHBs will be in the position to meet existing demands and meet increased requirements of a screening programme, should there be a national roll-out.
36. Developing and increasing current capacity and improving quality to become ready for the increased demand caused by the programme is a Ministry priority. The Ministry is working closely with professional Colleges, DHBs and Regional Cancer Networks to improve and extend existing services through a range of service development and workforce development programmes. Work includes increasing colonoscopy capacity, reducing system inefficiencies for diagnosis, improving patient flow, development and implementation of guidelines for referral and treatment, development of quality assurance measures and standardised training for colonoscopy, improving equity of access to treatment pathways, increasing workforce capacity (including additional trainee positions for gastroenterologists and pathologists), implementation of the New Zealand Familial Gastrointestinal Cancer Registry.
37. The programme will also increase demand for pathology (and pathologists) and other diagnostic tests. In the short to medium term there will also be increased demand for surgery and treatment with post-operative chemotherapy and/or radiotherapy for most bowel cancers diagnosed through the programme. Following treatment for cancer, follow-up to detect recurrence or spread of the cancer will be required.

#### **b) Pilot programme**

38. The pilot programme will begin by October 2011. Over a period of 4 years, eligible people aged 50-74 in the pilot area will be invited to participate in one screening round every two years.
39. Historically, screening programmes have not effectively covered the whole population range including Māori, Pacific and other ethnic minorities. There also is evidence of socio-economic inequalities and differences in bowel cancer incidence and mortality by gender and geographic region in New Zealand. A minimum sample of 60,000 invited to participate with a diverse ethnic, urban and rural mix, and a minimum of 6,000 Māori is required, to ensure the pilot

programme provides enough information to estimate the likely cancer detection rate overall, variations in participation and positivity rates between different populations and to inform cost-effectiveness analysis.

40. It will be important that the area has enough capacity to maintain adequate services for people with symptoms suggestive of bowel cancer, and those at higher or familial risk of bowel cancer, and be able to meet additional service demands resulting from the screening programme. In addition, there needs to be strong clinical support for the programme.
41. In line with the above requirements the pilot site could either involve one large DHB or two smaller DHBs (there are a number of possible DHB combinations). The associated cost would start at \$4.3 million each year for a pilot site inviting 60,000 people. If the largest single DHB was chosen, the numbers could exceed 130,000 people, and the cost could be up to \$7.6 million each year.
42. The Chair of CCNZ, Associate Professor Chris Atkinson has advised me that his preference would be for the pilot site to be at Canterbury DHB (CDHB). The reasons for his recommendations include; CDHB's strong record in attaining a high uptake of people participating in existing cancer screening programmes, the population size and profile would enable an assessment of access to screening by different population groups, such as Māori, the existence of public and private provision of colonoscopy services, and strong leadership and infrastructure.
43. The Ministry has advised that the final decision on where the pilot site/s will be located should be made following an Expression of Interest process. This would enable the Ministry to assess DHB willingness, capacity and readiness and allow a coordinated approach to planning and implementation.
44. The programme will be monitored and evaluated to inform the decision on whether to roll-out a national programme. Information collected will include data on participation; response to invitation strategies; iFOBT positivity and sensitivity rates in New Zealand and the impact on existing colonoscopy services. Extensive data will become available to inform cost effectiveness studies and other issues, such as the impact of the level of iFOBT positivity on colonoscopy services.
45. There is the potential, should the economy recover faster than expected and the pilot be extremely successful, to bring forward the decision about a wider roll-out perhaps by extending the number of sites in 2013/14. This would be subject to a further budget bid.
46. The main advantage of a pilot site is that it allows time to increase the capacity and quality of colonoscopy and related services throughout New Zealand, while developing the most effective programme in the New Zealand context, should a national programme be approved. The disadvantages of not commencing with a national roll-out are the longer period for full mortality benefit to be realised nationally and initial access to the programme being based on geographical location. However, a similar approach was taken to the introduction of the breast screening programme in the late 1990's and it was well supported.

