FOBT- Bowel screening by proxy outside of national programme

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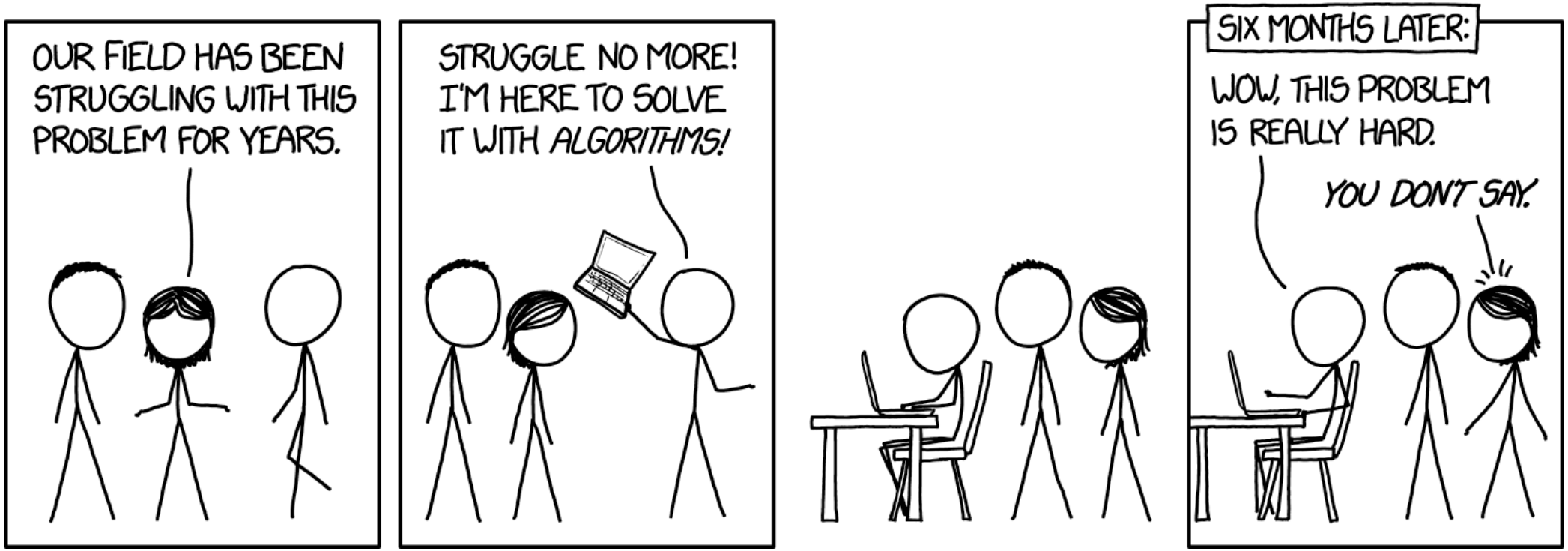
SDHB

