



MBS Review Advisory Committee

Colonoscopy Post- implementation Review

Final Report

February 2024

Contents

Abbreviations.....	4
Summary	5
Recommendations.....	7
Preamble.....	10
Medicare Benefits Schedule Continuous Review	10
Medicare Benefits Schedule Review Advisory Committee .	10
Medicare Benefits Schedule Continuous Review guiding principles	12
Government consideration.....	13
Background to the post-implementation review.....	14
Changes to MBS colonoscopy items.....	14
Post-implementation Review.....	15
Colonoscopy Working Group	16
Colonoscopy Working Group findings	17
Population.....	17
Intervention.....	18
Comparator	19
Outcomes	20
Assessment of main issues.....	21
Total colonoscopy items	21
Inequity of access for rural and low-socioeconomic populations	21
Lack of patient communication	22
Multiple claims for MBS item 32222.....	23
Information gaps and barriers to implementation.....	25
Missing information from MBS data	25
How colonoscopies are funded in Australia	25

References	26
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Abbreviations

CCS	Clinical Care Standard
CWG	Colonoscopy Working Group
Department	Department of Health and Aged Care
FOBT	faecal occult blood test
GP	general practitioner
IBD	inflammatory bowel disease
MBS	Medicare Benefits Schedule
MRAC	MBS Review Advisory Committee
NBCSP	National Bowel Cancer Screening Program
PIR	post-implementation review
SES	socioeconomic status

Summary

In 2021, colorectal cancer (also known as bowel cancer) was the fourth most diagnosed cancer in Australia and had the second highest cancer mortality rate (Australian Institute of Health and Welfare, 2021). Colonoscopy is the best way to diagnose colorectal cancer. In addition to modification of lifestyle risk factors that cause bowel cancer, colonoscopy can also help prevent colorectal cancer and is an important tool for managing inflammatory bowel disease (IBD). However, current access to colonoscopy services is not equitable, timely or appropriate, for many Australians, with people living in regional, remote, and low-socioeconomic areas being particularly disadvantaged. In 2018–19, the rate of Medicare Benefits Schedule (MBS)-subsidised colonoscopies was:

- 3.2 times higher in major cities than in remote areas
- 1.6 times higher in the highest socioeconomic areas than in the lowest (Australian Commission on Safety and Quality in Health Care, 2021; Australian Institute of Health and Welfare, 2021).

The number of colonoscopy services funded through the MBS has doubled in 20 years, with less than 300,000 MBS-funded colonoscopies performed in 2001–02 compared to more than 600,000 in 2021–22. The Gastroenterology Clinical Committee, established in 2015 as part of the MBS Review Taskforce (the Taskforce), identified concerns regarding the different patterns of servicing across the country and between practitioners, with variation in most services correlating with patient location and socioeconomic status (SES) (Gastroenterological Clinical Committee, 2016). The Committee noted that access to colonoscopy services may be compromised by a high volume of low-value services (asymptomatic low-risk patients undergoing too frequent screening), which may be contributing to decreased access for those in rural, remote, and low SES areas. To reduce the number of unnecessary colonoscopies and improve access to those with higher need, the Taskforce recommended that MBS items for surveillance colonoscopy services be restructured to align more closely with the Cancer Council Australia/National Health and Medical Research Council [Clinical practice guidelines for surveillance colonoscopy](#) (CCA/NHMRC guidelines) (Cancer Council Australia, 2018). These changes came into effect on 1 November 2019 and resulted in 8 new MBS items and the removal of 4 existing items (see [Changes to MBS colonoscopy items](#)).

Whenever changes are made to MBS items, they are subject to a post-implementation review. The standard timeframe for a post-implementation review is 24 months after MBS changes were effected, noting that this timeframe may vary where more or less data are needed to inform the review. The purpose of post-implementation reviews is to examine how the MBS items are being used in practice and to ensure that the item changes are achieving their intended outcomes.

In August 2022, the MBS Review Advisory Committee (MRAC) agreed to establish the Colonoscopy Working Group (CWG) to perform a post-implementation review of the 1 November 2019 changes to MBS-funded colonoscopy items. The CWG met 5 times over 2023 and reviewed 3 years of data on the new MBS items.

