TE AHO
O TE KAHU
CANCER
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Te Kāwanatanga
o Aotearoa
New Zealand Government

The State of Cancer in New Zealand 2025

Insights and Summary Report

He Pūrongo Mate Pukupuku o Aotearoa 2025

He Aroā, He Tīpako

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Document purpose and outline | Te whāinga me te rāpopoto

This insights and summary report is a companion publication to the full report, *The State of Cancer in New Zealand 2025 | He Pūrongo Mate Pukupuku o Aotearoa 2025* (*State of Cancer 2025*), published by Te Aho o Te Kahu | Cancer Control Agency. It includes:

- commentary that looks across the cancer system and uses the report's findings to describe how the system is working and spotlight some key trends and themes. It provides examples of where different indicator results, when viewed together, might reveal something of interest about the larger cancer system and its performance
- summaries of each section of the full *State of Cancer 2025* report, including key points of note and focus areas where long-term thinking, planning and investment are needed by the system.

Reading the full report will provide a more complete picture of the overall performance of the cancer system over the last 5 years. The full report uses evidence to highlight how the cancer system is performing, where progress has been made over the last 5 years and where opportunities for improvements remain. It contains the full references, data sources used in the writing of the report and explanations of the terms used (these are not included in this insights and summary publication).

These publications are available at teaho.govt.nz.

The *State of Cancer 2025* report has informed the *New Zealand Cancer Action Plan 2026–2029,* which will outline where change and actions are needed to improve the cancer system in New Zealand over the coming years. It is scheduled to be published in early 2026.

Insights into the *State of Cancer 2025* | He aroā o te *Mate Pukupuku 2025*

Introduction

People in New Zealand aspire to have access to a high-quality health care system that delivers timely and effective cancer services tailored to their individual and whānau needs. Te Aho o Te Kahu | Cancer Control Agency monitors and reports on the health sector's progress towards achieving this goal.

Like many countries, New Zealand's cancer system is responding to continuous advances in how cancers can be prevented, diagnosed and treated, and the cost implications of these innovations. At the same time, the demand for cancer services is projected to increase dramatically. Projections indicate that in New Zealand the number of people diagnosed with cancer annually will grow from over 30,000 in 2025 to over 45,000 by 2044. This will place substantial pressure on an already-stretched health system.

The cancer system cannot meet future demand by doing more of the same; it needs to continue to innovate and introduce new ways of planning and delivering care while focusing on the fundamentals of cancer control. These include:

- implementing prevention strategies (the most effective approach in cancer control)
- supporting the new models of care, designed to improve services and efficiency
- pursuing the promising potential of digital health, data and artificial intelligence
- preparing for rapidly emerging innovations in screening, diagnosis and treatment
- expanding access to culturally safe, person-centred support services that prioritise holistic care and have been shown to improve cancer outcomes.

Cancer services and outcomes have improved for people in New Zealand and their whānau since the first *State of Cancer* report was published in 2021. Some examples include:

- reductions in smoking rates across all ethnicities
- expansion of the eligibility for national cancer screening programmes
- additional supports for primary care, including easier referrals to radiology and more accessible systemic anti-cancer therapy medicines
- implementing new models of care (standardised frameworks for how health care is provided)
- providing more treatments closer to people's homes
- increasing funding for cancer medicines
- expanding or introducing new radiation treatment services
- investments in cancer navigation services led by kaupapa Māori providers.

However, more progress is needed if New Zealand is to effectively respond to the projected increase in demand for cancer care.

How rates are changing

There are three key 'indicators' that are used to monitor cancer at a population level. By looking at the number of people who are diagnosed with cancer (incidence rate), how long people survive after diagnosis (net survival) and how many people die from cancer (mortality rate), we can understand how cancer impacts people in New Zealand.

Cancer mortality rates are a way to measure how cancer impacts different populations. In New Zealand, mortality rates have steadily declined for decades, decreasing by almost 25% in the last 20 years. Such a decrease could be explained by two factors:

- a lower chance of being diagnosed with cancer (lower incidence rates)
- a higher chance of surviving cancer (higher net survival).

Incidence rates have dropped in the last 20 years, but only by 5% overall – and that decrease has levelled off over the past decade. The large drop in mortality rates (the number of people who die from cancer per 100,000 people, standardised for age[1]) is therefore likely due to substantial improvements in people surviving cancer. In fact, 5-year net survival for all cancers combined has improved by 15% in the last 20 years.

Cancer survival has likely improved due to a combination of factors, in particular, earlier detection (mainly through screening programmes) and greater access to more effective treatments (including advances in surgery, radiation treatment and systemic therapies).

While reporting on incidence, survival and mortality rates for all cancers combined is convenient for measuring the quality of care in New Zealand, more useful information can be obtained by focusing on specific cancers.

As an example, bowel cancer is one of the most-common cancers that affects both males and females. This type of cancer can be reduced through several prevention strategies (such as exercising, eating a nutritious diet, limiting alcohol and not smoking). It also has a national cancer screening programme so can often be detected at an early stage, and has a range of treatment options that continue to evolve rapidly. Looking across all available data, overall, people in New Zealand are much less likely to die of bowel cancer now than they were 20 years ago: mortality rates have dropped by 35% in the last 20 years, and there has been a 15% improvement in those surviving at least 5 years after diagnosis. Overall, incidence rates have dropped by 20% in that same period. However, outcomes vary for some population groups. It is interesting and important to consider what is contributing to these trends and the extent to which they are experienced consistently across all segments of the population.

How the risk of people developing cancer is changing

The risk of developing cancer has changed over time. Cancer is a complex disease that is influenced by many factors – for example, people's genetic makeup, the environments they live in, their lifestyle choices and their socioeconomic situation. The 'burden' of cancer – how it affects people and communities – reflects not only biological processes but also long-standing inequities and differences in the risks people are exposed to over time.

One of the biggest changes in recent decades has been the shift in risk factors that influence the likelihood of a person developing cancer. A big success is the dramatic decrease in smoking rates over the past 20 years. This reduction in smoking has happened across all ethnicities, with particularly steep reductions over the past 15 years among Māori (wāhine Māori (Māori females) especially); daily smoking rates for Māori dropped from almost 40% in 2011 to 15% in 2024. This has been a key factor in reducing cancer incidence rates, not just for lung cancer but for other tobacco-related cancers, including bowel cancer.

Progress has been less positive for other 'modifiable' risk factors (factors that people have some control over and that can increase or decrease their chance of developing cancer). Rates of excess body weight, harmful alcohol consumption, poor nutrition and physical inactivity have either increased or shown little improvement over the past 20 years. Compared with people in comparable countries, adults in New Zealand have the third-highest rates of obesity and second-highest childhood prevalence of obesity.

The overall rise in obesity rates in New Zealand continues to be a particular concern. These trends are likely to be contributing to worrying increases in cancers closely linked to excess body weight, such as uterine and breast cancers.

Between 2018 and 2022, the rate for uterine cancer was over five times higher for Pacific females than for females of European/other (non-Māori, non-Pacific, non-Asian) ethnicity and almost twice as high for wāhine Māori. For breast cancer, wāhine Māori and Pacific females have a higher rate of diagnosis than females of European/other ethnicity. In particular, there has been a notable increase in the rate of diagnosis among Pacific females, increasing by more than 50% between 2001 and 2022. The gap between different ethnic groups also exists in bowel cancer, for example, with rates for European/other dropping by an average of almost 1% per year between 2001 and 2022 while increasing by an average of 1.6% for Pacific peoples over the same time period.

The factors contributing to the risk of developing cancer often intersect with broader 'determinants' – the conditions in which people are born, grow, live, work and age, and their levels of power, money and resources, and access to culturally safe care. For example, a person's nutrition is influenced by whether healthy food options are available and affordable in their community. In many socioeconomically deprived areas – where more whānau Māori and Pacific families live – there is a higher density of fast-food and alcohol outlets, making healthy choices harder to access.

Improving survival outcomes

It is encouraging to see survival outcomes improving. Between 1998 and 2021, 5-year net survival in New Zealand improved substantially for 18 of the 23 most-common cancers that affect people living here. This can largely be attributed to improvements in screening, early detection and treatment.

For the three cancers with screening programmes, net survival has improved by 7.2% for cervical, 15.1% for female breast[2] and 14.5% for bowel. Improved screening methods, such as the human papillomavirus (HPV) self-test and expanded access to the breast cancer screening programme, have contributed at least partially to those improvements.

Net survival for those cancers should improve further if screening participation rates rise, especially for population groups with higher health needs, such as Māori and Pacific peoples. Between 2022 and 2024, cervical screening coverage rates for wāhine Māori and Pacific women improved by 8 percentage points and 15 percentage points, respectively. Similar improvements were seen for breast cancer screening participation, where the 70% target has been reached for European/other and Pacific peoples, although rates for Māori are increasing at a lower rate. For bowel cancer screening, the number of people invited to screen and those who completed screening increased by 500,000 and 280,000, respectively, between 2020 and 2024.

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[1] Rates are 'age standardised' in the *State of Cancer 2025* report. This is a way of adjusting rates as if the data came from a single, stable age structure (rather than one that is growing and ageing), which is able to be compared across different population groups. More information about this is available in the full report.

[2] While males do get breast cancer in very low numbers compared with females, they are not offered breast cancer screening via the publicly funded screening programme provided by BreastScreen Aotearoa.

These improvements in screening, combined with preventive measures such as immunisation for cancer-causing infections, should further improve people's cancer outcomes and net survival for those cancers in the next few years.

In addition to prevention, early detection is critical for improving outcomes. Almost 1,600 deaths per year in New Zealand could be avoided if all people diagnosed with late-stage bowel cancer were diagnosed at an early or mid-stage, when cancer can be treated more successfully (assuming survival outcomes similar to those diagnosed one stage earlier). Improved screening and early detection in primary care would also be expected to lower the percentage of people who are diagnosed with cancer after a visit to an emergency department or through an unplanned hospital admission – currently at 34% for bowel cancer (and as high as 46% and 57% for ovarian and lung cancers, respectively). Often these people are diagnosed when their cancer is at a late stage, when it is harder or more complex to treat.

This situation is worse when looking at inequities across ethnicities in New Zealand. For people with lung cancer of European/other and Asian ethnicities, 48% and 49%, respectively, are diagnosed following an emergency admission. For Māori, this proportion is far higher at 68% and for Pacific peoples higher still (73%).

Improving access to treatment

A key factor in improving peoples' survival outcomes is timely access to diagnosis and effective treatments.

One encouraging example is the improvements in survival for blood cancers. Unlike for solid tumours, there are no established prevention strategies, population-level screening or early detection programmes for blood cancers. Surgery is also not a treatment option. As a result, reductions in mortality and improvements in survival have been driven mainly by advances in treatment, particularly more effective stem cell and systemic therapy treatments (such as targeted therapies and immunotherapies). Between 1998 and 2021, 5-year net survival improved by 107% for myeloma and by 54% for leukaemia and 43% for non-Hodgkin lymphoma. However, there is still room for improvement through improved access to stem-cell transplants and systemic and cellular therapies for patients with blood cancer.

Solid tumours, like bowel cancer, often require a combination of surgery, radiation treatment, chemotherapy and immunotherapy. Wait times are a common measure of access to these treatments. Wait times for treatment are measured from urgent referral to first treatment – with a 62-day target – and from decision to treat to first treatment – with a 31-day target. These wait times had been on the rise since the COVID-19 pandemic, meaning people were waiting longer than the recommended timeframe. Recent efforts to achieve the 31-day target have improved performance for that measure. Based on monthly Faster Cancer Treatment results available at the writing of this report, as of July 2025, the 86% target for the 31-day measure had been achieved nationally.

Wait times should improve through efforts to support primary care in early detection and referral, and to expand access to radiology and other diagnostic services. Expansions of treatment capacity are promising, such as the establishment of new radiation treatment centres in Taranaki and Northland in 2025 and 2026, respectively, as is the expansion of systemic therapy infusion delivery to community, peripheral hospitals and primary care.

Treatment approaches are becoming more efficient; for example, the use of 'hypofractionation' is increasing. This is where the total dose of radiation is divided into larger doses per session, and treatments are given over fewer 'fractions' (sessions), meaning patients can be treated in a shorter timeframe. In 2018, all breast cancer radiation treatments involved at least 15 sessions of radiation; in 2023, half of all treatments were completed in under 15 sessions.

Increasing support for people with cancer

Cancer patients require services and support beyond the treatment of their disease. This includes psychosocial support, navigation and care coordination, transportation assistance, symptom management and quality-of-life supports, and in many cases access to early and effective palliative care services. It is encouraging that the number of people with cancer referred to allied health services continues to grow.

Cancer navigation services support people and whānau to navigate the many services, pathways of diagnosis and treatment options across all aspects of the cancer continuum. Funding has enabled cancer navigation services to help more people access the cancer care they need, but the services do not have capacity to support all patients needing help. The National Travel Assistance scheme is making cancer treatment more accessible, but there is recognised potential to strengthen and improve it further.

The needs of cancer patients do not stop when treatment ends; however, access to effective, patient-centred survivorship support is limited.

Palliative care is another area requiring close attention and investment. This is particularly critical given predictions that, by 2038, the number of people needing palliative care will increase by more than 50% compared with 2015 levels, and by 90% by 2068. While documents published by Hospice New Zealand (such as the *Hospice Guide for Carers* and the *Palliative Care Handbook*) provide valuable guidance and information, palliative care services must be embedded and funded consistently in the pathways of care.

Strengthening the enablers within the system

Cancer care and outcomes for people in New Zealand cannot be improved without strengthening the overarching system 'enablers' – aspects that are required across the entire continuum, namely health workforce, physical infrastructure, data and technology, and research and innovation.

New Zealand needs a well-supported, qualified health workforce. However, global and local shortages in clinical cancer roles and specialities persist. Health New Zealand's workforce plan for 2024–2027 needs full support from everyone working in the cancer system. This includes improving national workforce planning and aligning it with national and regional service planning; matching training volumes with the number of health workers needed in the future; creating private training capacity; changing how and where care is delivered using new models of care and service delivery approaches; expanding medical training in specialities at risk of depletion; and establishing advance practice roles and clear cancer specialisation pathways, particularly for nursing.

An effective and sustainable cancer control system needs to be underpinned by robust research with skilled researchers who are connected, funded and supported to implement their work. It also requires fit-for-purpose buildings, facilities and technologies; and comprehensive, timely and linked data to inform clinical and patient decisions, and system performance measurement.