#### **MONITORING AND EVALUATION INFORMATION SYSTEM REQUIREMENTS**

47. Information systems are vital to ensure the optimal and ethical delivery of screening activities. Without comprehensive information systems it is difficult to identify and invite eligible people to participate in screening, as well as provide failsafe mechanisms and adequate safety provisions for individual participants. These systems ensure comprehensive follow up with quality diagnostic testing

and that any cancers detected, are treated. Lastly, they provide information to determine how much benefit a screening programme is providing at a population level, and the impacts on service capacity.

48. There have been recent issues with monitoring and evaluating screening programmes due to inadequate information systems. In Australia almost half of screened participants with a positive FOBT test in the bowel cancer screening programme were 'lost to follow up'. However the thoroughness of the national data on FOBT positivity enabled the programme to quickly identify and respond to flaws in the FOBT they used. In New Zealand, the Gisborne Inquiry on the under-reporting of abnormal cervical smears highlighted problems linking laboratory results with cancers identified, due to the lack of centralised information for the programme.
49. A significant advantage of commencing with a small scale pilot programme is that an information system will initially be relatively inexpensive to establish. However, all the same issues that need to be addressed on a national scale must still be covered. The cost of a system for a national programme, however, will be significantly more expensive and will take at least 18 months to develop.

### **COSTS**

50. The pilot programme will require the development of an IT system, requiring capital expenditure estimated between \$0.52 million and \$1.125 million. These costs can be managed through the Ministry of Health's existing capital budget. Departmental Expenditure operating costs are included in the costs of the pilot project. Should a national rollout be considered, the development of, and learnings from, the information system for the pilot programme will inform the requirements for the national programme.

		<b>Estimated \$ millions required for Bowel Cancer Screening Programme, excluding IT costs</b>				
		<b>2010/11</b>	<b>2011/12</b>	<b>2012/13</b>	<b>2013/14</b>	<b>2014/15</b>
<b>Demo site</b>	<b>DE</b>		0.600	0.600	0.600	0.600
	<b>NDE</b>	1.200	3.700 to 7.000	3.700 to 7.000	3.700 to 7.000	3.700 to 7.000
<b>Total Programme</b>		<b>1.200</b>	<b>4.300 to 7.600</b>	<b>4.300 to 7.600</b>	<b>4.300 to 7.600</b>	<b>4.300 to 7.600</b>

### **Consultation**

51. CCNZ strongly supports the proposed approach to bowel cancer screening in this paper. It believes the proposed pilot sites are a necessary first step towards a national implementation of a bowel cancer screening programme for New Zealand. CCNZ believes that these sites will test aspects of the screening pathway, ensure benefits and provide critical information about how screening programmes can be maximised, and the costs minimised. CCNZ believes the consequence of not proceeding with this important work would be immense and has therefore prioritised bowel cancer screening as one of its seven key priority areas.
52. The Treasury, Department of Prime Minister, Ministry of Social Development and Te Puni Kokiri have been consulted and their comments have been incorporated.

### **Treasury Comments**

53. The Ministry of Health does not hold enough information to enable the preparation of a comprehensive Cost Benefit Analysis which is necessary to inform the decision as to whether a screening programme should be



implemented in New Zealand. In addition, previous New Zealand and international evidence suggests that the benefits of a screening programme may be modest, the costs significant, and that there is 'small but real' potential for harm. For these reasons, the pilot site should be viewed primarily as a feasibility study, designed to address several key unknowns including the efficacy of the test, evidence of mortality reduction, capacity for colonoscopies and treatment, prevalence of false positive and negative results and consequential unnecessary colonoscopies, harms resulting from the programme and participation rates at each stage of the patient journey. Further information is also required to inform an options analysis of the marginal benefits of screening different target groups/ages and the additional benefit that the programme is likely to result in compared with current systems, which target high risk patients only.

54. Consequently, it is important that the pilot is designed to gather the information required to complete a comprehensive CBA that is likely to be representative of a national programme and that it is communicated as a trial that is required in order to determine whether or not to proceed with a national programme.