The CWG considered that the changes to the surveillance colonoscopy items had not achieved (and without amendment will not achieve over time) their intended outcomes of:

- reducing the number of low-value colonoscopies performed
- addressing equity issues:
 - lower rate of colonoscopies for people living in rural, remote, or low-socioeconomic areas, and Aboriginal and Torres Strait Islander populations (Australian Institute of Health and Welfare, 2022).
 - high out-of-pocket costs for private colonoscopy services remain.

Data from the National Bowel Cancer Screening Program (NBCSP) emphasise the inequity in access to colonoscopy, with rural, remote and low-socioeconomic populations being less likely to have a colonoscopy following a positive faecal occult blood test (FOBT; assessment rate of 43–53%) than those in metropolitan and high-socioeconomic areas (assessment rate of 62–74%) (Australian Institute of Health and Welfare, 2022). This low follow-up is despite these groups having a higher incidence of, and higher mortality from, bowel cancer.

Modelling using MBS claims for colonoscopies from 2001 to 2019 shows that only 10–14% of MBS-funded colonoscopies in Australia (until 2030) will be generated by positive FOBT screening through the NBCSP (Worthington, et al., 2023). As such, it is likely that many colonoscopies performed to exclude colon cancer are occurring independently of the NBCSP.

Limitations remain in assessing the appropriateness of repeat colonoscopies. The CWG were concerned that the most frequent repeat colonoscopies in the 3 years since the MBS item changes came into effect were for the MBS item for the assessment of people at normal risk of colon cancer and with no diagnosis of IBD (Department of Health and Aged Care), indicating that many repeat colonoscopies could be considered low-value care. More than 100,000 repeat colonoscopies were performed on people in this category in the past 3 years, with a large proportion of these repeats being performed by different providers over this period. The CWG were concerned that a lack of access to results of previous colonoscopy may be resulting in unnecessary repeat colonoscopy for people at low or normal risk of colon cancer.

Recommendations

Given the lack of information on appropriateness of colonoscopy and concerns that this is impacting on unnecessary repeats in low- or normal-risk individuals, the CWG recommends the following:

- 1. MBS items for colonoscopy services are amended to require the reporting of results to platforms that enable ready access to results by all healthcare providers.**

Explanatory note TN.8.152 (related to existing colonoscopy MBS items 32222–32229, and for application to any new colonoscopy items) to be amended to specify that all colonoscopy reports should be provided to the patient, the general practitioner (GP), the facility’s medical records department, and be uploaded on the same day as the procedure to the patient’s My Health Record (where one exists). The pathology report and follow-up recommendations relating to the episode of care to be also provided to the above and uploaded at a later date, noting that this should occur within a reasonable timeframe, such as 10 working days from the time of the procedure. A 3-year horizon could be included, to give endoscopists the opportunity to obtain appropriate software to interact with My Health Record.

This recommendation would support appropriateness of colonoscopy and aligns with [Quality Statement 9 of the Colonoscopy Clinical Care Standard](#) (Colonoscopy CCS) (Australian Commission on Safety and Quality in Health Care, 2020), which states:

The colonoscopist communicates the reason for the colonoscopy, its findings, any histology results and recommendations for follow-up in writing to the general practitioner, any other relevant clinician and the patient, and documents this in the facility records. Recommendations for surveillance colonoscopy, if required, are consistent with national evidence-based guidelines. If more immediate treatment or follow-up is needed, appropriate arrangements are made by the colonoscopist.

- 2. The Conjoint Committee for Recognition of Training in Gastrointestinal Endoscopy amends the recertification approval process to require compliance with Quality Statement 9 of the Colonoscopy CCS.**

To emphasise the importance of quality of care, this should include a requirement that the applicant confirms their compliance with Quality Statement 9 for cases submitted. Additionally, in their by-laws for accreditation to the facility, private hospitals are requested to include a requirement for compliance with Quality Statement 9, and that a copy of both the colonoscopy report and pathology report must be sent to medical records.