Substantial progress has been made over the last 5 years, but further improvements are needed, as these insights show. This commentary covers just a fraction of the information and analysis included in the full *State of Cancer 2025* report. Readers can find more detailed information there, or a summary on the following pages.

The *State of Cancer 2025* overview | He rāpopoto mō te *Mate Pukupuku 2025*

The risk of dying from cancer is decreasing

2001

146
deaths per 100K

2021

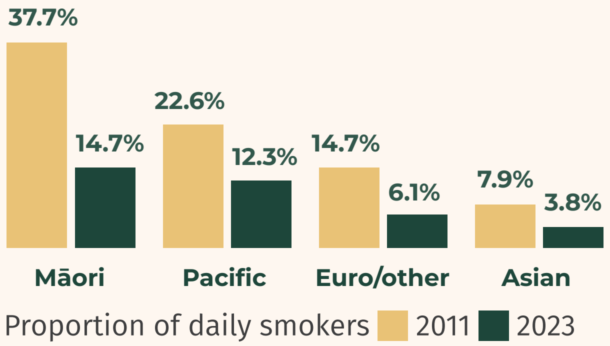
111
deaths per 100K

Down 24%

Cancer is New Zealand's leading cause of death, but mortality rates are declining thanks to prevention, better screening, earlier detection and more effective treatment.

Fewer people are smoking

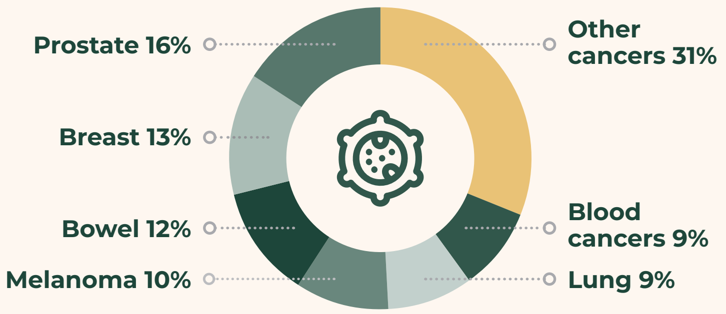
Smoking is the leading risk factor for lung cancer and a contributor to several other cancers. Cancer mortality is declining across ethnicities as smoking rates fall.



Up to 50% of cancers are preventable by reducing modifiable risk factors

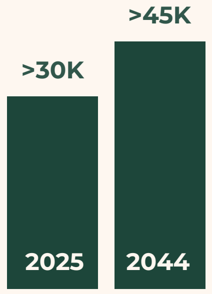
- Smoking
- Alcohol
- Physical inactivity
- Poor nutrition
- Excess weight
- Sun exposure
- Infection
- Chemical exposure

Most-diagnosed cancers in 2018–2022



Cancer diagnoses are increasing

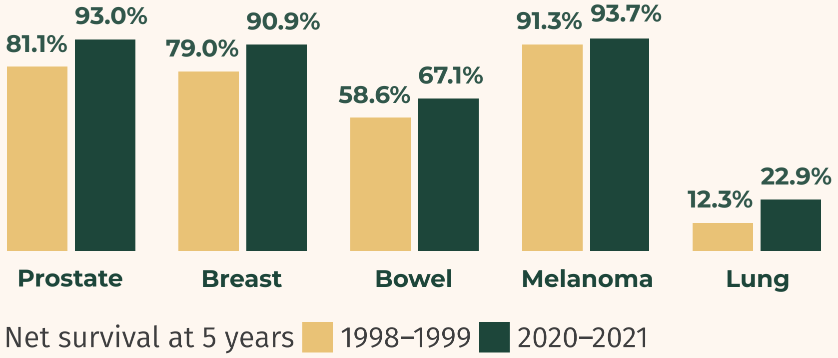
Projected to rise from over 30,000 to more than 45,000 diagnoses annually by 2044.



New Zealand has one of the world's highest melanoma rates

95% of melanoma is related to ultraviolet radiation.

More people are surviving cancer



Children, adolescents and young adults

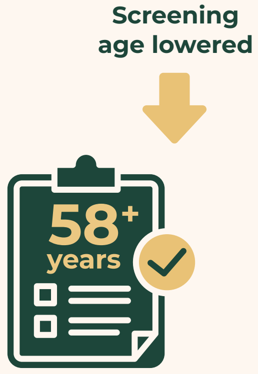
Children and young people have distinct developmental needs and often require specialised support.

160
children (0–14 years) diagnosed with cancer in 2022

170
adolescents and young adults (15–24 years) diagnosed with cancer in 2022

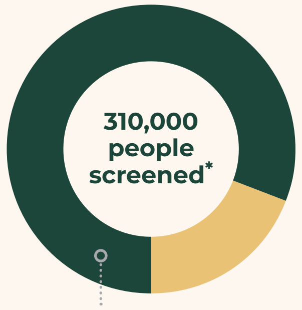
Bowel cancer

Early-onset bowel cancer is rising in people aged under 50 years.



The bowel cancer screening age is being lowered to 58 years from 2025.

Strong uptake in HPV self-testing for cervical cancer

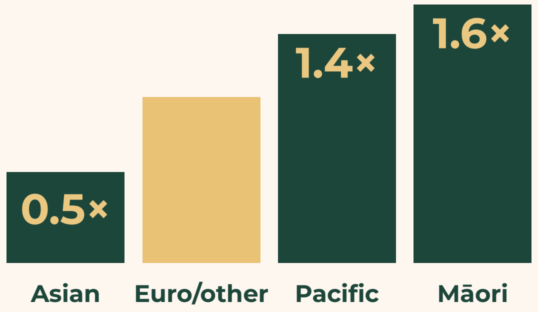


81%
chose the new HPV self-test option

* Between September 2023 and the end of 2024

Mortality varies between ethnicities

Between 2017 and 2021, Māori were 1.6 times more likely to die from cancer, and Pacific peoples were 1.4 times more likely to die from cancer than European/other.



$604 million
for new medicines

In June 2024, a $604 million boost to Pharmac's budget led to 33 new cancer medicines being funed in New Zealand by May 2025, benefiting over 2,350 people in the first year.

More investment is needed

- Workforce
- Medication
- Research
- Support services
- Data and AI
- Infrastructure
- Prevention

He aroā o te *Mate Pukupuku 2025*

He kupu whakataki

Ko ngā tāngata o Aotearoa e hōkaka ana kia whai wāhi atu ki tētahi pūnaha hauora kounga e whakaratohia ana ngā ratonga mate pukupuku e whai niho ana ki tā te tangata me tā te whānau e hiahia ana. Ko tā Te Aho o Te Kahu he aroturuki, he tuku pūrongo mō te kauneke o te rāngai hauora hei whakatutuki i tēnei whāinga.

Pērā ana i ētahi atu whenua kei te urupare atu tō Aotearoa pūnaha mate pukupuku ki ngā whakawhanaketanga huhua mō te pēhea e aukati ai i ngā tini mate pukupuku, te tautohu mai me te maimoatanga, ā, me te utu hoki mō ēnei aronga hou. Tāpiri mai ana ko te kaha tono i ngā ratonga mate pukupuku e whakapae ana ka tino piki ake. Matapae ana mō Aotearoa ka tipu ā-tau nei te tokomaha o ngā tāngata ka tautohua ki te mate pukupuku mai i te 30,000 i te tau 2025 kia neke atu i te 45,000 ā te tau 2044. Mā konei ka kaha pā mai te pēhanga ki tētahi pūnaha kua tanuku kētia.

E kore e taea te pūnaha mate pukupuku te whakatutuki i te hiahia o āpōpō mā te mahi pēnei tonu; me hihiko ake te hinengaro kia para huarahi hou mō te whakamahere tauwhiro, te whakarato tauwhiro me te aronga atu ki te tūāpapa o te whakahaere mate pukupuku. Tae atu:

- ki te whakarite rautaki ārai (koia nei te tino ara hei whakahaere mate pukupuku)
- ki te tautoko i ngā tauira hou mō te tauwhiro, hei whakapai ake i ngā ratonga kia rawe
- ki te aruaru atu i te tino pito mata o te hauora matihiko, te raraunga me te atamai hangahanga
- kia rite mai mō te terenga puta mai o ngā panoni hou mō te mātai, te tātari me te maimoatanga
- kia whakawhānui atu i te whai wāhitanga ki ngā ratonga haumaru ā-ahurea, ko te tangata te pūtahi, ngā ratonga e whakaarotau ana i te tauwhiro torowhārahi e kitea ana te whakapai ake o ngā hua mate pukupuku.

Kua whakapai ake i ngā ratonga mate pukupuku me ōna hua mō ngā tāngata kei Aotearoa nei me ō rātou whānau mai i te pūrongo *Mate Pukupuku* i whakaputaina i te tau 2021. Ko ētahi tauira:

- ko te hekenga iho o te mahi kaipaipa huri noa i ngā mātāwaka
- ko te whakanui o te taea e te tangata ngā hōtaka mātai mate pukupuku ā-motu te mahi
- ko te tāpiri mai i ētahi atu momo tautoko mō te tauwhiro tuatahi, tae atu kia māmā ake te tono ki te rongoā iraruke me whai wāhi mai ki ngā rongoā haumanu ārai mate pukupuku katoa
- ko te whakatinana i ngā tauira hou mō te tauwhiro (ngā anga whakarato tauwhiro hauora)
- ko te whakanui atu i ngā maimoatanga e tūtata ana ki ngā kāinga
- ko te whakanui atu i te pūtea āwhina mō ngā rongoā mate pukupuku
- ko te whakawhānui, te whakarite hou rānei i ngā ratonga maimoatanga iraruke
- ko te ārahina e ngā kaiwhakarato Kaupapa Māori te moni whakangao hei whakatere i ngā ratonga mate pukupuku.

Heoi anō, me mātua piki ake te kauneke kia tōtika te urupare a Aotearoa ki te matapae ka nui atu te hiahia ki te tauwhiro mate pukupuku.

Te panoni mai o ngā pāpātanga

E toru ngā tino 'tūtohi' hei aroturuki mate pukupuku kei te taumata-taupori. Mā te titiro ki te tokomaha o ngā tāngata kua tautohua mō te mate pukupuku (pāpātanga auau), te roa e ora tonu ai te tangata whaimuri i te tūtohinga (pāpātanga ora), me ērā ka mate i te mate pukupuku (pāpātanga mate), ka mārama tātou ki te pānga mai o te mate pukupuku ki ngā tāngata kei Aotearoa.

He huarahi ngā pāpātanga mate mō te mate pukupuku hei ine i te pēhea o te pānga mai o te mate pukupuku ki ngā taupori rerekē. Ki Aotearoa nei kua kaunuku iho te hekenga mai o ngā pāpātanga mate i ngā tekau tau maha nei, ā, e 25 ōrau tonu te hekenga mai i ngā 20 tau nei. E rua ngā take hei whakamārama mai i tēnei hekenga:

- he iti iho te tūpono mai kia tautohua ki te mate pukupuku (kua iti iho ngā pāpātanga auau)
- he nui kē te tūpono mai kia ora i te mate pukupuku (nui atu te pāpātanga ora).

Kua heke iho ngā pāpātanga auau i ngā tau 20 nei, engari i te 5 ōrau noa iho – kua papatahi mai taua hekenga i te tekau tau nei. Nā konei, ko te hekenga nui o ngā pāpātanga mate (ngā tāngata ka mate i te mate pukupuku o ia 100,000, hāngai ā-pakeke nei[3]) kua heke iho nā te kaha o ngā mahi whakapaipai kia ora te tangata i te mate pukupuku. Ina koa, ko te pāpātanga ora 5-tau mō ngā mate pukupuku katoa kua 15 ōrau te pikinga ake i ngā tau 20 nei.

Ko te pikinga ake o te oranga i te mate pukupuku e ahu mai ana i te tōpūtanga mai o ngā take, te wawe ai hoki o te hopuranga (mā ngā hōtaka mātai) me te tino whai wāhi mai ki ngā maimoatanga tika (tae atu ki te kauneke o ngā hāpara, maimoatanga iraruke me ngā haumanu katoa).

Nō tātou e kōrero ana mō te auau, mō te oranga me ngā pāpātanga mate mō ngā momo mate pukupuku katoa hei huarahi kia inea te kounga o te tauwhiro ki Aotearoa, he mōhiotanga atu anō ka riro mai mā te arotahi ki tēnā mate pukupuku me tēnā.

Hei tauira, ko te mate pukupuku kōpiro te mate pukupuku e kaha pā mai ana ki ngā wāhine me ngā tāne. Ka taea te pānga mai o tēnei momo mate pukupuku te whakaiti mā ngā rautaki ārai maha (pērā i te korikori tinana, te kai tika, kia iti te waipiro, kia mutu te kaipaipa). He hōtaka mātai ā-motu kia hopu wawetia, ā, he kōwhiringa maimoatanga hoki e whanake haere ana. Mā te titiro whānui i ngā raraunga e wātea mai ana, e mea ana kua āhua iti te tūpono kia mate ngā tāngata o Aotearoa i te mate pukupuku kōpiro i te tūpono o ngā 20 tau ki muri: e 35 ōrau te hekenga iho o ngā pāpātanga mate o ngā 20 tau nei, ā, e 15 ōrau te pikinga ake o ngā tāngata ka ora tonu i roto i te 5 tau whaimuri i te tautohua. Huri noa kua heke ngā pāpātanga auau i te 20 ōrau i taua wā tonu. Heoi anō ka rerekē ngā hua mō ētahi rōpū taupori. He mea nui kia whakaarohia nā te aha hoki e pēnei mai ana ēnei tikanga me te nuku hoki o te wheako tonu puta noa i ngā wāhi katoa o te taupori.

Ko te panoni mai o te tūraru mate pukupuku

Kua panoni mai te tūraru mate pukupuku i te haerenga o te wā. He mate tuatini te mate pukupuku e aweawetia ana ki ngā take tini – hei tauira, ko te huaira o te tangata, te taiao e nōhia ana, te kōwhiringa o te āhua noho me te āhua o te ohapori. Ko te 'taumaha' o te mate pukupuku – ko tōna pānga mai ki te tangata me ngā hapori – e whakaata mai ana kaua ko ngā tukanga koiora anake engari ko ngā tautika-kore me te rerekētanga o ngā tūraru mōrearea ki te tangata ka haere te wā.