### **Financial Implications**

55. The costs for the pilot programme and its associated information technology development will be funded from within available funding in Vote Health as part of Budget 2010. Decisions regarding a national rollout, and the financial implications therein, will be made at a later stage. Note that these costs fall between \$27.6 million and \$61.9 million per annum. Nonetheless, even though a decision on the full programme lies in the future, expectations will be raised in the health sector and amongst the public and there will be pressure placed upon Health to fund a national programme once a pilot site has commenced.
56. If a decision was taken not to roll out a national programme there is an ethical obligation to continue to offer and fund screening to those that have participated in the pilot programme until they are no longer in the eligible age range.

### **Human Rights**

57. There are no human rights implications.

### **Gender Implications**

58. The incidence and mortality rates for bowel cancer in New Zealand are higher for men than women. This will be the first screening programme for a cancer where both men and women are affected. International experience shows that men are poorer responders than women and additional effort will be required to promote the programme to them.

### **Disability Perspective**

59. There is evidence some people with intellectual and physical disabilities are likely to have increased difficulty in completing a FOBT. However, the programme will address the requirement for accessibility for people with disabilities through the development of National Policy and Quality Standards.

### **Publicity**

60. In light of recent media queries and reporting, the Ministry anticipates high public, media and sector interest in the bowel cancer screening programme. Following consideration of this paper by Cabinet, I may seek approval to issue a media statement as a pre-budget announcement confirming the Government's commitment to implement a Bowel Cancer Screening pilot programme in New Zealand.

## Recommendations

It is recommended that Cabinet:

1. **Note** that bowel cancer is the most frequently diagnosed cancer and the second highest cause of cancer death in New Zealand, with approximately 2,750 new cases and in 2008, 1,222 deaths per year
2. **Note** that modelling suggests that the newer generation iFOBT to be used in New Zealand could provide a lifetime reduction in the incidence of mortality from bowel cancer of 36 percent
3. **Note** that 19 of the 27 European Union member states already operate either national programmes or pilots for screening bowel cancer and that other countries with population programmes include Australia, Israel, the Canadian states of Alberta and Ontario, South Korea and Japan
4. **Note** that there is strong support from Cancer Control New Zealand and the sector for the implementation of a national bowel cancer screening programme alongside improvement in existing bowel cancer services
5. **Note** that a successful and equitable screening programme will increase demand for colonoscopy for diagnostic and ongoing surveillance requirements, pathology, and in the short to medium term, surgery and other cancer treatment services, and that the Ministry is working with the health sector to develop and increase workforce and service capacity prior to the commencement of screening
6. **Note** that the previous Government committed to fast tracking the implementation of a national bowel cancer screening programme but it failed to appropriate any funding and failed to address the workforce and infrastructure issues necessary to support both existing services and a screening programme
7. **Agree** to support the implementation of a bowel screening pilot, to enable the Ministry of Health to gather information on impact on health services, costs and benefits to allow Ministers to decide whether or not to roll out a national programme and, if so, appropriate timing of a wider rollout.
8. **Note** the final decision on which DHB or DHBs will be the pilot site/s will be made following an Expression of Interest process. This will enable the Ministry to assess willingness, capacity and readiness and allow a coordinated approach to planning and implementation
9. **Note** that the full cost of the pilot programme will be at a maximum cost of \$31.6 million across a five year period
10. **Note** that I have asked that the estimated costs for the information systems are carefully scrutinised and that all options be considered
11. **Note** that the costs of developing and implementing the pilot programme for bowel cancer screening, including the associated IT development costs, will be part of Health's package in Budget 2010
12. **Note** that the Ministry of Health will report back to Cabinet in February 2011 regarding the progress of the pilot programme
13. **Note** that at this time, the total estimated annual cost of a fully implemented National Bowel Cancer Screening Programme (excluding capital costs) would be between \$24 million (restricted age range 60-69 yrs) and \$53 million (full age

range 50-74 yrs), and an information system to support the national programme is currently estimated to be between \$6.5 and \$14.4 million with additional operating costs of between \$3.6 and \$7.9 million per year in out years

- 14. Invite** the Minister of Health to issue a media statement as part of a pre-budget announcement confirming the Government's commitment to implementing a Bowel Cancer Screening pilot, commencing from October 2011

**Hon Tony Ryall**  
**Minister of Health**

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