

Summary of Breast Cancer Aotearoa Coalition Briefing to Minister of Health on Breast Cancer Issues, March 2021

Key messages and discussion points

- Breast cancer is the most common cancer for NZ women: 3500 are diagnosed, 670 die each year (around 2 women every day)
- Māori women are 76% more likely to die, Pasifika twice as likely than Pākehā
- Deprivation and lack of access to care contribute to worse outcomes
- Our women with advanced breast cancer live half as long as those globally (16 months in NZ compared to 32 months or more in Europe)
- We're more likely to die than Australians

Input from across BCAC's 30+ member groups has provided insight into many coalface issues that women with breast cancer face, revealing real opportunities for improvement (please refer to Appendix 1 of full briefing document).

We have identified three key issues with solutions that will make a big difference to the lives of New Zealanders with breast cancer and bring greater equity to our health system. They provide the longer term focus and leadership looked for in the Health and Disabilities Review.

1. Managing risk and better targeting screening
2. Greater access to medicines
3. Gene-based testing for greater precision

All of these solutions will modernise our current system and ensure the right treatments are delivered only to the people they will work for, at the right time, to achieve greater efficiency and better health outcomes.

1. Risk management and targeted screening

Currently all women aged 45 – 69 are offered 2 yearly mammograms. The Government has committed to extending this to 70 – 74 and we ask that this be done with urgency.

The current screening programme is based on a woman with average risk and we could do much better by using a more tailored approach. It would allow those at high risk to be more closely watched than those at low risk and identify cancers earlier.

For example, Māori and Pasifika women tend to be diagnosed younger and with more aggressive disease, and could be screened from age 40.

High breast density is seen on mammograms as whiteness or cloudiness and this masks tumours. High density also comes with a higher risk of breast cancer. In the US, breast density *must* be reported to all women who have mammograms, allowing women to know if they're at higher risk and need additional screening. BreastScreen Aotearoa does not report density, although women screened in the private system often do have density reported and are advised if they need further imaging. There is evidence that Māori women have

higher breast density, so are at greater risk. Our screening programme should report density and offer extra imaging where it is needed. Appendix 2 describes advances in imaging technologies that could be used, along with costs.

There are also genetic differences among women that contribute to their risk of getting breast cancer. Not just the BRCA genes that are very well known but there are a number of other genes that have been well characterised and more are being identified as research continues. The current criteria for genetic testing in NZ are very narrow – local research has shown that more than 50% of carriers of known mutations are missed. Women who have been adopted or with small families may not know enough of their family history to qualify. Our genetic services need to be expanded so that those at risk can be screened appropriately and their cancers can be caught at an earlier, more treatable stage.

There are some very good risk assessment tools that take many risk factors into account and could now be used to good effect in primary care.

2. Medicines access

We're grateful that a handful of medicines were recently funded for breast cancer but there are many more. Appendix 3 lists 9 that are already funded in Australia and not here, and a further 5 for which strong evidence is emerging and will soon become the global standard of care.

PHARMAC's briefing to the incoming Minister in 2017 showed that of all 36 OECD countries, *only Mexico* spends less per capita than NZ. We are consistently at the bottom of compared countries in access to modern medicines. To reach the OECD average in medicines investment we would need to triple our medicines budget – we are absolutely *worlds* behind where we should be and this is simply not good enough. This is the reason that a wide range of health groups continue to petition Parliament for access to particular evidence-based medicines that are not funded.

The failure by successive governments to invest properly in medicines leads to poorer health outcomes for our people and both drives and compounds socioeconomic and ethnic inequities. Those who can pay will live longer, healthier lives.

With an inadequate and capped budget PHARMAC is continually declining to fund medicines that people and their doctors know will make their lives better. Many of these have been recommended as priorities for funding by PHARMAC's own specialist advisory committees. It's incredibly concerning that PHARMAC is predicting a lower budget over the next three years. There are huge benefits to be gained from providing effective, targeted medicines to breast cancer patients.

Early breast cancer is curable when effectively treated but we fall well short of the global standard of care. Advanced breast cancer is fast becoming a chronic treatable disease that can be lived with for many years but we need the medicines that can accomplish this. Oncologists need a toolkit that can be used to treat individuals depending on subtype and response. One size does not fit all – if something isn't working other medicines should be available, but we are left with very few options.

It's good to see a review of PHARMAC is under way. We are looking for greater timeliness, transparency and honesty. Also inclusion of a genuine patient voice within their processes along with a drive to provide better medicines access and improved patient outcomes. The budgetary constraints dictate a culture of rationing and preclude any future-focus or aspiration. This is really holding us back as a nation and it is certainly perpetuating huge inequities in cancer care and outcomes.

3. Precision testing

Breast cancer is a complex disease, with an increasing number of subtypes being identified through research. Therapies that target specific molecular features of a subtype have been largely responsible for the reductions in mortality from breast cancer in recent decades (e.g. those targeting oestrogen-driven and HER2-driven cancers). New medicines for breast cancer are almost exclusively based on the concept of targeting particular subtypes with ever greater accuracy and effectiveness. To take advantage of the benefits these treatment can bring, patients and their doctors need to be able to know precisely which subtype they are dealing with and how aggressive the disease is.

The tests required for this are based on gene sequencing and gene expression tests similar to those being used in response to the Covid crisis. Private health providers are increasingly offering these tests to patients, enabling more precise diagnosis and better targeting of effective treatments. **Genomic tumour sequencing** accurately defines the subtype which identifies the most effective treatments. It can also track changes in the tumour over time so treatment can be adjusted.

Gene expression profiling shows how active or aggressive the cancer is and, for instance, whether cytotoxic chemotherapy needs to be added to anti-oestrogen therapy or not. A recent local study showed that around 70% of women who received chemo could have safely avoided it. Imagine the cost savings, the reduced pressure on DHB chemo units and importantly, the reduced impacts on women's lives, if we could avoid unnecessary treatments.

We need our Government to develop the infrastructure and processes for routine genetic testing so this doesn't become yet another source of inequity in NZ cancer care.

As with the Covid response, there will be an upfront cost but it will bring a downstream benefit. By adopting advanced testing technologies, our health system will be able to break away from being a *reactive late-follower* and ensure that we take advantage of the cost savings and societal benefits that well-selected modern cancer treatments offer.

Conclusion

Our main message is that we really need aspiration and investment in cancer care to see an improvement and to achieve equity for all across the motu. Our Covid response, as a nation was exemplary and world-leading. Let's do the same with cancer. We need to recognise, adopt and resource technological innovation to give New Zealanders confidence that we have a modern health system delivering the level of care we expect and deserve.