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[3] Ka 'hāngai ā-pakeke' nei ngā pāpātanga i te pūrongo *Mate Pukupuku 2025*. Mā konei ka whakatika i ngā pāpātanga ānō nei i puta te raraunga i tētahi anga pakeke kotahi (hāunga anō ko tētahi e tipu koroua ana), ka āhei te whakataurite puta noa i ngā rōpū taupori rerekē. He mōhiohio atu anō kei te pūrongo matua.

Ko tētahi o ngā tino panoni i ngā tekau tau tata nei ko te nekehanga o ngā take tūraru e aweawe ana i te tūponotanga kia pāngia te tangata ki te mate pukupuku. Ko tētahi mea angitu nui ko te kaha hekenga o ngā pāpātanga kaipaipa i ngā 20 tau ka hori. Kua pēnei tēnei hekenga puta noa i ngā mātāwaka katoa, inā hoki ko te tino hekenga i ngā 15 tau i waenga i te Māori (ko ngā wāhine tonu); i heke ngā pāpātanga kaipaipa o ia rā, o ia rā mai i te āhua 40 ōrau i te tau 2011 ki te 15 ōrau i 2024. Koia nei tētahi tino take hei whakaiti i ngā pāpātanga auau mate pukupuku, kaua anake mō te mate pukupuku pūkahukahu engari mō ngā mate pukupuku ā-tupeka nei, tae atu ki te mate pukupuku kōpiro.

Kāore i te pērā te pai o te kauneke mō ētahi atu tūraru 'urutau' (ngā tūraru kei te tangata te tikanga kia iti, kia nui rānei te tūpono mai o te mate pukupuku). Ko ngā pāpātanga tino mōmona, te kai waipiro whakakino, te kai hē me te korenga e korikori kua piki ake, kua iti rānei te pikinga i ngā 20 tau nei. Kia whakataurite ki ngā iwi o ngā whenua āhua ōrite, kei ngā pakeke o Aotearoa te pāpātanga ikeike-tuatoru mō te tino mōmona me te ikeike-tuarua mō te tino mōmona o ngā tamariki.

He mea tino āwangawanga te pikinga o ngā pāpātanga tino mōmona i Aotearoa. Ko ēnei tikanga pea te take kei te piki haere ngā mate pukupuku e hāngai ana ki te tino mōmona, pērā i te mate pukupuku pūkano, mate pukupuku ū.

I waenga i ngā tau 2018 me 2022, ko te pāpātanga mate pūkano mō ngā wāhine pasifika i neke atu kia rima te ikeike i ngā wāhine Pākehā/mātāwaka (ehara i te Māori, te Pasifika, te Āhia), ā, ka rua te ikeike ake mō ngā wāhine Māori. Mō te mate pukupuku ū kei ngā wāhine Māori me ngā wāhine Pasifika te pāpātanga ikeike o te tautohu i tō ngā wāhine Pākehā/mātāwaka. Ina koa kua kitea te kaha pikinga o te pāpātanga tautohu i waenga i ngā wāhine Pasifika, e neke atu i te 50 ōrau i waenga i ngā tau 2001 me 2022. Ko te āputa i waenga i ngā mātāwaka rerekē ka kitea hoki mō te mate pukupuku kōpiro, hei tauira, mō te hekengā pāpātanga mō te Pākehā/mātāwaka 1.6 ōrau te toharite mō ngā iwi Pasifika i taua wā tonu.

Ko ngā take tūraru kia whanake te mate pukupuku ka kukuti mai me ngā 'take' whānui – te taiao ka whānau mai te tangata, te tipu, te noho, te mahi, te pakeke haere me te mana kei a rātou, te moni, ngā rauemi me te whai wāhi atu ki te tauwhiro haumaru ā-ahurea. Hei tauira, ko ā te tangata kai ka aweawetia e te āhei o ngā kai tika i tō rātou hapori me te āhua o te utu. I ngā rohe ohapori kore – e noho rā te tokomaha o ngā whānau Māori me ngā whānau Pasifika – he maha ake ngā toa hoko ō rangaranga, toa hoki waipiro, ka mutu, he uaua te kite i ngā kai hauora.

Te whakapai hua ora

He mea whakatītina te kitenga atu i ngā hua ora e whakapai ake ana. I waenga i ngā tau 1998 me 2021, i kaha piki ake te pāpātanga ora 5-tau i Aotearoa mō ngā mate pukupuku noa 18 o ngā mea 23 e pā mai ana ki te tangata e noho ana ki konei. Ko te take kua pēnei o ngā mahi e whakapaipai ake ana i te mahi mātai, te hopu wawe me te maimoatanga.

Mō ngā mate pukupuku e toru me ngā hōtaka mātai kua pai ake te pāpātanga ora i te 7.2 ōrau mō te mate pukupuku o te waha whare tangata, i te 15.1 ōrau mō te mate pukupuku ū[4] and 14.5% for bowel. Mā te whakapaipai i ngā tukanga mātai, pērā i te tēhi-whaiaro wheori tōkai (HPV) me te whakawhānui i te huarahi ki te hōtaka mātai ū mō te mate pukupuku kua paku āwhina mai i ērā whakapaipai.

Ka whakapai ake anō te pāpātanga ora mō ērā mate pukupuku ina tokomaha ake ngā tāngata ka mātaihia, ina koa mō ngā rōpū taupori e nui ana ngā matea hauora, pērā i te iwi Māori me te iwi Pasifika. I waenga i ngā tau 2022 me 2024, i piki ake te mahi mātai waha whare tangata mai i te 8 ōrau mō ngā wāhine Māori mai i te 15 ōrau mō ngā wāhine Pasifika. Ka pērā anō te kitenga atu mō te mātai mate pukupuku ū, kia eke i te 70 ōrau mō te iwi Pākehā/mātāwaka me ngā iwi Pasifika, hāunga anō te pōturi o te pikinga o ngā pāpātanga mō te Māori. Mō te mātai mate pukupuku kōpiro, i piki ake te tokomaha i pōhiritia kia mātaihia 500,000 ki ērā i tutuki te mātai 280,000 i waenga i ngā tau 2020 me 2024.

Ko ēnei mahi whakapai mō te mahi mātai me te mahi ārai pērā i te tuku awhikiri mō ngā pokenga e tipu ai te mate pukupuku ka whakapai ake ngā hua mate pukupuku o te tangata i ngā tau tata nei.

Hei tāpiri atu i te mahi ārai he mea tino nui te hopu wawe kia pai ake ngā hua. Tata ki te 1,600 ngā mate i ia tau ki Aotearoa e taea ai te ārai ina hopu wawe te tautohu o ngā tāngata i tautohua tōmuatia, tautohua i waenga rānei, ki reira ka tika te maimoatanga (when cancer can be treated more successfully (ina he ōrite ngā hua ora ki ērā i hopukia i te wā o mua). Ko te whakapai mātai me te hopu wawe i te wā tauwhiro tuatahi ka whakaarohia kia whakaheke i te ōrau tangata ka tautohua ki te mate pukupuku i muri i tētahi toronga ki te taiwhanga ohotata, i tētahi urunga ohorere rānei ki te hōhipera – i tēnei wā e 34% mō te mate pukupuku kōpiro (e 46 ōrau mō te mate pukupuku ruakano e 57 ōrau mō te mate pukupuku pūkahukahu). I te nuinga o te wā ka tautohua ēnei tāngata i te wā tōmuri, te wā he uaua, te mahi tuatini hei maimoa.

E kino iho ina tirohia te tautika-kore puta noa i ngā mātāwaka i Aotearoa. Mō ngā Pākehā/mātāwaka e 48 ōrau e whai mate pukupuku pūkahukahu ana, mō ngā Āhia e 49 ōrau i tohua nō muri mai i te whakauru ohotata. Mō te Māori, e 68 ōrau te tokomaha ake, ā, mō ngā Pasifika ka tokomaha ake anō (e 73 ōrau).

Kia māmā ake te huarahi ki te maimoatanga

Ko tētahi tino take kia whakapai ake i ngā hua ora o ngā tāngata ko te wā tika kia tautohua me te maimoatanga tika.

Ko tētahi tauira hei whakatītina mai ko ngā mahi whakapai kia ora te tangata i ngā mate pukupuku toto. Heoi anō mō ngā pukupuku mārō karekau he rautaki ārai, he mātai taumata-taupori, he hōtaka hopu mō ngā mate pukupuku toto. Ehara hoki te hāpara i tētahi kōwhiringa. Ka mutu, ko te hekenga iho o ngā mate me te pikinga ora o te tangata kua kōkiritia e ngā whakapaipai o te maimoatanga, ngā maimoatanga haumanu pūtau-pūroro ai hoki (pērā i ngā haumanu matawhāiti me ngā haumanu ārai-kore). I waenga i ngā tau 1998 me 2021, i piki ake te pāpātanga ora i te 107 ōrau mō te myeloma, te 54 ōrau mō te mate ruru toto me te 43 mō te mate pukupuku waitinana Hodgkin-kore. Heoi anō, he wāhi tonu hei whakapaipai ake mā te whakapai ake i te huaranga pūtau-pūroro me ngā haumanu pūtau katoa mō ngā tūroro e whai mate pukupuku toto ana.

Ko ngā pukupuku mārō pērā i te mate pukupuku kōpiro, ka tōpū mai te hāpara, te maimoatanga iraruke, te haumanu matū me te haumanu ārai-kore. Ko te wā tatari he ine noa i te whai wāhi mai ki ēnei maimoatanga. Ka inea ngā wā tatari mai te tuku whawhai ki te maimoatanga tuatahitanga – kia 62 ngā rā te aronga – mai i te whakatau kia maimoatia ki te maimoatanga tuatahitanga – kia 31 ngā rā te aronga. E piki haere ana ēnei wā tatari mai te wā o te mate urutā o KOWHEORI-19 me te aha e roa tonu ana te wā tatari i te wā e tatari e tohua ana. Nā te hiahia kia tutuki te 31-rā kua pai ake te mahi mō taua ine. Nā ngā hua ā-marama e kitea ana mō te Faster Cancer Treatment i te tuhinga mai o tēnei pūrongo, i te marama o Hōngongoi 2025, ko te aronga kia 86 ōrau mō te 31-rā ine kua tutuki ā-motu nei.

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[4] Ahakoa ka pāngia te tāne ki e mate pukupuku ū he tino iti te tokomaha ina whakataurite ki te wahine, kāore te tāne e whai wāhi ana ki te mātai mate pukupuku ū mā te hōtaka mātai nā BreastScreen Aotearoa te pūtea tūmatanui e tautoko.

Me whakapai ake ngā wā tatari mā te ngana kia tautokona te tauwhiro tuatahi i te hopu wawetanga me te tuku, ā, kia whakanui atu te whai wāhi ki te rongoā iraruke me ētahi atu ratonga tātari. E kitea ana te pai o te whakanui maimoatanga, pērā i te whakatū i ngā whare iraruke hou i Taranaki i te tau 2025 me Te Tai Tokerau i te tau 2026, me te whakanui atu i te whakarato mai o ngā haumanu katoa ki ngā hapori, ngā hōhipera ki tuawhenua me te tauwhiro tuatahi.

Kei te tika haere ngā mahi maimoa; hei tauira, ko te piki haere o te whakamahi i te 'iraruke kaha'. Koia nei te mahi ka kaha ake te tuku iraruke i ia wā, ā, ka iti haere ngā maimoatanga, ka mutu, ka iti iho te wā hei maimoa. I te tau 2018, i 15 ngā maimoatanga mō te iraruke mō te mate pukupuku ū; i te tau 2023 i oti te haurua o ngā maimoatanga i raro iho i te 15 maimoatanga.

He pikinga tautoko

E hiahia ana ngā tūroro mate pukupuku ki ngā ratonga i tua atu i te maimoatanga mō ō rātou mate. Ko te tautoko ā-hinengaro tēnā, te āwhina whakatere me te whakarite tauwhiro, te āwhina ā-waka nei, te whakahaere tohumate me te kounga manapou, ā, i te nuinga o te wā kia wawe te whai wāhi atu ki ngā ratonga pairuri e tika ana. He mea whakatītina te kitenga mai i te tipu haere o te tokomaha ngā tāngata whai mate pukupuku kua tukua ki ngā ratonga hauora haumi.

Ko ngā ratonga whakatere mate pukupuku ka tautoko i ngā tāngata me ngā whānau ki te whakatere i ngā ratonga maha, ngā ara tātari me ngā kōwhiringa maimoatanga e puta noa ana i ngā āhuatanga katoa o te ao mate pukupuku. Mā te pūtea tautoko e āhei ai ngā ratonga whakatere mate pukupuku ki tautoko i ngā tāngata hei whai wāhi atu ki te tauwhiro mate pukupuku, engari kāore i ngā ratonga te āhei ki te tautoko i ngā tāngata katoa e hiahia āwhina ana. Ko te kaupapa National Travel Assistance e āwhina mai ana kia māmā ake te whai wāhi mai ki te maimoatanga mate pukupuku, engari ka kitea te pito mata kia whakakaha ake anō kia whakapai ake anō hoki.

Kāore e mutu ngā hiahia o ngā tūroro mate pukupuku e mutu ai te maimoatanga; heoi anō e uaua tonu te whai wāhi mai ki tautoko tika, te tautoko whakaora tūroro.

Ko te wāhi o te pairuri tētahi atu wāhi me āta tirotiro, me kaha tautoko. He tino āhua kia kaha tautokona nā te matapae nei ā te tau 2038, ka piki ake te tokomaha o ngā tāngata e hiahia pairuri ana ka neke atu i te 50 ōrau ina whakataurite mai ki ngā tokomaha o te tau 2015 levels, ka 90 ōrau ā te tau 2068. Ahakoa kei ngā tuhinga kua whakaputaina e Te Kahu Pairuri o Aotearoa (pērā i te *Hospice Guide for Carers* me te *Palliative Care Handbook*) he ārahitanga, he mōhiohio hoki, me mau nei ratonga pairuri ki ngā ara tauwhiro me te kaha tautoko ā-pūtea nei.

Te whakakaha āheinga ki rō pūnaha

E kore e taea te tauwhiro mate pukupuku me ōna hua mō ngā tāngata o Aotearoa te whakapaipai ake ki te kore e whakakaha ake i ngā 'āheinga' puta noa i te pūnaha – me kī, ngā āhuatanga me mau nei ki te pūnaha whānui, arā, te ohu mahi hauora, te hanganga, te raraunga me te hangarau, te rangahau me ngā panoni hou.