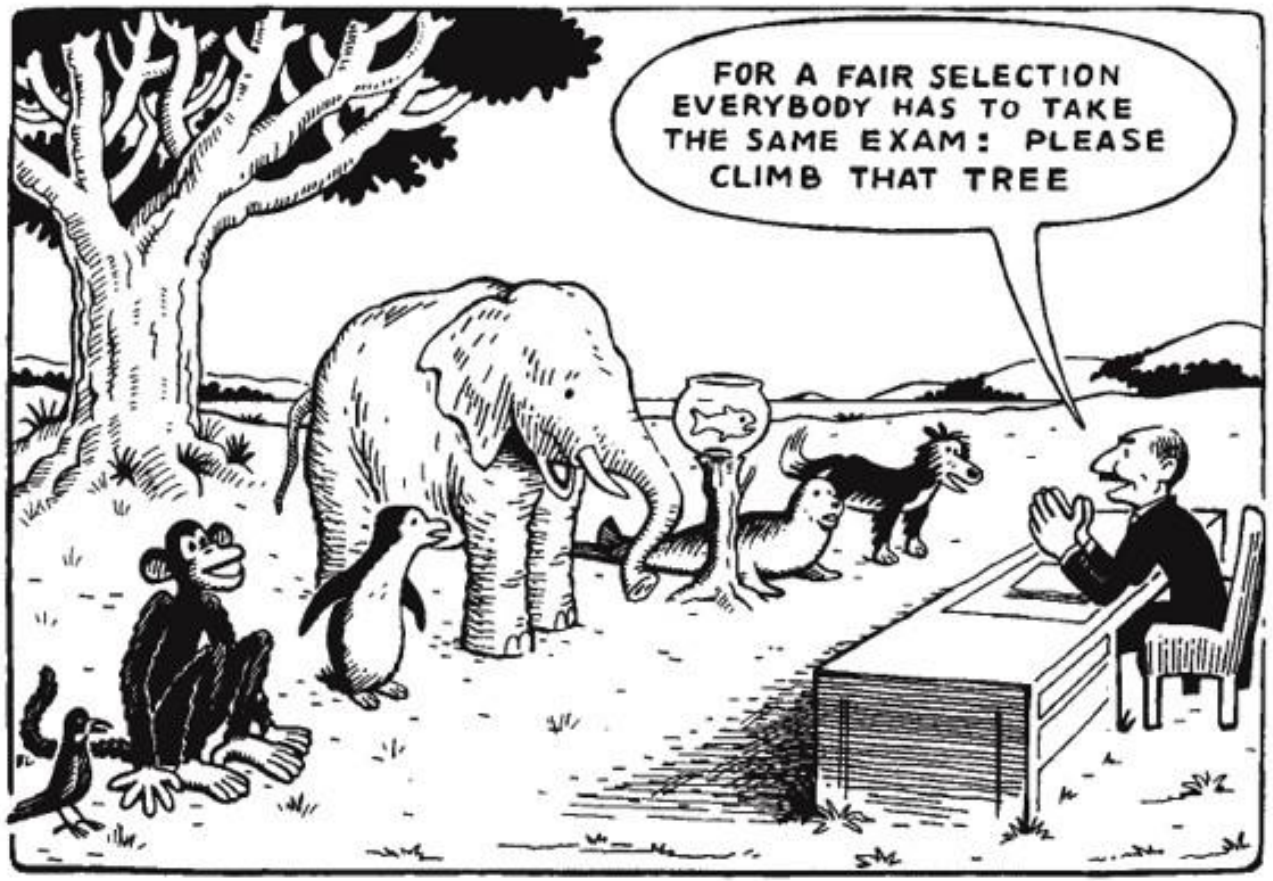
Declarations

- I am a fulltime public Colorectal Surgeon with very limited capacity to treat anything other than malignant disease electively
- I perform colonoscopies for the NBCSP
- All aspects of my practice are severely limited by cost restraints both cancer and non cancer work.
- Prioritisation and declining people (rationing) care for which I believe they will benefit is a daily occurrence and has been part of my entire career.
- I wish I worked in a system where I could deliver care to all who would benefit.
- I believe that unless clinicians engage in the process of prioritising care others will do it.

Problems with ad hoc screening for Bowel cancer



Equity


FOR A FAIR SELECTION EVERYBODY HAS TO TAKE THE SAME EXAM: PLEASE CLIMB THAT TREE

Colorectal cancer

- Māori and Pacific peoples had higher proportions (28 and 25 percent, respectively) with distant disease than other ethnic groups (who ranged between 17 and 21 percent).
- More Māori (39 percent) and Pacific peoples (41 percent) were diagnosed with bowel cancer following ED presentation.(cf 27% national average)

Atlas of Healthcare Variation
accessed 2018

Health Quality & Safety Commission New Zealand
Kupu Taurangi Hauora o Aotearoa

- Māori adults were more likely than non-Māori adults to have experienced 1 or more types of unmet need for primary health care in 2013/14 (RR 1.37, CI 1.27–1.48).
- Māori adults were more than 1.5 times as likely as non-Māori adults to have experienced an unmet need for a GP due to cost (RR 1.51, CI 1.34–1.69).

2013/14 New Zealand Health Survey, Ministry of Health

Colorectal cancer patients in the lowest income quintile experienced 13% greater excess mortality compared to patients in the highest income quintile, with an EMRR of 1.13 (95% CI 1.05, 1.21), a lesser difference than for ethnicity but with the 95% confidence interval excluding the null.

Soeberg M, Blakely T, Sarfati D, et al. Cancer Trends: Trends in cancer survival by ethnic and socioeconomic group, New Zealand 1991-2004. Wellington: University of Otago; Ministry of Health; 2012.


SO TELL ME, DOC. WHAT DO I NEED TO IMPROVE MY QUALITY OF LIFE? A NEW HIP?
A NEW GOVERNMENT.
SENIORS' CARE HIT BY HEALTH CUTBACKS
CLOSED
RAESIDE

Demand management

- Demonstrated already at this meeting colonoscopy demand for symptomatic patients is growing above projections.
- Screening demands from the NBCSP will further exacerbate this.
- Plans for further roll out will be slowed by inability to meet colonoscopy targets.
- Our service is already doing additional lists to try and keep up.
- Our DHB is already under the administration of a commissioner and team with the express command to reduce our deficit.

- Funding can be found for this but typically at the cost to something else.
- Targeting funding to one area seems always to at another’s expense
- FCT cancer targets have had a major effect on our clinic profile as colorectal cancer symptoms are vague.

Code of patient rights.

- Right 6 of the Code states that every consumer has *‘the right to the information that a reasonable consumer, in that consumer’s circumstances, would expect to receive’.* Specifically, the Code states patients are entitled to:
  - (a) an explanation of his or her condition; and
  - (b) an explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; and
  - (c) advice of the estimated time within which the services will be provided; and

If only we knew what the response of our DHB might be?

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A statement from National Bowel Screening Programme Clinical Director Dr Susan Parry and GP lead Dr John McMenamin.

One of the consequences of increasing awareness about bowel screening appears to be that some people are buying FOBT self-testing kits, such as those available from pharmacies. The expectation is that asymptomatic individuals, who get a positive result from a self-purchased kit, are entitled to further investigation through the public health system. This is not the case.

- The screening programme should respond to a recognized need.☺
- The objectives of screening should be defined at the outset.☺
- There should be a defined target population.☹
- There should be scientific evidence of screening programme effectiveness.
- The programme should integrate education, testing, clinical services and programme management.☹
- There should be quality assurance, with mechanisms to minimize potential risks of screening.☹
- The programme should ensure informed choice, confidentiality and respect for autonomy.☹
- The programme should promote equity and access to screening for the entire target population.😭
- Programme evaluation should be planned from the outset.😭
- The overall benefits of screening should outweigh the harm.

Revisiting Wilson and Jungner in the genomic age: a review of screening criteria over the past 40 years
Anne Andermann [a], Ingeborg Blancquaert [b], Sylvie Beauchamp [b], Véronique Déry [c]
Bulletin of the World Health Organization Volume 86: 2008

Summary

- Colonoscopic screening or FIT testing will demonstrate CRC at an asymptomatic stage
- This is done at the cost of the procedure and the 20 further colonscopies performed to diagnose a cancer.
- The people who are likely to take up opportunistic screening are more likely to come from socially advantaged groups and the entire population is subsidising an increase in this inequity.
- At some stage one straw will break the camels back
- Unfortunately I believe currently we cannot afford the opportunity cost of this intervention. Financially or in the counterbalanced reduction in other services.