

Equity deferred is equity denied: cancer outcomes for Māori and Pacific peoples

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ABSTRACT

Persistent inequities in cancer outcomes for Māori and Pacific peoples remain one of the most significant challenges facing the Aotearoa New Zealand health system. These disparities are evident across incidence, stage at diagnosis, access to treatment and survival. While often attributed to behavioural risk factors, the predominant drivers are structural, including barriers to access, health system design, workforce limitations and broader socio-economic determinants. Despite long-standing recognition, progress has been inconsistent and insufficient. Addressing these inequities requires a shift from description to accountability, with equity embedded as a core performance metric. Culturally aligned services, improved access to care, strengthened primary care and the use of registry-based data to drive quality improvement are essential components of a system capable of delivering equitable outcomes. Comprehensive cancer centres could offer a further opportunity to reduce variation and improve access to high-quality multidisciplinary care. In parallel, screening policy must better reflect epidemiological realities, including the earlier onset of colorectal cancer among Māori. Equity in cancer care is fundamental to the definition of a high-performing health system. Without measurable progress, equity remains deferred—and therefore denied.

Cancer remains a leading cause of mortality in Aotearoa New Zealand, with approximately 25,000 new cancer diagnoses annually and a growing burden driven by population ageing.¹ However, this burden is not evenly distributed. Māori experience substantially higher cancer mortality than non-Māori, and Pacific peoples similarly experience poorer outcomes across a range of malignancies.¹ These inequities have been consistently documented over decades and remain a defining feature of the health system.

Equity is frequently articulated as a central objective of health policy in New Zealand, reflecting obligations under Te Tiriti o Waitangi and broader commitments to fairness.^{2–4} Yet persistent disparities in cancer outcomes indicate that this objective has not been realised in practice. A health system that delivers high-quality care for some but not for all cannot be considered effective. Equity must therefore move beyond aspiration and become a measurable dimension of system performance.

Incidence, stage at diagnosis and survival

The scale of inequity is evident across incidence, stage at diagnosis and survival. Colorectal cancer alone accounts for about 3,500 diagnoses and more than 1,200 deaths annually in New Zealand, making it one of the leading causes of cancer mortality.⁵ More broadly, cancer is one of the principal

contributors to premature mortality, with Māori bearing a disproportionate share of this burden.⁵

Disparities in stage at diagnosis are particularly striking. Māori and Pacific peoples are significantly more likely to present with advanced disease, with 28% of Māori and 25% of Pacific patients diagnosed with distant metastatic disease compared with approximately 17–21% in other populations.^{6,7} This difference in stage distribution has profound implications for treatment options and survival.

Colorectal cancer illustrates these inequities clearly. While overall incidence has been relatively stable or declining in older populations, early-onset colorectal cancer is increasing, particularly among Māori. Māori are more likely to develop colorectal cancer at younger ages, with approximately 18% of Māori cases diagnosed before age 50 compared with 8.5% in the overall population. Furthermore, more than half of colorectal cancers in Māori occur before the age of 60, compared with less than one-third in non-Māori populations.^{6,8}

These epidemiological patterns expose a fundamental misalignment between disease burden and current screening policy. The national bowel screening programme, which begins at an older age threshold, fails to capture a substantial proportion of at-risk Māori. Lowering the screening age, particularly for Māori and Pacific populations, represents a necessary and evidence-based response to these disparities.

Importantly, inequities persist beyond stage at diagnosis. Survival differences remain even after adjustment for stage, indicating that disparities extend into access to treatment, quality of care and broader determinants. These findings confirm that inequity is embedded throughout the cancer pathway rather than confined to a single point.

Structural and behavioural determinants

Explanations for inequity often focus on behavioural risk factors such as smoking, diet and screening participation. While these are relevant, such framing risks obscuring the structural determinants that shape both risk exposure and access to care.⁹

Structural barriers are the dominant drivers of inequity.⁹ Access to healthcare is influenced by geography, cost, transport and service availability, all of which disproportionately affect Māori and Pacific communities. Delays in accessing primary care contribute to later diagnosis, while fragmented referral pathways and inconsistent co-ordination further exacerbate delays.

Health system design also plays a role. Systems that assume high levels of health literacy and navigational capacity may disadvantage those who require additional support. Workforce factors are equally important. Limited representation of Māori and Pacific clinicians and variable cultural safety across services can affect communication, trust and engagement. Institutional bias may also influence clinical decision making and access to treatment.