Me noho mai ki Aotearoa he ohu mahi hauora e kaha tautokona ana, e whai pūkenga ana. Heoi anō, kei konei tonu te tokoiti ā-ao nei, ā-kāinga nei o ngā tūranga rongoā, me ngā mea mātanga. Ko tā Te Whatu Ora Mahere ohu mahi hauora mō ngā tau 2024–2027 me whai tautoko e ngā tāngata katoa e mahi ana i te pūnaha mate pukupuku. Tae atu kia whakapaipai ake i te whakarite mahere ohu mahi ā-motu me ngā mahere ratonga ā-rohe; te hāngai i te tokomaha hei whakangungu ki te tokomaha o ngā kaimahi hauora e hiahia ana mō anamata; te waihanga whare whakangungu tūmataiti; te panoni i te āhua o te whakarato tauwhiro me ngā wāhi e tū ana mā te whakamahi tauira tauwhiro hou me te āhua o te whakaratohia; te whakawhānui atu i te whakangungu rongoā mō ngā tino wāhi e noho tūraru ana kei iti; me te whakatū i ngā tūranga hou me ngā ara motuhake mō te mate pukupuku ko ngā nēhi tonu te whakaaro.

Ko tētahi pūnaha tika hei whakahaere mate pukupuku me whai rangahau pakari me ngā tino kairangahau e mahi tahi ana, i runga i tētahi pūtea tautoko kia tutuki pai te mahi. Me whai hoki he whare tika, whare mahi me ngā hangarau; he raraunga mata whānui, he raraunga honohono hei whakamōhio mai i ngā whakataunga rongoā, whakataunga ā ngā tūroro me te ine i te mahi a te pūnaha.

Kua tino piki kauneke i ngā tau e 5 ka hori, engari tonu he mahi tonu hei whakapaipai ake ki tā te tuhinga nei e kite ai. Kei te kōrerotia i tēnei tuhinga he mōhiohio paku, he tātaringa paku o te *Pūrongo Mate Pukupuku o Aotearoa 2025*. He mōhiohio atu anō ki reira, ā, he whakarāpopoto rānei i ngā whārangi e whai ake nei.

He rāpopoto mō te *Mate Pukupuku* 2025

Iti haere ana te tūraru kia mate i te mate pukupuku

2001

146

ngā mate ki ia 100K

2021

111

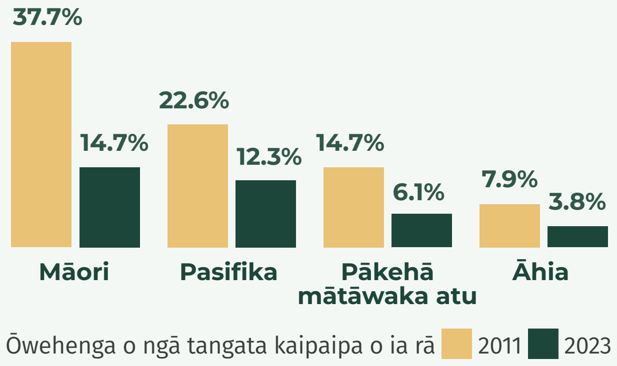
ngā mate ki ia 100K

24 ōrau te hekenga

Ko te mate pukupuku kei mua hei whakamate tangata i Aotearoa, engari e heke haere ana mā te ārai, mā te mātai tika, te hopu wawe, me te maimoatanga tika.

Tokoiti e kaipaipa ana

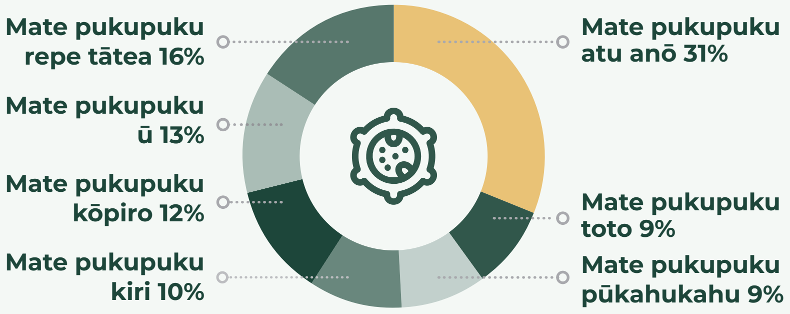
Ko te kaipaipa kei mua mō te mate pukupuku pūkahukahu me ētahi atu oi ngā mate pukupuku. Iti haere ana ngā matenga i ngā rōpū mātāwaka i te hekenga o te kaipaipa.



Neke atu ki te 50 ōrau o ngā mate pukupuku ka āraia nā te whakaiti take tūraru

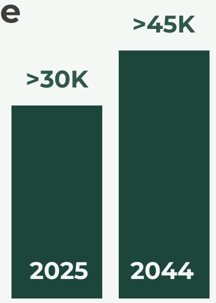
- Kaipaipa
- Waipiro
- Korikori kore
- Kai hē
- Tino mōmona
- Huranga ki te rā
- Poke
- Huranga ki te matū

Ngā mate pukupuku i 2018 ki te 2022



E piki ana te tautohu mate pukupuku

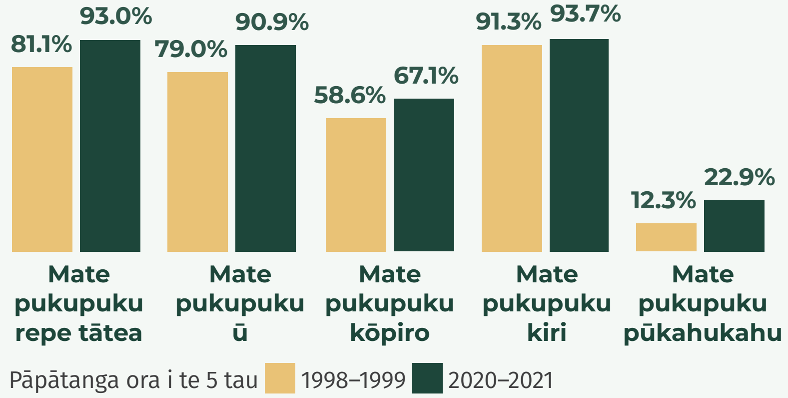
Matapae ana ka piki mai i te 30,000 kia neke atu i te 45,000 i ia tau ā te tau 2044.



Kei Aotearoa te pāpātanga ikeike o te ao mō te mate pukupuku kiri

E 95 ōrau o te mate pukupuku i ahu mai i te iraruke hihi katikati.

Tokomaha e ora ana i te mate pukupuku



Ngā tamariki, taiohi, taitama, taitamāhine

He matea whanake motuhake ō ngā taiohi, taitama kia āta tautokona.

160

ngā tamariki (0–14 tau) i tautohua ki te mate pukupuku i te tau 2022

170

170 ngā taiohi me ngā taitama, taitamāhine (15–24 tau) i tautohua ki te mate ukupuku i te tau 2022

Mate pukupuku kōpiro

E piki ana te pānga wawe o te mate pukupuku kōpiro ki ngā tāngata i raro i te 50 tau.

Kua heke te tau kia mātaihia

Kei te heke ki te 58 tau hei mātai mate pukupuku kōpiro mai i te tau 2025.

Kua kaha ake te tēhi-whaiaro mō te mate pukupuku waha whare tangata

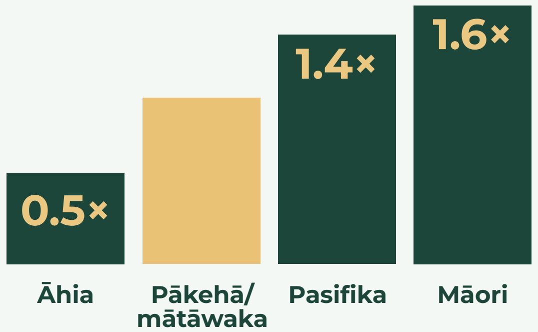
81%

ōrau e kōwhirihia kia tēhi-whaiaro

* I waenga i te Hepetema 2023 me te mutunga o te tau 2024

Ka rerekē te mate mō ngā mātāwaka

I waenga i ngā tau 2017–2021, 1.6 te nui ake o ngā wā ka mate te Māori i te mate pukupuku, mō te iwi Pasifika ka 1.4 ngā wā i ērā o ngā Pākehā/mātāwaka atu.



$604m

E $604m mō ngā rongoā hou

I te marama o Hune 2024 ka tāpirihia te $604m ki te pūtea o Te Pātaka Whaioranga, me te aha, e 33 ngā rongoā hou e whai pūtea ana i Aotearoa, ā, 2,350 ngā tāngata ka whaihua mai i te tau tuatahi.

Me nui atu te haumi

- Ohu mahi
- Rongoā
- Rangahau
- Ratonga tautoko
- Raraunga me te atamai hangahanga
- Hanganga
- Te ārai

TE AHO
O TE KAHU
CANCER
CONTROL
AGENCY

The *State of Cancer 2025* summary report | He tīpako o te *Mate Pukupuku 2025*

Introduction | He kupu whakataki

It is important that people in New Zealand have a health care system that delivers world-class cancer care; a system that provides timely access to high-quality services designed around their specific needs and those of their whānau. The most reliable way to assess if this is being delivered is to measure and report on the performance of that system. Bringing together data, evidence and patient perspectives helps to paint a meaningful and complete picture of progress and opportunities for improvement.

Te Aho o Te Kahu | Cancer Control Agency provides strong central leadership and oversight of cancer control and unites efforts to deliver better cancer outcomes for people in New Zealand.

The 2021 report by Te Aho o Te Kahu | Cancer Control Agency *He Pūrongo Mate Pukupuku o Aotearoa 2020 | The State of Cancer in New Zealand 2020* provided a point-in-time snapshot of how cancer was affecting communities and how the national cancer system was supporting and serving them. It provided a benchmark for monitoring progress and encouraged and challenged the health sector to provide more equitable, effective care for people and whānau affected by cancer.

The State of Cancer in New Zealand 2025 | He Pūrongo Mate Pukupuku o Aotearoa 2025 (*State of Cancer 2025*) continues this work and provides an overview of and update on the state of cancer in New Zealand over the last 5 years. During these years, cancer services have felt the ongoing impacts of several major and unprecedented events including the reform of the New Zealand health system, the disestablishment of Te Aka Whai Ora | Māori Health Authority and a global pandemic.

The *State of Cancer 2025* presents evidence-based changes that have taken place over the last 5 years, as well as initiatives that are underway. It also highlights changes in inequities over time and provides commentary and the most recent available data to support this.

The report cannot address all aspects of the cancer system in New Zealand; the focus is on some areas where important changes have occurred or where improvements are needed. As a result, some of the work that happens in research, university, non-governmental organisation (NGO) and private health settings has not been included. Data sources are also limited to usable and statistically valid data that has been collected and made available.

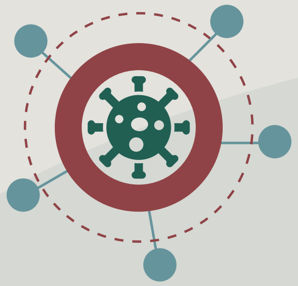
The topics discussed in the full *State of Cancer 2025* report are summarised below and include:

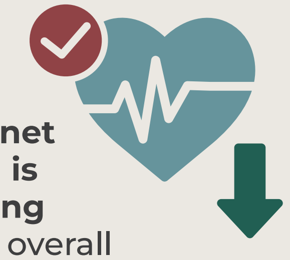
- the burden of cancer in New Zealand – trends in cancer over time and how these are different for different population groups
- preventing cancer
- screening for cancer
- getting a cancer diagnosis
- undergoing cancer treatment
- supporting people during their entire cancer experience – psychosocial support, cancer navigation, travel assistance, survivorship and care after treatment, and palliative care
- enablers of cancer care – workforce, physical infrastructure, data and technology, and research and innovation.

Key insights

Māori, Pacific peoples and people living in socioeconomically deprived areas are **at higher risk of being diagnosed with cancer**

The most-diagnosed cancers in New Zealand are prostate, breast, bowel, melanoma and lung cancer

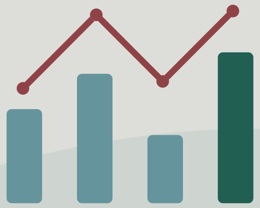




Cancer net survival is improving and the overall risk of dying from cancer is decreasing

Rates of childhood cancer have remained stable

Half of all cancer deaths are from five cancers – lung, bowel, breast, prostate and pancreatic cancer

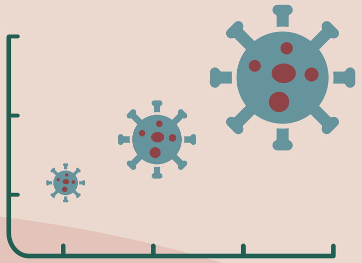


The number of people being diagnosed with cancer is increasing, but the overall risk of developing cancer is relatively stable

Areas for action

Reduce deaths from lung cancer, particularly for Māori. Preventing cancer and improving outcomes through reducing smoking and screening will be key

Reduce incidence rates of cancer. Over 30,000 cancer cases are diagnosed each year; this is projected to increase to over 45,000 cases per year by 2044



Reduce inequities in the risk of developing cancer and cancer outcomes affecting some population groups

The burden of cancer in New Zealand | Te taumaha o te mate pukupuku i Aotearoa

Understanding how cancer impacts people in New Zealand involves looking at the number of people who are diagnosed with cancer (incidence rate), how long people survive after diagnosis (net survival) and how many people die from cancer (mortality rate).

Cancer does not affect all population groups in New Zealand equally. People face different risks of developing cancer and have different and inequitable outcomes when cancer does occur. This is due to factors such as their environments and exposure to risk factors for cancer, how advanced their cancer is when they are diagnosed, what their treatment is and how they and their whānau are supported. Socioeconomic status, income and education influence how cancer affects people. Also, the health care system is designed in ways that can make it harder for certain groups to access the care they need.

Measuring how New Zealanders are affected by cancer

In New Zealand, the total number of people diagnosed with cancer continues to increase, as the population grows and ages. A total of 137,000 people were diagnosed with cancer in 2018–2022; this is projected to be over 30,000 per year in 2025 and increase to over 45,000 new cases per year by 2044. This increase will put substantial pressure on the cancer system.

When population changes are considered, there has been minimal overall change in the risk of developing cancer in recent years. However, there are substantial differences in incidence rates across cancer types and population groups.