3. Improved education of both providers (including GPs, endoscopists and private hospitals) and patients is needed to promote high-quality colonoscopy.

Better communication with patients should be developed to inform their risk of bowel cancer, modifiable lifestyle risk factors, the maximum safe interval between a positive FOBT and diagnostic colonoscopy (120 days, according to the Clinical practice guidelines for the prevention, early detection, and management of colorectal cancer (Cancer Council Australia, 2023)) and the appropriate use of colonoscopy. These further resources should be developed by clinicians and organisations, such as Cancer Council Australia (alongside the clinical practice guidelines), along with the Department's Cancer Screening Programs Branch or Healthdirect, with guidance from consumer groups.

Better education is also needed for GPs and proceduralists around the increasing rate of early-onset bowel cancer in patients aged under 50 years, symptoms that lead to colonoscopy referrals, and the role of new tests in informing referrals (outside population screening). This includes the use of faecal calprotectin for IBD; the appropriate use of FOBT in symptomatic, low-risk individuals; and guidelines for the investigation of iron deficiency among people who menstruate. These resources could be developed by the Gastroenterological Society of Australia (GESA) in collaboration with the Australian Commission on Safety and Quality in Health Care.

The Department should reach out to stakeholders to determine other areas where education is lacking and who should be responsible for developing education materials.

4. The Department to encourage health agencies to promote or develop clinical decision support tools that inform the absolute risk of colon cancer for different age groups, for both patients and clinicians.

This includes helping to upscale tools already in development for widespread implementation. This would promote informed decision-making by empowering both consumers and clinicians to make shared decisions that support high-quality colonoscopy.

5. Improve equity of access for regional and remote populations by supporting ongoing development of the GP-endoscopist workforce through rural generalist training and expanding outreach models.

The CWG noted that a review of rural generalist training was currently under way; a greater focus on GP-endoscopist training could be incorporated in the program, noting that the improved focus should not have a detrimental impact to the current roles performed by GPs and nurses in a procedure.

Local health districts should map capacity for colonoscopy in their region and develop a visiting program for endoscopists to travel to disadvantaged areas. Training and broadening of the nurse endoscopist workforce should also be supported and can increase the capacity of visiting programs.

6. Separate the positive FOBT indication from MBS item 32222 and make it a stand-alone item.

Separation of the positive FOBT indication from the current MBS item 32222 descriptor will assist in the monitoring of appropriate use of colonoscopy. It will also improve interaction with the NBCSP to ensure that future changes to either the MBS or the NBCSP can be calibrated.

All other indications will remain under MBS item 32222.

It is believed that continuing to allow direct access to colonoscopy will improve equity of access for people in rural, remote, and low-socioeconomic areas.

The fee for the new FOBT specific item should be the same and remain unchanged from MBS item 32222.

Proposed item descriptor:

Category 3 – THERAPEUTIC PROCEDURES
GroupT8 - Surgical Operations
Subgroup2 – Colorectal
<p>Endoscopic examination of the colon to the caecum by colonoscopy, for a patient:</p> <p>(a) following a positive faecal occult blood test</p> <p>Applicable only once on a day under a single episode of anaesthesia or other sedation</p> <p>Multiple Operation Rule</p> <p>(Anaes.)</p> <p>Fee: \$368.00 Benefit: 75% = \$276.00</p> <p>(See para TN.8.2, TN.8.17, TN.8.152 of explanatory notes to this Category)</p>

Preamble

Medicare Benefits Schedule Continuous Review

The MBS is a list of health professional services (items) subsidised by the Australian Government for health consumers. MBS items provide patient benefits for a wide range of health services including consultations, diagnostic tests, therapies and operations.

The MBS Continuous Review builds on the work of the MBS Review Taskforce (the Taskforce). From 2015 to 2020, the Taskforce provided the first extensive, line-by-line review of the MBS since its inception in 1984.

In October 2020, the Australian Government committed to establishing a continuous review framework for the MBS, consistent with recommendations from the Taskforce Final Report.