Socio-economic determinants underpin many of these issues. Income, education and housing influence both exposure to risk factors and the ability to engage with healthcare. For example, higher rates of stomach cancer among Māori have been linked to structural factors such as overcrowding and *Helicobacter pylori* exposure, as well as broader socio-economic conditions.

Behavioural factors are therefore best understood as downstream effects of these structural conditions. Addressing inequity requires a primary focus on structural reform, supported by but not limited to behavioural interventions.

Access across the cancer pathway

Inequities are evident across the entire cancer pathway.⁹ Preventive interventions have not achieved equivalent impact across populations,

and disparities in screening participation persist. Delayed diagnosis remains a critical issue, with barriers to primary care access contributing to missed opportunities for early detection.

Once cancer is suspected, access to diagnostic services such as imaging and endoscopy can be variable. These delays contribute to the higher proportion of advanced disease at presentation among Māori and Pacific patients. Treatment inequities are also evident, with differences in access to surgery, systemic therapy and radiotherapy observed even after adjusting for clinical factors.

In this context, the development of comprehensive cancer centres offers a potential mechanism to reduce variation in care and improve outcomes.¹⁰ By integrating multidisciplinary expertise, advanced diagnostics, surgical services and systemic therapies within coordinated pathways, such centres can standardise care delivery and support adherence to best practice. They also provide a platform for research, training and quality improvement. For Māori and Pacific patients, comprehensive cancer centres may improve access to high-quality care, particularly when supported by effective outreach, navigation services and strong links with regional providers. However, centralisation must be accompanied by investment in transport, accommodation and community-based services to avoid exacerbating existing barriers.

Post-treatment care and survivorship services similarly require attention. Equitable access to follow-up care, rehabilitation and palliative services is essential to improving both survival and quality of life.

Culturally aligned care

Culturally aligned healthcare is central to achieving equitable outcomes. Services that reflect the values and needs of Māori and Pacific peoples are more likely to be acceptable and effective. Whānau-centred approaches recognise the importance of collective decision making and support, while navigation services can assist patients in engaging with complex health systems.

Community-based service delivery can reduce barriers to access and enhance trust. Workforce development, including increasing Māori and Pacific representation and ensuring cultural safety across all services, is critical. These approaches must be embedded within mainstream care rather than treated as peripheral initiatives.

Data, registries and system performance

Robust data systems are essential for understanding and addressing inequity. National cancer registries provide critical information on incidence, treatment and outcomes, while clinical quality registries enable benchmarking and continuous quality improvement. The value of screening programmes in improving stage at diagnosis and survival is well established, with earlier detection associated with significantly improved outcomes.¹¹

However, data must be actively used to drive change. Equity metrics should be incorporated into performance frameworks, with disparities monitored and addressed. Registry-based approaches, providing risk-adjusted outcomes and real-time feedback, offer a powerful tool for identifying variation and supporting improvement.

Accountability and the path forward

A key barrier to progress is the lack of clear accountability. While equity is widely acknowledged as a priority, it is often not linked to measurable targets or consequences. A shift is required towards explicit goals for reducing disparities in cancer outcomes, supported by transparent reporting and performance management.

This includes aligning screening programmes

with population risk, improving access to primary care, investing in culturally aligned services, strengthening data infrastructure and developing the workforce. These actions are well recognised; the challenge lies in implementation and sustained commitment.

Conclusion

The inequities in cancer outcomes for Māori and Pacific peoples represent a fundamental test of the New Zealand health system. They reflect systemic issues that have persisted despite long-standing recognition. Addressing them requires structural reform, culturally aligned care and robust accountability.

Equity must be understood as a core dimension of quality. A system that fails to deliver equitable outcomes cannot be considered high performing. The continued existence of disparities in cancer outcomes is therefore a reflection of system performance as much as clinical care.

Progress will require leadership and a willingness to act on evidence. This includes lowering the age of colorectal cancer screening to reflect earlier onset in Māori, investing in comprehensive cancer centres to reduce variation in care and ensuring that services are accessible, culturally appropriate and accountable for outcomes. Equity deferred is, in effect, equity denied. The imperative now is to move from recognition to measurable and sustained improvement.

COMPETING INTERESTS

Frank Frizelle is the Editor in Chief of the *New Zealand Medical Journal*; President CSSANZ; Chair PCORANZ (prostate cancer registry); Deputy Chair BCORANZ (bowel cancer register); Chair Christchurch Cancer Foundation; Board Member Southland Charity Hospital.

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