The most-diagnosed cancers in New Zealand are prostate, breast, bowel, melanoma and lung cancer. Blood cancers also affect many people in New Zealand. Different blood cancer types are often considered individually, however when leukaemia, Hodgkin lymphoma, non-Hodgkin lymphoma and myeloma are considered as a group, these make up the sixth most-diagnosed cancer type in New Zealand.

More people are surviving after their cancer diagnosis, however, this also varies depending on cancer type. Despite this improvement in survival, New Zealand is not improving as fast as comparable high-income countries. Due to limitations in the data available at the time of analysis, survival across different population groups has not been included in the *State of Cancer 2025* report. Further analysis will be needed to examine whether there has been any shift in inequities in survival across ethnic groups, such as those previously shown for Māori and Pacific peoples, and other population groups, such as disabled people or people living in areas of higher deprivation. This is an important area of focus for future work.

Incidence and net survival both influence the mortality rate (how many people die from cancer). This number has been steadily falling over the past 2 decades, which is positive; however, differences between ethnicities remain. For example, while the overall cancer mortality rate for Māori has been improving more quickly than for other ethnicities, Māori are still much more likely to die from cancer.

Half of all cancer deaths are from five cancers: lung, bowel, breast, prostate and pancreatic cancer. In some cases, this is because the cancers are among the most common (breast and prostate cancers) and in other cases, it is because survival is relatively poor (lung and pancreatic cancers).

Various cancer types are discussed next. For more details on these and other cancer types, please see the full *State of Cancer 2025* report.

Prostate cancer

Prostate cancer is the most-diagnosed cancer in New Zealand. Over the last decade, rates have remained largely stable for Māori and Pacific peoples, while steadily increasing for European/other and Asian populations. Rates of diagnosis are higher among males of European/other ethnicity compared with tāne Māori (Māori males) and Pacific males. Asian males have substantially lower rates of prostate cancer diagnosis. However, these rates may not reflect the true pattern of disease in different population groups because the use of prostate-specific antigen (PSA) testing for prostate cancer differs by ethnicity and level of deprivation.

More males have been surviving prostate cancer in recent decades and the overall mortality rate is decreasing over time. Within this, however, Māori and Pacific males are more likely to die from prostate cancer compared with males of European/other ethnicity, despite having a lower prostate cancer incidence rate. Asian males continue to be much less likely to die from prostate cancer compared with other ethnicities.

Breast cancer

Breast cancer is the most-diagnosed cancer in females. The overall diagnosis rate has been relatively stable in recent years; however, there are substantial differences across ethnicities. Wāhine Māori and Pacific females have a higher rate of diagnosis than females of European/other ethnicity. In particular, there has been a notable increase in the rate of diagnosis among Pacific females. Asian females continue to experience the lowest rate of diagnosis; however, this rate has been increasing over the past 2 decades.

More females have been surviving breast cancer in recent decades, although the latest survival information about specific population groups is not yet available. The risk of dying from breast cancer has been continually decreasing, although, again, wāhine Māori and Pacific females continue to be at higher risk of death, and are seeing slower improvements in the mortality rate. Socioeconomic deprivation is also closely linked to the breast cancer mortality rate; there is a persistent gap in rates between females living in areas of high deprivation (who are more likely to die from breast cancer) and those living in more affluent areas (who are less likely).

Bowel cancer

Bowel cancer is the third most-diagnosed cancer in New Zealand. By ethnicity, the European/other population has the highest rate of disease, while rates among Māori and Pacific peoples are lower, and much lower for the Asian population. Although rates for people of European/other ethnicity have been decreasing, the same trend is not seen for Pacific populations, where rates have been increasing, and Māori, where rates have remained relatively stable over the same time period. There has also been a steady increase in rates of early-onset bowel cancer (occurring in people under the age of 50 years). This increase is also happening internationally, and the causes are not yet understood.

The overall risk of dying from bowel cancer has been steadily decreasing, particularly among the European/other population. This decrease has not been seen as consistently in other population groups.

Lung cancer

The overall rate of lung cancer diagnosis has continued to decrease over the last 5 years. Rates remain high for Māori and people living in the most socioeconomically deprived areas. Emerging evidence based on analysis completed by Te Aho o Te Kahu | Cancer Control Agency shows that disabled people also experience a high burden of lung cancer. Overall, Māori are particularly affected, being more than three times as likely as people of European/other ethnicity to be diagnosed with lung cancer. This difference may be even more pronounced for tāngata whaikaha Māori (disabled Māori).

While there have been improvements in survival for lung cancer over the past 2 decades, survival is still poor. Often lung cancer is quite advanced at the time of diagnosis, which limits treatment options. Smoking is a major risk factor for lung cancer, with approximately 85% of cases attributable to smoking. Lung cancer is the biggest cause of cancer death in New Zealand and one of the largest contributors to the life expectancy gap between Māori and non-Māori (6.6 years between 2020 and 2022). The lung cancer mortality rate has continued to decrease across all ethnicities over the past 2 decades, with these improvements occurring at a faster rate for Māori compared with people of other ethnicities in New Zealand. Despite this, Māori were more than three times as likely to die from lung cancer than people of European/other ethnicity. Wāhine Māori have the highest rates of lung cancer mortality.

Melanoma

Alongside Australia, New Zealand continues to have one of the highest rates of melanoma in the world. It is most common among people of European/other ethnicity, particularly males and older adults. While the risk of being diagnosed with melanoma is lower among Māori compared with people of European/other ethnicity, Māori have worse outcomes once diagnosed. Despite rates of diagnosis of melanoma being high, net survival is also high. It is also a relatively preventable cancer, with more than 95% of cancers related to ultraviolet (UV) radiation.

Cancer in children and young people

In New Zealand, cancer in children (aged 0–14 years) represents less than 1% of all cancer diagnoses. The incidence of childhood cancer has remained stable over time and is comparable with rates in other high-income countries. In 2022, children diagnosed with cancer were most likely to have leukaemia followed by central nervous system tumours. Approximately one-quarter of children with newly diagnosed cancer in 2022 were Māori.

In New Zealand, the age range for adolescent and young adult (AYA) cancer services is defined as 12–24 years. For the purposes of the *State of Cancer 2025* report, however, the age range is 15–24 years, with the younger years incorporated into the preceding child cancer section. AYA experience different types of cancer to those experienced by children and adults, although there is overlap with both. AYA also have different psychosocial and developmental needs. The number of AYA diagnosed with cancer in 2022 slightly exceeded the number of children who were diagnosed. The most common cancers for AYA were carcinomas, such as gastrointestinal carcinomas and thyroid carcinomas.

Some population groups are disproportionately affected by cancer

There are many factors that influence cancer outcomes in New Zealand. Some of these are specific to cancer care, while others are broader social factors that affect people in a range of ways, including their exposure to risk and protective factors. When combined, these factors can significantly affect a range of cancer outcomes. At a population level, local and international evidence shows that these factors disproportionately affect some population groups more than others. This is often referred to as unwarranted variation, disparity or inequity. In New Zealand, Māori, Pacific peoples and people living in the most deprived areas disproportionately experience poorer cancer outcomes.

There have been both positive and negative changes in cancer incidence across different population groups over time. For example, improvements have been seen in the gap between stomach cancer rates for Māori and European/other over the past 2 decades, with this inequity reducing over time. Similarly, the gap between lung cancer incidence rates has also narrowed for people living in the most socioeconomically deprived areas and those in more affluent areas.

In contrast, gaps have been getting worse in other areas. For example, Pacific females have the highest incidence of uterine cancer, being more than five times as likely to be diagnosed compared with females of European/other ethnicity. This gap has increased over the past 2 decades.

There is evidence of inequities in rates of cancer diagnosis for disabled people. There are also indications of differences in cancer outcomes between rural and urban communities. However, more work is needed to explore this further.

Key insights

Up to half of all **cancers can be prevented by reducing exposure to cancer risk factors** and strengthening public health measures

In the last 5 years, alcohol consumption, rates of excess body weight, poor nutrition and physical inactivity have **increased or stagnated, likely contributing to rises in certain cancers**

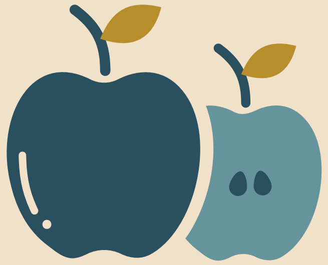
The environments in which people live, work and play **influence their exposure to cancer risk factors**

In the past decade, **daily smoking rates have declined significantly**, reducing the incidence of tobacco-related cancer

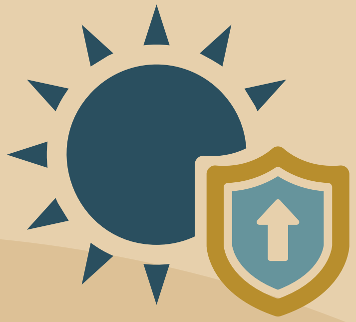
Screening and immunisation are reducing most cancer-causing infections

Skin cancer caused by UV radiation from the sun remains the **most-diagnosed site of cancer in New Zealand**

Areas for action



Improve access to nutritious and affordable food environments



Improve investment in skin cancer prevention and early detection

Continue efforts to reduce smoking – the leading cause of preventable death and disease in New Zealand

Preventing cancer | Te ārai mate pukupuku

Cancer prevention is a critical, long-term public health strategy that offers the most cost-effective approach to controlling some cancers. As the New Zealand population ages and increases in size, along with cancer incidence, 'treating our way out' of the significant increase that is forecast will not be possible. Prevention must be prioritised – improved prevention efforts could see between approximately 8,000 and 14,000 fewer cancer diagnoses each year.

Up to half of all cancers are preventable through reductions in tobacco use, alcohol intake, poor nutrition, physical inactivity, sun exposure and chronic infections. These modifiable risk factors are shaped by individual choices as well as the social, political, commercial, economic and environmental contexts people live in. For example, in low-income areas, healthy food options are often less accessible and affordable, and there are more fast-food and alcohol outlets.

Tobacco smoking is the single greatest preventable cause of cancer

Tobacco smoking is a leading cause of preventable death and disease in New Zealand. It accounts for more than one-fifth of all cancer deaths and is linked to at least 16 different cancer types, most notably lung cancer. Māori, Pacific peoples and people living in areas of high deprivation experience higher rates of tobacco-related disease and death.

While daily smoking among adults has declined from 16.4% in 2011/2012 to 6.9% in 2023/2024, progress may now be plateauing. Daily smoking rates also declined for all ethnic groups, except Asian. Despite this progress, significant differences remain for some ethnicities. Māori are 2.75 times as likely to smoke daily than non-Māori, and wāhine Māori are 3.72 times more likely to smoke daily than non-Māori females. Those in the most deprived areas are six times more likely to smoke than those in the least deprived.

The decline in smoking rates over recent decades has been largely driven by a comprehensive tobacco control strategy combining taxation, advertising bans, public health campaigns, smoke-free environments and free quit-smoking services. In the last 5 years, legislative changes included the Smokefree Environment and Regulated Products (Smoke Tobacco) Amendment Act 2022, which was repealed in 2024 and replaced by a new non-legislative action plan focusing on reducing uptake, increasing quit attempts, improving access to support and helping people remain smokefree.

More people are taking up vaping

In the last 5 years, vaping (e-cigarettes) has surpassed smoking as the most common daily habit, especially among young people, some of whom have never smoked. Daily adult vaping increased from 3.5% in 2019/2020 to 11.1% in 2023/2024, with Māori (28.8%) and Pacific peoples (21.5%) having the highest rates.

While vaping products can help smokers quit or reduce the number of cigarettes smoked, emerging research points to likely cancer risks due to inhaled particles and carcinogenic chemicals. However, more research is needed and the long-term effect of using vapes in developing cancer is not yet fully understood.

Recent Government measures to regulate vaping include advertising restrictions, increased penalties for sales to minors and a ban on disposable vapes.

Alcohol is a risk factor for many cancers

Alcohol is a risk factor for at least seven types of cancer, including two of the most-diagnosed cancers in New Zealand: bowel and breast. The risk of a person developing cancer increases the more alcohol they consume, with heavy drinking carrying the greatest risk. However, light and moderate alcohol consumption has also been found to cause cancers.

Around three-quarters of adults (76%) in New Zealand drink alcohol. The proportion of adults drinking alcohol has decreased in the last 5 years from 82%. A New Zealand study found that alcohol accounted for an estimated 1,250 new cancer cases in 2018, or 4.8% of all cancer registrations in New Zealand, with Māori facing disproportionately higher rates and dying from alcohol-related cancers 2 years earlier than non-Māori.

Some progress has been made in alcohol harm reduction, such as regulation changes, an increase in the alcohol levy and allocation of funding, yet public awareness of the risk remains low: just one in five adults in New Zealand knows alcohol causes cancer. Currently, New Zealand does not have any large-scale public awareness campaigns addressing alcohol as a cause of cancer, and mandatory alcohol labelling only addresses pregnancy risks.

The number of people in New Zealand eating a nutritious diet is decreasing

The food people eat can increase or decrease the risk of them developing several cancers, including bowel and breast cancers. For example, cancer-protective diets rich in fibre and calcium can reduce the risk of bowel cancer while high red meat intake can increase risk.

In 2023/2024, only 1 in 10 adults ate the recommended amount of vegetables and just 1 in 17 ate the recommended amount of both fruit and vegetables. For children, only 1 in 12 ate the recommended amount of vegetables, and daily breakfast consumption is declining.

Household food insecurity has increased over the last 5 years, limiting regular access to cancer-protective foods such as fresh fruit and vegetables. In 2023/2024, one in four children lived in households where food ran out often or sometimes, with rates highest among Pacific (one in two) and Māori (one in three) children, compared with one in five European/other and one in six Asian children.

The Government is improving access to nutrition through initiatives such as Ka Ora, Ka Ako (Health School Lunches Programme), which provides daily healthy lunches to children most in need. However, a 2024 report found that New Zealand's food system is out of balance, and further action is needed to support the wellbeing of people here.

Excess body weight is a risk factor for cancer

Excess body weight increases the risk of several cancers, including bowel, breast and uterine cancers, through biological changes such as elevated insulin and chronic inflammation.

Between 2019 and 2023, 5.1% of cancers among adults aged 30 years and over were attributable to excess body weight. Māori and Pacific peoples have a higher burden of cancers related to excess body weight, such as uterine and breast cancers, with Pacific females experiencing the highest rates (16.1%).