Established in 2021, the MBS Continuous Review allows for ongoing rigorous and comprehensive reviews of Medicare items and services by experts, on a continuous basis, to ensure that the MBS works for patients and supports health professionals to provide high-quality care.

Medicare Benefits Schedule Review Advisory Committee

The MBS Continuous Review is supported by the MRAC. The Committee's role is to provide independent clinical, professional and consumer advice to Government on:

- opportunities to improve patient outcomes in instances where a health technology assessment by the Medical Services Advisory Committee (MSAC) is not appropriate
- the safety and efficacy of existing MBS items
- implemented changes to the MBS, to monitor benefits and address unintended consequences.

The MRAC comprises practising clinicians, academics, health system experts and consumer representatives. The current MRAC membership is listed in Table 1.

Table 1 Medicare Benefits Schedule Review Advisory Committee members, October 2023

Member	Speciality
Conjoint Professor Anne Duggan (Chair)	Policy and Clinical Adviser / Gastroenterology
Ms Jo Watson (Deputy Chair)	Consumer Representative
Dr Jason Agostino	General Practice / Epidemiology / Indigenous Health
Dr Matt Andrews	Radiology
Professor John Atherton	Cardiology
Professor Wendy Brown	General Surgeon – Upper Gastrointestinal and Bariatric Surgery
Ms Janette Donovan	Consumer Representative
Professor Adam Elshaug	Health Services / Systems Research
Ms Margaret Foulds	Psychology
Associate Professor Sally Green	Health Services / Systems Research
Adjunct Associate Professor Chris Helms	Nurse Practitioner
Professor Harriet Hiscock	Paediatrics
Ms Alison Marcus	Consumer Representative
Associate Professor Elizabeth Marles	General Practice / Indigenous Health and Health Policy
Dr Sue Masel	Rural General Practice
Professor Christobel Saunders	General Surgeon – Breast Cancer and Reconstructive Surgery
Associate Professor Ken Sikaris	Pathology
Ms Robyn Stephen	Paediatric Speech Pathology
Associate Professor Andrew Singer	Principal Medical Adviser, Department of Health and Aged Care

Medicare Benefits Schedule Continuous Review guiding principles

The following principles guide the deliberations and recommendations of the MBS Continuous Review:

a) The MBS:

- is structured to support coordinated care through the health system by
 - recognising the central role of General Practice in coordinating care
 - facilitating communication through General Practice to enable holistic coordinated care
- is designed to provide sustainable, high-value, evidence-based and appropriate care to the Australian community
 - item descriptors and explanatory notes are designed to ensure clarity, consistency and appropriate use by health professionals
- promotes equity according to patient need
- ensures accountability to the patient and to the Australian community (taxpayer)
- is continuously evaluated and revised to provide high-value health care to the Australian community.

b) Service providers of the MBS:

- understand the purpose and requirements of the MBS
- utilise the MBS for evidence-based care
- ensure patients are informed of the benefits, risks and harms of services, and are engaged through shared decision making
- utilise decision support tools, Patient Reported Outcome and Experience Measures where available and appropriate.

c) Consumers of the MBS:

- are encouraged to become partners in their own care to the extent they choose
- are encouraged to participate in MBS reviews so patient healthcare needs can be prioritised in design and implementation of MBS items.

The MRAC and its working groups recognise that General Practice general practitioners are specialists in their own right. Usage of the term ‘General Practice’, both within this report and in the MBS itself, does not imply that general practitioners are not specialists.

The MRAC notes that the MBS is one of several available approaches to funding health services. The MRAC and its working groups apply a whole-of-healthcare-system approach to its reviews.

Government consideration

If the Australian Government agrees to the implementation of recommendations, it will be communicated through Government announcement.

Information will also be made available on the Department of Health and Aged Care websites, including MBS Online, and departmental newsletters.

Background to the post-implementation review

Between 2015 and 2016, there were more than 600,000 MBS-funded colonoscopies (under MBS items 32090 and 32093) performed in Australia (Services Australia, 2023). The MBS Review Taskforce considered that this possibly represented overutilisation – especially in metropolitan areas and among high-socioeconomic groups – and was concerned that some colonoscopies were being performed when they were not clinically necessary. The Taskforce therefore recommended that the structure of colonoscopy MBS items be revised to clarify appropriate frequency intervals for colonoscopies based on individual patient risk of developing colorectal cancer, and to better align payment of MBS benefits with best clinical practice for appropriate colonoscopy.

