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Systemic racism as inaction in the face of need: A call to action from the Royal Australasian College of Surgeons

The Royal Australasian College of Surgeons believes that a strong focus on health advocacy is a central competency of a surgeon, and a core value of this college. RACS advocates strongly for Indigenous health equity, and specifically supports its Māori, Aboriginal and Torres Strait Islander Fellows and trainees in their advocacy work to reduce the burden of inequity and systemic racism in health systems that under-serve Indigenous communities.

Māori are over-represented in cancer registrations (430/100,000 pop.) and overall mortality (188/100,000) than non-Māori (320/100,000 registrations and 110/100,000 mortality). This disparity cannot be explained away by socioeconomic status, comorbidity or consent to treatment, as has been purported previously. Institutional racism is a known important determinant of health and is a major cause of health inequities between Māori and non-Māori in New Zealand. A pilot bowel screening programme at Waitemata District Health Board from 2012-2017 confirmed the success of the programme in detecting significant levels of early cancer, and pre-cancerous polyps. Of the cancers found in the screening pilot, 39% were at an early, localised stage. This is associated with a 95% five-year survival and is a significantly greater pick-up rate than early cancers found in the non-screened population (13%). Diagnosis of cancers found at the most advanced stage in the screening pilot was just 8% compared with 24% of the non-screened population. This is associated with a 10% five-year survival. These findings informed the development of the National Bowel Screening Programme, however the minimum age was reduced after colonoscopy capacity was only deemed satisfactory to serve a screening population aged 60-74 years. Data from the Ministry of Health suggests, however, that only 1,100 more colonoscopies are needed to provide access to equitable screening for Māori and Pasifika people across the country. Broken down by DHB, it is clear that only five of the 21 DHBs would need to do more than 50 extra per year. The largest number a DHB would have to do is an estimated 93 - less than one extra list per fortnight; this is a tertiary gastroenterology centre. Five DHBs would have fewer than four extra lists per year. Of an estimated 10,126 screening colonoscopies nationally for the year 2021/2022, the lowered age would add an extra 756 for Māori, and 311 for Pasifika patients.

This is surely a drop in the ocean for equity.

With this knowledge, it is therefore with both shock and disappointment that RACS learns of the decision of the New Zealand Ministry of Health to not extend the minimum bowel screening age for Māori and Pasifika People to ensure equitable coverage to the entire population. The NZ National Bowel Cancer Screening Programme is being rolled out in New Zealand using an age-range that does not provide the same levels of health gains for Māori as it does to non-Māori, non-Pasifika people. This is because Māori have a higher incidence of bowel cancer at ages 50-59 (20% compared with 10% in non-Māori), and a lower rate of bowel cancer in the screening population (66% compared with 79% for NZ European). The Ministry of Health has long understood the importance of extending the minimum age for equitable bowel screening to Māori and Pasifika through expert opinion it has received on a regular basis, informed by both its own bowel cancer data, by the Cancer control agency advisory council, many expert groups identified below, and by extensive community engagement and feedback. The Ministry conducted its own research, and sought expert opinion about the importance for, and evidence for extending the screening age for Māori. Feedback it received was overwhelmingly towards extending the minimum screening age to 50 for Māori and Pasifika People.



Committed to
Indigenous health

RACS understands that while the best balance for benefits and cost of bowel cancer screening lies within the age-range of 60-74 at a population level, Māori have less capacity to benefit from this owing to a shorter life-expectancy (73 Māori males, 77.1 Māori females compared with 80.3 and 83.9 for non-Māori), lower participation rates and poorer bowel cancer survival. This is evidence that even if Māori were to achieve equal participation rates in bowel screening at the current age, health gain inequities would persist. Any measurement of an 'Equity Impact' must take a 'Rights-Based' approach, an understanding that good governance means honouring Te Tiriti o Waitangi, which for Māori ensures the right to equity in health gains, and equity in health outcomes.

In summary, the Royal Australasian College of Surgeons joins the call by Dr Rawiri Jansen and Shelley Campbell (Co-Chairs of the National Māori bowel cancer stakeholder group) to the New Zealand Government, and the New Zealand Ministry of Health, to act on the evidence for Māori health equity, for the extended age-range of screening colonoscopy to 50-59 for Māori. A position statement released by RACS in 2012 calling for the New Zealand government to ensure nationwide screening for bowel cancer for people aged 50years is still ideal, as is this renewed call for responsiveness and action for equity.

RACS is committed to action in the face of need, as a clear indication of its policies to advocate for, and work towards the elimination of health disparities in cancer outcomes for Māori.

Issued by:

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