In 2023/2024, one in three adults and one in eight children were classified as obese, with prevalence highest in people living in the most deprived areas and among Pacific and Māori adults.

Weight loss through diet, exercise, behavioural support, medication or surgery can reduce cancer risk. However, maintaining long-term weight loss is difficult and long-term, population-level, focused prevention should also be considered.

The number of people in New Zealand being physically active is decreasing

Physical activity can help protect against several cancers, while physical inactivity can increase the risk of developing some cancers including bowel, breast, lung and uterine cancers.

In 2023/2024, less than half of adults (46.6%) met physical activity guidelines, down from 50.9% in 2018/2019. One in seven adults (13.6%) did little or no physical activity and this was more likely for adults living in the most deprived areas compared with adults in the least deprived (19.9% and 11.1%, respectively).

The Government has progressed several actions to improve physical activity, including support to deliver the National Physical Activity and Play Plan, led by SportNZ, however, more initiatives are needed.

Sun exposure and skin cancer

UV radiation from the sun or sunbeds is the main cause of skin cancer – the most-diagnosed site of cancer in New Zealand. New Zealand has one of the highest incidence rates in the world, largely due to its exceptionally high UV levels.

Each year, more than 3,000 melanomas and over 90,000 non-melanoma skin cancers are diagnosed, with melanoma causing a disproportionate number of deaths. The burden is greatest for people of European/other ethnicity, with males and older adults particularly affected. While the risk of being diagnosed with melanoma is lower among Māori, research has found that Māori have worse outcomes once diagnosed.

Skin cancer causes around 500 deaths annually and this number is projected to rise due to the ageing population. It costs New Zealand an estimated $495 million annually, but Government prevention funding dropped to $275,000 in 2023/2024 – over 1,600 times less than treatment costs.

A new Skin Cancer Prevention and Early Detection Strategy (2024–2028) aims to reduce incidence and improve outcomes through stronger prevention and early detection efforts.

Infection-related cancers

It is estimated that, globally, around 13% of all cancers are caused by infections. Four main types of infections account for approximately 90% of the infection-related cancers: *Helicobacter pylori (H. pylori)*, human papillomaviruses (HPVs) and hepatitis B and C viruses.

Most people who get these infections do not develop cancer. However, they are more likely to develop cancer if the infection remains in the body for a long period of time (chronic infection) or if other contributing high-risk factors such as alcohol or smoking are present.

Improvement work in this area includes:

- new studies that aim to personalise antibiotic treatments and address incidence disparities relating to *H. pylori*
- free HPV vaccination to 9–26-year-olds (although coverage remains below target)
- the introduction of primary HPV screening that gives the option of self-testing
- hepatitis B childhood immunisation reaching nearly 90% coverage in 2024, with a new health target now aiming for 95% coverage
- a National Hepatitis C Action Plan 2020–2030, which focuses on prevention, testing, care and equity.

Workplace carcinogens

In New Zealand, workplace exposures to carcinogens cause nearly one-third of work-related harm and roughly 650 deaths annually from cancer and respiratory diseases.

The New Zealand Carcinogens Survey, commissioned by WorkSafe New Zealand in 2021, found that 58% of workers were exposed to at least one carcinogen at work, with Māori, Pacific peoples and males facing higher exposure. Recommendations from the survey included establishing an occupational health service and targeted screening for workers at high risk.

Additionally, in the last 5 years, accelerated silicosis has emerged as a serious occupational health condition, prompting the creation of new assessment pathways and health protections.

Key insights

Screening detects cancer earlier and improves survival – however, several population groups are under-screened

New Zealand currently has three national cancer screening programmes: breast, cervical and bowel

Cervical screening now uses HPV testing, enabling self-testing and longer intervals between tests

A lung cancer screening programme is being proposed, which could significantly reduce lung cancer mortality

The breast screening age is being extended to people aged 70–74 years, supported by Te Puna, a new platform for invitations and bookings

70–74 years

The bowel screening eligibility starting age has dropped from 60 years to 58 years (from October 2025) and planning is underway to drop it further towards 50 years in future

58 years

Areas for action

Achieve all targets for screening coverage

Investigate options to develop existing national screening programmes or introduce new screening programmes for other cancers

Address screening inequities and barriers to access

Screening for cancer | Te mātai mō te mate pukupuku

New Zealand currently has three national cancer screening programmes for breast, cervical and bowel cancers. These programmes aim to detect cancer early or identify precancerous changes, which significantly improves treatment outcomes for patients and net survival.

Participation varies widely by ethnicity, geography and other factors. To increase access and improve the effectiveness and quality of the programmes, substantial investment and reforms have occurred across all cancer screening programmes. Yet major equity and participation challenges remain. Continued investment, community engagement and innovation will be critical to achieving the full benefits of early cancer detection through screening for people in New Zealand.

Breast cancer screening

Breast cancer screening has undergone important changes. In February 2024, the Government confirmed plans to progressively extend the age range for free breast screening to include 70–74-year-olds. Implementation of the extension began in the Nelson Marlborough district in October 2024. It is being progressively rolled out across New Zealand from October 2025.

A 2023 quality improvement review of the national breast screening programme, BreastScreen Aotearoa, led to 27 funded initiatives addressing identified weaknesses, particularly in the experience of wāhine Māori and Pacific females.

A new digital system, Te Puna, replaced eight regional systems with a single national register in 2025. This means eligible individuals are now automatically identified and invited to participate, rather than needing to opt in.

Despite these advances, BreastScreen Aotearoa is not meeting its national coverage targets, although it is close. As of December 2024, screening coverage was 69.7% (target 70%). Breast screening rates are lower for wāhine Māori and Asian females (63% and 62%, respectively) compared with females of other ethnicities.

Cervical cancer screening

In cervical cancer screening, a major update came in September 2023 with the transition to primary HPV testing replacing cytology-based ('smear') testing. The HPV test is more sensitive and allows for a longer interval (5 years vs 3 years), as well as self-testing options. The introduction of primary HPV testing has driven recent increases in cervical screening uptake: by the end of 2024, more than 310,000 people had been screened, and 81% of them chose to use the new method, and of those choosing the new method, 19% were previously unscreened or under-screened.

Cervical screening is the only national cancer screening programme where most people pay a fee to participate. However, free cervical cancer screening is offered to priority groups, including Māori, Pacific peoples and those holding a Community Services Card.

Despite improvements to access, the cervical cancer screening programme is not meetings its national coverage target. As of December 2024, screening coverage was 72.7% (target 80%).

Ethnic disparities in cervical cancer remain stark. Wāhine Māori and Pacific females continue to be more likely to develop and die from cervical cancer. Around 85% of cervical cancer cases in New Zealand occur in people who have never or rarely been screened. The recent increase in participation since HPV testing was introduced offers promise, but a continued focus on equity is essential.

New Zealand is committed to the World Health Organization's cervical cancer elimination strategy, targeting 70% of females being screened by age 35 years and again by age 45 years. The WHO aspiration is a world where cervical cancer is eliminated as a public health problem.

Bowel cancer screening

Bowel cancer screening has expanded nationwide, with the initial programme rollout completed in June 2022. A key development was the 2022 Budget commitment to lower the starting age for bowel screening. While initially planned to lower the threshold to 50 years of age for Māori and Pacific peoples, this was revised in March 2025 to 58 years of age for all people in New Zealand.

The two-stage rollout began in October 2025, with further plans to eventually align the eligibility age with Australia's starting point of 45 years of age, once system capacity allows. A national awareness campaign (2022–2024), co-designed with Māori and Pacific communities, raised awareness and knowledge.

The total number of people screened for bowel cancer has increased due to the completion of the programme rollout. Between August 2020 and August 2024, over 819,000 people were invited to screen and 470,691 participated in screening.

Despite the expansion of this screening programme, it is not yet meeting its national coverage target. As of August 2024, screening coverage was 57.1% (target 60%). Bowel screening uptake remains significantly below target for Pacific peoples (38%).

Barriers facing disabled people

Disabled people face significant barriers to cancer screening. International evidence shows lower participation rates among disabled populations, with even worse outcomes for Indigenous disabled people and those with learning disabilities. While no comprehensive New Zealand data currently exists, it is likely there are similar inequities locally.

COVID-19 disruptions

COVID-19 significantly disrupted screening uptake in New Zealand, particularly in 2020–2021. While cervical screening coverage rates have nearly recovered, breast screening coverage has not yet returned to pre-pandemic levels. These disruptions made existing inequities worse, especially among Māori and Pacific peoples. Although data for bowel screening during this period is unavailable due to the programme's rollout, participation trends suggest the presence of similar challenges.

Steps towards a lung cancer screening programme

New Zealand is constantly evaluating the potential for new screening programmes. Any decision about introducing new programmes weighs benefits, harms, equity impacts and resource allocation. Two advisory groups, the National Screening Advisory Committee and the Māori Monitoring and Equity Group, advise Health NZ on changes to existing screening programmes and any potential new programmes for consideration.

The National Screening Advisory Committee also monitors technological advancements that may change the way screening is undertaken in the future, including the use of biomarker testing, multi-cancer early detection tests and the use of artificial intelligence (AI) in screening.

Since 2018, researchers from the University of Otago have been gathering evidence to inform the design of an equitable, culturally safe and effective lung cancer screening programme in New Zealand. This project, called Te Oranga Pūkahukahu, is in response to lung cancer being the leading cause of cancer-related death in New Zealand, and one of the cancers often being diagnosed late following emergency admission to hospital and therefore leading to worse outcomes for those patients.

Lung cancer screening has potential to improve health equity, particularly for Māori (who are nearly three times more likely to be diagnosed than non-Māori) and disabled people. International trials show that low-dose computed tomography (CT) screening can reduce mortality by 20%–26%, with even higher benefits for females.

Te Oranga Pūkahukahu research is directly informing work on a potential national lung cancer screening programme.

Key insights

Investment in improving access to primary care, updates to criteria in radiology and strengthened multidisciplinary meeting systems are all part of the solution

Regional and socioeconomic inequities in diagnosis persist

New national pathways aim to make diagnostics more consistent

Earlier diagnosis improves survival and quality of life

Delays in diagnosis are contributing to the decline in the proportion of people starting treatment within the 62-day target for cancer care

The FIT for Symptomatic Pathway 2025 trial prioritises high-risk patients, easing pressure on colonoscopy services

Areas for action

Remove barriers to primary care and to accessing diagnostic testing

Strengthen opportunities for earlier detection through continued innovations

Reduce inequities in timely cancer diagnosis

Getting a cancer diagnosis | Te tautohu mate pukupuku

Cancer is more treatable when it is diagnosed quickly and accurately at the earliest stage possible. The tests and procedures needed to investigate symptoms that may indicate cancer must be easily available and quickly accessible. These tests should also produce straightforward results that clearly indicate whether patients have cancer.

Diagnosing cancer can be a complex process because people's symptoms can often be non-specific, and some cancers can have few, if any, early symptoms. People may need to have multiple different tests, performed by different clinicians and in different settings, such as primary care, the local community and/or a hospital or specialist setting. At the same time, over-testing can lead to avoidable investigations that carry risk of harm; this is why a balance is needed to ensure the right tests are ordered for the right symptoms.

New Zealand continues to lag behind comparable countries in terms of timely diagnosis.

Later-stage diagnosis leads to significantly more years of life lost for patients with cancer. Earlier diagnosis could substantially reduce mortality. For example, if bowel cancer alone were detected just one stage earlier, it is estimated that over 1,000 lives could have been saved between 2017 and 2019. For females, earlier detection of bowel, lung, ovarian and breast cancers would yield the greatest survival gains; for males, it is bowel, prostate and lung cancers.

Regardless of the stage of their cancer when it is diagnosed, however, Māori experience higher average years of life lost than non-Māori. This suggests persistent and inequitable flaws in the design and delivery of health services.

Emergency admissions: A red flag

A key concern in New Zealand is the high proportion of cancer diagnoses arising from emergency department (ED) admission. A 2022 International Cancer Benchmarking Partnership study found that New Zealand had the highest ED-associated diagnosis rates among six peer countries for seven of eight major cancers (except liver). This is a concerning result. This diagnosis pathway is often associated with late-stage cancer and poorer survival (higher mortality) for patients. People diagnosed via ED are significantly more likely to die within 12 months compared with people diagnosed through other (non-emergency) pathways.

Nearly one in four cancer patients in New Zealand are diagnosed following an emergency admission. Māori, Pacific peoples, males and those living in the most deprived areas have disproportionately high emergency diagnosis rates compared with other population groups.

Some cancers, such as brain, pancreatic and ovarian, are more likely to be diagnosed after an emergency admission because they present with sudden or 'silent' symptoms. However, diagnosis rates are also high for lung, stomach and bladder cancers, despite patients usually showing symptoms early enough to allow for non-emergency detection of their cancer.

Progress in transforming cancer diagnosis

National initiatives are underway to improve the diagnostic process, particularly in terms of access, speed and equity. This includes a strong focus on earlier detection, patient-centred care and reducing system barriers. Innovations such as standardised diagnostic pathways, expanded imaging services and new models of care in primary care settings aim to improve cancer outcomes for many.

Development of cancer diagnosis pathways

To address variation and improve equity in diagnosis, New Zealand has invested in standardised diagnostic guidance through Community HealthPathways and Optimal Cancer Care Pathways (OCCPs). The OCCPs cover 16 cancer types and outline principles of safe, consistent care across prevention, diagnosis, treatment, survivorship and palliative care. They are scheduled for phased rollout from 2025.

In 2023, Health NZ designed a standardised pathway of care for abnormal uterine bleeding that is now operational in Hawke's Bay and Counties Manukau. It supports timely triage for conditions like post-menopausal bleeding and is designed to reduce delays in diagnosing endometrial cancer.

Improved imaging access

PET-CT is a crucial diagnostic tool for cancer staging. It is a medical imaging technique that combines a positron emission tomography (PET) scan with a CT scan. Access has improved through the addition of fixed sites in Tauranga and Hawke's Bay, and a mobile service reaching Rotorua, Palmerston North, Lower Hutt and Dunedin. In 2024, national clinical criteria were standardised and funding was extended to include prostate-specific membrane antigen (PSMA) PET-CT for prostate cancer – an important diagnostic test.

Lung cancer fast-tracking

A National Lung Cancer HealthPathway was launched in 2023 to enable GPs to refer patients directly for CT after abnormal chest x-rays, bypassing specialist respiratory services. This initiative aims to eliminate current inequities, particularly for rural and Māori patients. It aligns with the national lung cancer OCCP and will require further community radiology investment.