The aims of the revised structure were to:

- facilitate the provision of effective, evidence-based colonoscopy services
- reduce low-value care
- improve appropriate access to MBS-funded colonoscopy.

Changes to MBS colonoscopy items

An Implementation Liaison Group was established from the Gastroenterological Clinical Committee in early 2018. The role of the group was to develop new items to replace colonoscopy MBS items 32088, 32089, 32090 and 32093.

Following stakeholder feedback, the new items were developed in conjunction with key stakeholders, including GESA and the Colorectal Surgical Society of Australia and New Zealand. The then Department of Health presented the changes to key stakeholders at forums, circulated communication materials to relevant professional groups, and encouraged dissemination of these materials to their members. Information was also made available on MBS Online.

On 1 November 2019, 8 new MBS items were implemented. These were:

- 7 MBS items (32222 to 32228) for endoscopic examination of the colon to the caecum by colonoscopy
- 1 MBS item (32229) for the removal of one or more polyps during colonoscopy, in association with a service to which items 32222–32228 apply.

Additionally, 4 MBS items that were either replaced by, or consolidated into, the new items were deleted. These were MBS items 32090, 32093, 32088 and 32089.

A new explanatory note (TN.8.152) was also included to detail the appropriate use of items 32222–32229. Two existing explanatory notes (TN.8.17 and TN.8.134) were amended to remove deleted item numbers and add reference to the new item numbers.

Some item numbers were updated in May 2020 and March 2021 to either:

- reflect modern clinical practice
- ensure consistency with the CCA/NHMRC guidelines
- address stakeholder concerns.

Post-implementation Review

Whenever changes are made to MBS items, they are subject to a post-implementation review. The standard timeframe for a post-implementation review to commence is 24 months after MBS changes were effected, noting that this timeframe may vary where more or less data is needed to inform the review.

The purpose of a post-implementation review is to examine how the MBS items are being used in practice and to ensure that the item changes are achieving their intended outcomes.

Consultation and feedback review process

Consultation with relevant and interested organisations, peak bodies and consumers is considered essential in the formulation of advice to Government on recommended changes to MBS items. The MRAC and its working groups seek feedback on their understanding of the existing model of care and issues of consideration, with particular emphasis on any (yet) unidentified consequences that may result from proposed changes.

All feedback provided through consultation processes is considered.

Public consultation

The CWG findings report was presented to the MRAC at its meeting on 8–9 August 2023. The MRAC provided further comments and endorsed the report for public consultation.

The CWG findings report was published on the Department's Consultation Hub for a 6-week public consultation period between 18 August and 29 September 2023. A total of 30 submissions was received during the consultation period, comprising 13 responses from organisations, 12 responses from healthcare consumers and 5 responses from individual healthcare providers. Most submissions were supportive of the intent of the recommendations.

The CWG considered all feedback and made its final recommendations at its fifth meeting on 12 October 2023.

Colonoscopy Working Group

The CWG was established as a subgroup of the MRAC to provide the Committee with a post-implementation review of the 1 November 2019 changes to colonoscopy MBS items. The CWG comprises MRAC members, including endoscopists, general practitioners and a consumer representative.

The Working Group was established as a subgroup of the MRAC to provide the Committee with a post-implementation review of the 1 November 2019 changes to Colonoscopy MBS items. The Working Group is comprised of several MRAC members that conduct the review and provide expert advice to the full MRAC.

The CWG met on 4 occasions: Friday 3 February, Wednesday 22 March, Thursday 20 April and Thursday 22 June.

Colonoscopy Working Group findings

The CWG considered the PIR in line with the PICO framework (population, intervention, comparator, outcomes).

Population

The CWG noted that the aim of the changes to colonoscopy MBS items was to address repeat colonoscopies and repeat intervals, particularly for average-risk populations.