Fecal Immunochemical Test (FIT) for Symptomatic Pathway

Access to timely colonoscopy remains difficult. In 2024, only 40% of non-urgent referrals and half of surveillance patients received colonoscopies within target timeframes. To alleviate this, the FIT for Symptomatic Pathway is being trialled in five districts in 2025. Patients with bowel cancer symptoms not meeting urgent referral criteria will receive a FIT test. Negative results will be managed by GPs, reducing pressure on colonoscopy services.

Radiology sector transformation

Radiology access is highly variable across regions and is under strain due to increasing complexity of needs and demand for services. In 2024, the Radiology Transformation Programme was launched to standardise access and prioritisation. Key actions include:

- increasing workforce training
- establishing triage hubs and national access criteria
- removing community radiology co-payments
- using integrated data to manage waitlists
- developing clinical guidelines to standardise practice.

The National Radiology Clinical Network, launched in 2024, supports these efforts by setting national standards, identifying gaps and guiding investment and workforce planning.

Enhancing multidisciplinary care

Multidisciplinary (MDM) meetings enable collaborative decision-making among clinicians. The South Island completed implementation of an electronic MDM solution in 2021. It is being used to support 15 cancer tumour streams as well as providing clinicians with data that enables them to monitor MDM quality indicators and undertake audits and service improvement work.

The Midland region has also made progress on implementing an electronic Clinical Pathway – MDM solution.

Oncology support in primary care

A successful pilot in the MidCentral district now allows GPs to access oncology advice and directly request imaging for patients with non-specific symptoms. This bridges gaps for patients who do not meet standard referral criteria and may otherwise face delays. This initiative is now part of standard care in the region and shows potential for national scalability.

Primary care access barriers

Primary care is at the front line of cancer detection but there are barriers preventing some people from seeing their GP. While nearly everyone in New Zealand is enrolled with a GP, wait times are increasingly problematic. In 2023/2024, one in four (25.7%) adults and nearly one in five (18.5%) children reported long wait times as a barrier to seeing a GP – figures that have doubled since 2021. Cost is also a factor. In 2023/2024, one in six (15.5%) adults skipped GP visits due to cost. The impact is worse for disabled people (22.3%), Pacific peoples (22.3%) and Māori (19.6%).

To help address some of these issues, the Government announced a $285 million uplift for general practice over 3 years, increased nurse practitioner training and a 24/7 online GP access service beginning in 2025.

Delays in treatment pathways

There is an expectation that people with a high suspicion of cancer will start treatment within 62 days of referral. However, the proportion of people starting treatment within this timeframe has been declining over the last 5 years. Delays in diagnosis will be contributing to this.

Key insights

Cancer treatment includes surgery, radiation, systemic anti-cancer therapy and stem cell transplant

New models of care have been developed and are being implemented

Surgery is most common, but use of advanced radiation is growing

33 new cancer medicines have been funded since 2024

Investments are improving access to medicines and biomarker testing, expanding treatment locations and improving data systems

Dedicated pathways are available that support children, adolescents and young adults

Areas for action

Remove financial, logistical and other barriers

Reduce avoidable delays in access to treatment

Reduce geographic variation in access to services, wait times and outcomes

Undergoing cancer treatment | Te maimoatanga

Cancer treatment in New Zealand includes surgery, radiation oncology, systemic anti-cancer therapy (SACT) and stem cell transplant.

Treatment decisions are based on factors such as cancer type, stage and patient age, health status and preferences. While some treatments aim to cure, others focus on life extension and symptom relief.

Access and timeliness of treatment

Efforts have been made in the last 5 years to improve models of care and decentralise treatment, enabling more people to access services closer to home. However, some population groups, including Māori, Pacific peoples, disabled people, people living in rural areas and low-income populations, still have inequitable access to services.

Fewer patients are receiving timely treatment, which is reflected in the Faster Cancer Treatment (FCT) health target – where 86% of eligible patients should receive cancer management within 31 days of the decision to treat. Achievement of this target has declined since 2020, although preliminary data from 2025 suggests a recent improvement.

Surgery

Surgery remains the most-common first-line cancer treatment, used in nearly half of newly diagnosed patients between 2020 and 2024.

While New Zealand offers high-quality cancer surgery, equity gaps persist. For example, Māori with non-small cell lung cancer had the lowest rates of curative surgery (16.8%) between 2019 and 2022 compared with people of Asian (24.4%) and European/other (20.0%) ethnicities. Those living in rural areas were also less likely to receive a curative surgical resection (17.6%) compared with those living in urban areas (20.2%). It is not yet possible to identify if these gaps are due to a higher likelihood of being diagnosed with late-stage disease (where surgery is not typically done) or if these groups are less likely to receive surgery for reasons unrelated to the stage of their disease.

The proportion of people in New Zealand who received surgery within the target timeframe of 31 days of a decision to treat declined from 80.9% in 2020 to 72.7% in 2024.

Emergency surgery for bowel cancer is a particular area of concern. Between 2017 and 2019, 19.4% of major bowel cancer resections were completed as emergencies, which are associated with poorer health outcomes. Māori (24.9%) and Pacific peoples (28.2%) had higher emergency surgery rates compared with people of other ethnicities.

A set of frameworks is in development, outlining the knowledge, skills and abilities needed to perform complex cancer surgeries to standardise service quality.

Radiation oncology

It is estimated that approximately half of cancer patients would benefit from radiation treatment, however, it is accessed at a lower rate than this nationally and there is geographic variation. Achievement of the FCT target 31-day decision to treat timeframe for radiation treatment dropped from 89.1% in 2020 to 83.0% in 2024.

Where people live influences how quickly they can access radiation oncology. Radiation oncology is only provided at seven public centres and supplemented by four private centres. One of those private centres exclusively provides care for public patients in Bay of Plenty. Currently, radiation treatment centres are only located in main cities, requiring many patients to travel long distances.

There is considerable variation across the country, which particularly impacts Māori and people living in rural areas.

Despite access challenges, there has been a positive shift towards high-complexity radiation treatments, which reduce side effects and can replace surgery for some patients. 'Hypofractionation' (higher doses delivered in fewer sessions) is increasingly being used, particularly for breast and prostate cancers. This is positive for patients because it means they generally attend fewer treatment appointments with no worsening of side effects.

Over the last 5 years, fewer patients are accessing low- and medium-complexity treatment, with a significant increase in high-complexity treatment. There has been minimal change in the number of patients receiving very high-complexity treatment (brachytherapy). As treatment technology continues to advance, services must be able to plan ahead so they are ready to provide optimal modern care to patients.

Improvements include the 2024 Radiation Oncology Model of Care, which aims to improve consistency in the quality of care, a new centre opening in Taranaki in 2025 and two new linear accelerator (LINAC) machines for Northland and Hawke's Bay. New radiation oncologist training positions and national telehealth guidelines have also been introduced.

Systemic anti-cancer therapy

SACT includes chemotherapy, hormone therapy, immunotherapy and targeted therapies. SACT was the first treatment for 19.9% of cancer patients between 2020 and 2024, with 97.5% receiving treatment within 31 days, a consistently good performance.

Despite positive treatment rates, patterns of treatment indicate access is not equitable, particularly for some ethnic groups. For example, only 40.5% of Asian and 46.0% of Pacific patients with stage II/III breast cancer received neoadjuvant therapy (treatment given before the main treatment to increase the chances of a cure) compared with 53.6% of European/other patients.

This is compounded by variation in SACT service delivery across different districts. For example, in the Greater Auckland region, the Counties Manukau and Waitematā districts can only deliver SACT treatment for females with some types of breast cancer. All other patients must travel to Auckland City Hospital for their SACT treatment. This is particularly problematic for Pacific peoples and people living in areas of high deprivation – and Counties Manukau is home to nearly 40% of New Zealand's Pacific population.

More broadly, there has been considerable concern in recent years that a range of treatments is available in other countries, but not in New Zealand. The 2022 report by Te Aho o Te Kahu | Cancer Control Agency *Mārama ana ki te Āputa | Understanding the Gap* identified 20 cancer medicines funded in Australia but not in New Zealand. A follow-up 2024 report showed Australians also had access to 12 additional blood cancer medicines of notable clinical benefit.

A $604 million boost to Pharmac's budget in 2024 led to 33 new cancer medicines being funded in New Zealand (as at May 2025). These new medicines will benefit an estimated 2,350 people in the first year. Investments will also enable more SACT treatments to be delivered locally, meaning more patients with different cancer types will be able to access care closer to home. Some of the new medicines require biomarker testing, which has prompted investment in nationally consistent testing.

Other SACT-related improvements over the last 5 years include: the 2024 SACT Model of Care, which outlines goals for community-based delivery, sustainability and equity; new services launched in Taupō, Whanganui and the Bay of Islands, supported by minimum standards; and the ACT-NOW (Anti-Cancer Therapy – Nationally Organised Workstreams) programme, which is improving data infrastructure to monitor SACT across public and private providers.

Stem cell and cellular therapies

Demand for transplant and cellular therapies continues to rise. By 2030, demand for allogeneic transplant and cellular therapy, and autologous hematopoietic stem cell transplantation is expected to grow by 40% and 51%, respectively. Chimeric antigen receptor (CAR) T-cell therapy is also projected to be required by 150 adults annually. These are all types of therapy involving stem cells and immune cells. At the same time, access to stem cell transplant treatment continues to be a challenge given limitations in capacity across the country.

A new transplant and cellular therapy model of care was introduced in 2023, which provides a framework for commissioners, funders, managers and clinicians to deliver high-quality, efficient, effective, sustainable and equitable care for people in New Zealand.

Health NZ invested $4.5 million in 2024/2025 and $6.1 million in 2025/2026 to expand capacity in stem cell transplant centres in Auckland and Christchurch so more transplants can be delivered. Further investment is planned so that capacity meets forecast demand.

A waitlist management tool is also being developed that will support operational management at all five centres (Auckland, Hamilton, Palmerston North, Wellington and Christchurch) and will provide nationwide visibility of how long people are waiting once they are clinically ready to receive their transplant. Development of the tool will be completed in 2025 and implementation in the first half of 2026.

Paediatric and adolescent cancer care

Children (aged 0–14 years) and young people (aged 15–24 years) experience different types of cancer than adults. In 2022, 160 children and 170 young people were diagnosed with cancer.

Most children with cancer are treated at Auckland or Christchurch centres. About half live more than 100 km from these locations, although 14 shared-care centres allow some treatment closer to home. Adolescents and young adults (AYA) are treated in either paediatric or adult settings. Since 2007, six dedicated AYA centres have provided specialised support. The 2016 AYA Standards and 2020–2025 AYA Action Plan have improved service consistency.

Key insights

Cancer survival is improving so more people need support beyond active treatment

Cancer navigation services offer crucial support but require sustained funding to meet demand

The National Palliative Care Work Programme will make care more consistent

Primary care could play a greater role in prevention, early detection and survivorship, if better resourced

Survivorship guidance, expanded lymphoedema services and rehabilitation models are strengthening post-treatment care

Palliative care improves quality of life for people with life-limiting illness and supports carers

Areas for action

Invest further in post-treatment care and services, including community and primary care

Continue improvements to the National Travel Assistance scheme

Address access inequities, underfunding and workforce shortages in palliative care

Supporting people during their entire cancer experience | Hei tautoko tūroro

Cancer patients require services and support beyond the treatment of their disease. This can include psychosocial support, navigation and care coordination, transportation assistance, symptom management and quality-of-life supports, and in many cases access to early and effective palliative care services. In addition, allied health specialists often support patients to prepare for, undergo and recover from cancer treatment.

Psychosocial support

The Cancer Psychological and Social Support Service (CPSSS), launched in 2015, has expanded to employ over 43 clinicians nationally. It addresses mental, emotional and logistical barriers for people who are most likely to experience barriers in accessing care, including people living rurally, people with additional mental health or physical health needs, and Māori and Pacific peoples.

A ground-breaking achievement of the CPSSS, in collaboration with Te Aho o Te Kahu | Cancer Control Agency, is the implementation of a standardised data collection system, the first of its kind globally. This system tracks service flow and effectiveness, providing invaluable insights into the service's impact (such as ethnic or regional access) and areas for improvement.

Cancer navigation

Cancer navigation services help people and whānau to access timely, culturally safe cancer care and wraparound support. Delivered in clinical and community settings, these services assess patient needs, coordinate care and provide emotional, spiritual and practical guidance.

Feedback from over 2,500 whānau Māori in a nationwide hui series held by Te Aho o Te Kahu | Cancer Control Agency highlighted navigators as pivotal in improving continuity of care, reducing delays and improving the experience of care for patients and whānau.

Significant Government investment in 2023 and 2025 enabled Hauora Māori organisations to expand community-based navigation services, which are now available in most districts. However, the services do not have capacity to support all patients needing help and sustained funding will be required to meet future demand. A national model of care is also being developed, informed by the learnings from these investments.

Travel assistance

Health NZ's National Travel Assistance (NTA) scheme supports people who must travel long distances or frequently for treatment. While this support is not exclusively for cancer patients, they account for nearly one-third of all NTA spending.

The scheme provides vital financial support but patients and whānau still experience challenges accessing NTA support, including having to pay costs up front before they can be reimbursed.

In response, the Government committed $18 million in 2024 to support a reform of the NTA scheme. This included increasing mileage and accommodation reimbursement rates and piloting flexible payment options. Further long-term changes are planned, including improved promotion and possible changes to eligibility criteria to better target those in need.

Survivorship and care after treatment

Over 67% of people now survive at least 5 years post-diagnosis, compared with 58% in 1998–1999. This positive change also means there is a greater demand for care beyond the active treatment stage.

Survivorship care includes managing the effects of treatment; providing a variety of psychosocial supports; monitoring for recurrence and new cancers; and coordinating care across specialists, primary care and community providers.

Survivorship support varies by cancer type, where patients live and their level of access to public and/or private care providers.

Post-treatment care improvements

Some initiatives to improve the care of people after they complete treatment include:

- the Optimal Cancer Care Pathways (OCCPs), which aim to reduce inconsistency in care; however, their success depends on adoption within the wider health system, workforce capacity and funding
- strengthened guidelines for lung cancer follow-up. These include a primary care framework, recognising GPs' role in recurrence monitoring and psychosocial support; however, primary care will require adequate resourcing to optimise the guidelines
- resources on fertility and life after cancer to support adolescents and young adults.

Improvements to lymphoedema services

Lymphoedema is a common, long-term side effect of cancer and treatment. Up to 20% of breast cancer survivors develop it, while research suggests lymphoedema also affects up to 37% of gynaecological cancer survivors and over 90% of head and neck cancer survivors.

All regions now offer publicly funded lymphoedema services, with Wellington becoming the final region in 2023. However, the lymphoedema workforce has not been invested in and grown proportionally with demand.

Gaps in care for cancer survivors

Survivors report often feeling abandoned after active treatment ends. Concerns about cancer recurrence are common and survivors can also struggle with rehabilitation, work reintegration and navigating fragmented services.

Primary care is increasingly expected to manage survivorship but lacks resources and integration. Surveillance practices also vary by region. To address aspects of this, the National Radiology Clinical Network has called for standardised follow-up imaging to reduce unwarranted variation between districts and individual referrers.

The need for strengthening survivorship care and support is a global issue, with studies showing cancer survivors frequently lack adequate follow-up care despite research into models of survivorship.

Allied health and rehabilitation

There are at least 43 allied health professions playing critical roles in cancer prevention, treatment and recovery. The 2024 *Hauora Haumi Allied Health* report identified workforce challenges facing allied health that affect service delivery. These challenges need to be addressed to optimise survivorship care and other aspects of cancer care.

NGOs and rehabilitation

Across New Zealand many NGOs are also working to support people who have completed cancer treatment. Physical exercise and rehabilitation initiatives continue around the country. Counselling and support groups and resources are offered to people affected by cancer by the Cancer Society and several other cancer NGOs.

Rongoā Māori

Rongoā Māori is a cultural healing practice and incorporates deep, personal connections with the natural environment. The Rongoā Māori Action Plan was developed in 2023 with tohunga and rongoā experts as a guiding cross-agency tool to drive action to support rongoā in five aronga or focus areas: investment, partnerships, workforce development, system coordination and public awareness.

Leadership of the plan now sits with ACC and Health NZ following the disestablishment of Te Aka Whai Ora | Māori Health Authority.

Palliative care

Palliative care is an essential health service for people of all ages with a life-limiting illness. It aims to optimise people's quality of life until death and support whānau and other formal and informal carers during caring and bereavement.

Palliative care services may be suitable whether death is days, weeks, months or even years away. At times palliative care may be provided alongside treatments aimed at extending life and should be available wherever a person and whānau may be. It includes both primary palliative care (through a person's usual health team) or, if required, specialist palliative care (by health professionals specialising in palliative care). It is estimated that 90% of people who die from cancer in New Zealand receive specialist palliative care.

Several actions have been taken in the last 5 years to improve palliative care services, including a National Palliative Care Work Programme, new care pathways, resources for people caring for someone with a life-limiting illness and pockets of 'compassionate communities'.

Pressures on the palliative care system

Despite the publication of the *Palliative Care Action Plan* in 2017 and palliative care being a recognised priority within the *New Zealand Health Plan Te Pae Waenga* for 2024–2027 and the *New Zealand Cancer Action Plan 2019–2029*, there has been little progress to address the ongoing challenges the palliative care system is facing.

Access to palliative care in New Zealand varies. Factors including location and diagnosis affect access, with Māori and Pacific peoples in particular facing inequities in access. Primary palliative care services, such as general practice teams and aged residential care, and hospices, the largest providers of specialist palliative care in the community, are under pressure due to funding gaps, workforce shortages and increasing demand and complexity of care.

Demand on palliative care services is expected to increase as the population ages and more people live longer. Modelling shows that, by 2038, the number of people needing palliative care will increase by more than 50% compared with 2015 levels, with an increase of 90% by 2068. People living with cancer are likely to continue to be a significant proportion of those needing palliative care in future.

Palliative care experiences and reports

Recent reports and surveys have provided critical insights into the experiences of whānau Māori and other underserved communities with palliative and end-of-life care in New Zealand, highlighting areas of strength and persistent systemic challenges.

The 2023 report by Te Aho o Te Kahu | Cancer Control Agency *Rongohia Te Reo, Whatua He Oranga: The voices of whānau Māori affected by cancer* identified critical issues facing Māori in palliative contexts and underscored the importance of mātauranga Māori, rongoā and holistic care models in ensuring culturally responsive support.

A 2024 report, released by the Te Ārai Palliative Care and End of Life Research Group, highlighted persistent inequities in palliative and end-of-life care for nine underserved communities. The report found that 'systemic' barriers – such as inconsistent access, cultural insensitivity and discrimination – undermine care for different populations, often resulting in mistrust and reduced engagement with available services.

Assisted dying

The End of Life Choice Act 2019, which came into force in New Zealand in 2021, led to the establishment of the Assisted Dying Service | Ngā Ratonga Mate Whakaahuru. The service gives a person experiencing unbearable suffering from a terminal illness the ability to take, or be given, medication to end their life. There are strict criteria, processes and safeguards in place for people using the service.

Health NZ oversees and monitors all operational aspects of the Assisted Dying Service, while the Ministry of Health is responsible for regulating it.

Key insights

The CanShare national cancer informatics platform aims to support timely sharing of data

The diverse cancer workforce spans specialist and generalist professionals

More sustainable growth and support of the workforce are needed to meet future demand

Emerging technologies like AI and genomics will make cancer care more personalised and efficient

Physical infrastructure takes time to complete and deliver full benefit

High-quality cancer research and innovation drive evidence-informed practice improvements

Areas for action

Improve availability and use of genomics in prevention and treatment

Support clinical trial capacity and strengthen links between research and policy

Address shortages of skilled workers and increasing demands on the workforce by moving to new workforce models

Enablers of cancer care | Te hunga tautoko tauwhiro

There are several aspects of cancer service delivery that are relevant across the entire cancer continuum. Examples include workforce, physical infrastructure, data and technology, and research and innovation. These enablers are highlighted and discussed in this section.

The people providing cancer care

New Zealand's diverse cancer workforce spans specialist and generalist professionals in hospitals, primary care, community settings, academic institutions, NGOs and palliative care.

Several initiatives to strengthen the cancer workforce have progressed in the last 5 years. The Ministry of Health developed the *Health Workforce Strategic Framework* in 2023. This was followed by Health NZ's 2024–2027 workforce plan, which includes targeted cancer workforce actions such as clearer specialisation pathways, particularly for nursing and kaiāwhina roles.

Other initiatives also introduced aim to build a sustainable workforce pipeline capable of meeting rising demand while delivering more care closer to home. These include:

- specific uplifts in the cancer workforce through additional radiation oncology registrar and nurse practitioner roles and investment
- changes to recruitment and retention approaches through the Health NZ workforce taskforce
- the Cancer Nursing Workforce Pipeline programme for modelling cancer and haematology nursing needs
- developing oncology capability in primary care through various innovations
- establishing the Cancer National Clinical Network in 2025
- a nationalised advanced practice programme for radiation therapists
- investment in primary care workforce development
- approving a new medical school at the University of Waikato, to begin training 120 doctors annually from 2028, with a focus on rural and primary care.

Pressures on the current workforce

Despite these positive initiatives, the cancer workforce has been facing persistent and growing challenges over the last 5 years. These challenges include shortages across nearly all professions and unsustainable pressure as cancer incidence rises.

Workforce challenges are contributing to longer wait times for patients and placing significant pressure on the existing workforce. This, in turn, can result in skilled professionals leaving the health system, which makes the problem worse.

Understanding workforce supply and demand can help identify potential workforce gaps and determine strategies to address these gaps so patients receive high-quality care in a timely way. However, cancer workforce models in New Zealand do not take current workforce shortages into account and can only forecast how many workers will be needed in certain cancer professions in the future if nothing changes. In 2022, a comprehensive demand model for radiation oncology provided reliable estimates for future planning, but similar modelling is still needed for other areas of oncology.

Physical infrastructure supporting cancer care

There has been historic underinvestment in health sector infrastructure, resulting in poor building, site-wide infrastructure and clinical facility condition. This affects many aspects of the health sector including cancer care.

Infrastructure (physical and digital) is one of five focus areas in the *Government Policy Statement on Health 2024–2027*, which calls for stronger national planning and investment to improve the quality and timeliness of health facility upgrades. In 2025, Health NZ established an Infrastructure and Investment Group and published the *National Asset Management Strategy – Infrastructure* and the *Health Infrastructure Plan 2025*. These documents set out a long-term, coordinated approach to managing and investing in health assets across the country.

In the last 5 years, groundwork has started for physical infrastructure projects to improve facilities for patients; however, many of these projects are not yet complete.

The ongoing and substantial investment in the regional LINAC rollout remains a key project to improve patients' access to radiation oncology. The LINAC investment programme includes:

- the construction of the Taranaki Cancer Centre, now complete
- a new LINAC in Whangārei, expected to be operational in mid-2026. This will mean many patients will no longer need to travel to Auckland to receive radiation treatment
- a new LINAC approved for Hawke's Bay but still in the planning phase
- as part of the Taranaki Cancer Centre, Hawke's Bay and Whangārei LINAC builds, additional bunkers being included in their designs to plan for future growth, meaning other LINACs can be placed when required to expand service capacity
- planned investment outlined in the *Health Infrastructure Plan 2025* for new LINACs in the next 5 years.

In parallel, 10 ageing LINAC machines have been replaced in public hospitals, and private providers have invested in advanced technologies including CyberKnife and MR-LINAC systems.

Infrastructure investment has also extended beyond cancer-specific services. Radiology upgrades – such as new MRI and CT scanners in Auckland, Whanganui, Dunedin and other centres – are critical for cancer diagnosis and broader health system capacity. Several hospitals have undergone refurbishments, and the new Dunedin Hospital is under construction. *The Health Infrastructure Plan 2025* outlines a sequenced approach to hospital redevelopment over the next decade.

There is a clear shift towards delivering cancer care closer to where people live. Historically, patients often had to travel to main centres for treatment, but new community-based models are improving access and reducing pressure on hospital services.

Data and technology needed to improve cancer care

Information technology and data systems are increasingly recognised as powerful tools to improve cancer care. Large volumes of information are currently collected within the wider New Zealand health system but much of it is hard to access. Information is recorded in different ways and kept in hundreds of separate systems that have not been designed to connect, communicate or work together. This lack of integration makes it difficult to use data effectively to guide clinical decisions, improve services or support patients and whānau.

To improve access to and use of cancer data, a national programme called CanShare is being developed. CanShare is focused on turning cancer data into insights that can be used by health services to make informed decisions and track progress. A key focus of this work is the development of national data standards, which will allow different systems to work together more easily and for data to be more reliable, complete and timely.

Beyond CanShare, several other projects and programmes are improving access to cancer data. The Health NZ cancer web tool provides public access to registration, diagnosis and mortality data through interactive visualisations. The Cancer Quality Performance Indicator programme tracks performance across five major cancer types and includes dashboards such as the Cancer Care Data Explorer and the route to diagnosis dashboard, which highlight disparities in cancer presentation and outcomes. More broadly, the Health Data Platform currently being developed by Health NZ will serve as a unified, standardised data resource for the entire health system.

Together, these initiatives represent a positive step towards building a more integrated, equitable and data-driven cancer system. However, their success depends on sustained funding, capacity and, ultimately, their adoption and consistent use by health practitioners.

Emerging technologies

Several emerging technologies and innovations hold great promise and potential for providing more personalised and effective care across the continuum of cancer prevention, early detection and treatment. The Ministry of Health's 2023 *Long-term Insights Briefing* highlighted AI and genomics as examples of technologies that can support more precise ways of keeping people healthy ('precision health').

AI is already being used in diagnostic imaging and pathology, helping clinicians interpret scans and tissue samples with greater speed and accuracy. It is also being explored as a tool to integrate clinical and genetic data to support more informed decision-making. In early 2025, the Government released guidance for public sector adoption of generative AI and launched New Zealand's first national AI strategy to support broader uptake across sectors.

Genomics is playing an increasingly vital role in cancer care, enabling more precise interventions. Genomic or biomarker testing can identify treatments that are more targeted, more effective and less likely to cause adverse side effects for patients, improving their quality of life. In New Zealand, genetic screening is already being used to assess the risk an individual or family has of some types of breast or stomach cancers. However, the wider use of genomics in New Zealand is limited compared with other comparable countries, and unevenly distributed. This limits the impact genomics can have on delivering high-quality cancer care for everyone in New Zealand.

Initiatives underway to address these challenges include:

- the Ministry of Health's precision health programme, which aims to guide the safe, equitable and effective use of AI and genomics
- the Rakeiora pathfinder programme, commissioned in 2019, which is building infrastructure to support high-impact genomic research while upholding Māori data sovereignty
- Genomics Aotearoa, led by the University of Otago, now funded through to 2030 to expand its work, with a focus on capability-building and research that delivers health and economic benefits.

Cancer research and innovation

High-quality cancer research and innovation can generate evidence and knowledge that drive practice improvements, improving cancer outcomes and making services more sustainable.

There is a substantial volume of activity in both cancer research and policy in New Zealand, and cancer remains among the most-funded, most-studied areas of health research here. However, a lack of connection between research and practice and policy is limiting the ability of cancer research to influence cancer system improvement and innovation. It is likely that there is overlapping or duplicate research underway.

In 2024, a cross-sector workshop brought together cancer researchers, policy makers and members of the cancer sector to identify potential solutions. These included a national cancer research strategy, fast-track mechanisms for policy-relevant studies and activities to strengthen collaboration between researchers, government and stakeholders.

In the last 5 years, there has also been an increased focus on improving access to clinical trials. The 2022 *Enhancing Aotearoa New Zealand Clinical Trials* report recommended a roadmap to improve equitable access. Another study is looking to embed a decentralised trial model in New Zealand, allowing patients to participate from home or community settings.

To further support equity in cancer outcomes, a targeted research fund of $6.2 million was launched in 2021 by Te Aho o Te Kahu | Cancer Control Agency, the Health Research Council and the Ministry of Health. Six projects were funded in the areas of lung cancer screening and clinical research. Final reports are expected in early 2027.

This insights and summary publication spotlights key trends and themes, and key points of note and focus areas where long-term thinking, planning and investment are needed by the system.

Please read the full *State of Cancer 2025* report (available at teaho.govt.nz) for a complete picture of the overall performance of the cancer system over the last 5 years, including the full references and data sources used in the writing of the report and explanations of the terms used.

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