The CWG considered that many repeat colonoscopies continued to be performed for seemingly inappropriate purposes, largely within MBS item 32222; in the 3 years since the MBS item changes (November 2019—November 2022), over 100,000 people had repeat colonoscopies under item 32222, with a large proportion of these repeats being performed by different endoscopists (Department of Health and Aged Care).

The CWG also considered that increased prevalence of iron deficiency in young females had contributed to an increased number of colonoscopies being performed in this population. The rate of colonoscopy among females aged 15–54 years was up to double that of males of the same age; outside of this age range, rates of colonoscopy were only 10% higher among females compared to males (Department of Health and Aged Care). Clear guidance around the investigation and management of iron deficiency in premenopausal females is needed to assist with addressing this issue, especially as heavy menstrual bleed is under-recognised and potentially a driver of inappropriate referral to an endoscopist. As females who menstruate may present with bowel cancer (Australian Institute of Health and Welfare, 2022), it is important that practitioners consider the possibility of this, noting that risks associated with complications of colonoscopy, such as perforation, should also be considered (as for all patients referred for the service). However, the CWG also noted that this group may be more likely to present with other symptoms or blood tests requiring further investigation, so this was a complex area.

The CWG also considered that there were still problems with inequity, with rural, remote, low-socioeconomic, and Aboriginal and Torres Strait Islander populations having lower rates of colonoscopies than those in metropolitan, high-socioeconomic groups and areas, and compared with non-Indigenous Australians. The CWG considered that the identified populations reflect:

- workforce and access issues
- financial barriers, including out-of-pocket expenses for patients, lack of incentives for endoscopists from metropolitan areas to travel to rural and remote areas, and the funding of colonoscopy by small public hospitals
- potentially, a lower rate of screening in some areas.

The CWG also noted that the identified populations were less likely to have a colonoscopy following a positive FOBT (assessment rate of 43–53%) than those in metropolitan and high-socioeconomic areas (assessment rate of 62–74%) (Australian Institute of Health and Welfare, 2022).

The CWG noted that many people have trouble accessing public colonoscopy services, particularly after a positive FOBT, and there are almost inevitably additional costs outside of the MBS for procedures performed in the private sector – the average cost for colonoscopy and biopsy is \$280 above the MBS rebate (for consumers with private health insurance), with any uncovered hospital costs, pathology and anaesthesia potentially added to that (Department of Health and Aged Care, 2023). The CWG also noted that only 20% of colonoscopies are bulk billed.

Intervention

The CWG considered that it was too early to tell whether the item changes had reduced the number of repeat colonoscopies. However, the changes had not been effective in reducing the total number of colonoscopies and therefore the associated cost of colonoscopies to the MBS, nor had they improved equity of access.

Along with the gap in colonoscopy rates for different populations, the CWG noted that patient anxiety may be negatively impacted if there is a lack of communication with patients regarding how changes to MBS items for colonoscopy services may affect their colonoscopy interval.

The CWG also considered that the long waitlist for public colonoscopy services causes anxiety for patients who have had a positive FOBT, which can lead to them feeling forced to seek private colonoscopy services. As such, the CWG considered that discussions should be had with private health insurers to ensure they support high-quality colonoscopy. The CWG was also aware of several successful jurisdictional initiatives to improve timely access to colonoscopy in the public sector by reviewing the appropriateness of indications against guideline recommendations as part of continuous quality improvement activities.

Additionally, if FOBT kits are provided through GPs, they can communicate the risk to the patient – however, most kits are sent directly to the patient. While most NBCSP kits are posted directly to eligible screeners by the National Cancer Screening Register, GPs do have the ability to issue NBCSP kits directly to eligible patients which provides an opportunity to discuss risks.

The CWG acknowledged that some patients were also inconvenienced by deferred procedures and the inflexibility of recall timing, noting a lack of a grace period for procedures performed outside of set time intervals that resulted in procedures not being payable through the MBS. However, the CWG considered that this did not significantly impact the patients' absolute risk of developing cancer between colonoscopies.

The CWG also noted anecdotal evidence that patients were concerned about being asked to come back for a separate procedure because clinicians may not perform a gastroscopy and colonoscopy with polypectomy on the same day, due to the financial impact of the multiple operation rule. However, the CWG noted that this was not reflected in the data, as less than 0.01% of colonoscopies had a gastroscopy in the following 6 months.

Overall, the CWG considered that there were opportunities for educating both practitioners and patients, including having greater involvement of GPs in the NBCSP, and working with both GPs and gastroenterologists on the appropriateness of direct colonoscopy referrals. The CWG considered that this could be done through a visiting program.

The CWG considered that a possible MBS solution to the problem of lack of access to previous results could be to modify the item descriptors to require the upload of colonoscopy reports and pathology results for reimbursement (that is, temporarily withholding payment of MBS item 32229 until pathology is received). Initially, this would be to a patient's My Health Record, and to the National Bowel Cancer Screening Register or another register fit for purpose in supporting high-value colonoscopy. However, logistics considerations would need to be explored with Services Australia, and there were also concerns around the impact of up-front costs for patients.

The CWG also noted that Quality Statement 9 of the Colonoscopy CCS states that:

The colonoscopist communicates the reason for the colonoscopy, its findings, any histology results and recommendations for follow-up in writing to the general practitioner, any other relevant clinician and the patient, and documents this in facility records. (ACSQHC, 2020)

However, compliance with Quality Statement 9 is currently not required for an endoscopist's certification/recertification, nor is it required for accreditation to the facility in which they work. The CWG considered that, if this was a requirement for certification and accreditation, it would ensure that every colonoscopy (done in both the public and private sectors) is followed by a report that becomes part of a patient's medical records and is sent to their GP. This would increase medical transparency, allow more clinicians to find a patient's previous report, and also comply with the Australian Charter of Healthcare Rights.

The CWG acknowledged that there needs to be simple, efficient systems in place that allow clinicians to not only report results, but also retrieve data in a useful format for both them and their patients.

Comparator

The CWG considered that other ways to address the issues around colonoscopy items include:

- improving communication with patients

- better engaging General Practice and Primary Care in bowel screening and the assessment of people with iron deficiency and anaemia
- incentivising clinicians (including endoscopists, anaesthetists and nursing staff) to work in disadvantaged areas. This may include supporting existing programs and organisations that encourage proceduralists to visit these areas (for example, [CheckUP](#)).

The CWG also considered that the training and broadening of both the nurse endoscopist and rural generalist workforce should be supported, as this could be a way of improving access for disadvantaged populations in the future. It was noted that both these workforce groups make up a very small proportion of the total clinicians performing colonoscopy in Australia.

Regarding potential new interventions, the CWG noted that computed tomographic (CT) colonography was emerging, but it still required bowel preparation and could not provide histopathology. The CWG considered that the role of CT colonography in screening assessment has yet to be fully defined.

Outcomes

The CWG considered that the implemented changes had neither achieved their purpose nor were on track to do so. Further, the benefits for patients and the healthcare system have not been realised at this stage.

Assessment of main issues

Total colonoscopy items

The CWG noted that there had not been a reduction in the number of claims for colonoscopy items on the MBS following the 2019 changes. The CWG considered that this may be due to:

- the ability of providers to directly refer patients for colonoscopy
- a lack of clarity around time frames for follow-up colonoscopies based on the findings of the current colonoscopy
- potential misinterpretation of the likelihood of bowel cancer, particularly for women with heavy menstrual bleeding.

Some overseas population screening programs overseas recommend repeat colonoscopies every 10 years after an initial, low-risk colonoscopy finding. In the Australian context, NBCSP participants who have had a low-risk colonoscopy finding skip the next round of iFOBT screening in accordance with the NHMRC endorsed Clinical practice guidelines for the prevention, early detection, and management of colorectal cancer. However, it remains at a participant's discretion if they instead choose to resume screening with an FOBT every two years. The CWG considered that there needs to be better education of, and communication with, patients and GPs on appropriate intervals for repeat colonoscopy in the context of an individual's health needs outside population screening and as it relates to population screening.

Inequity of access for rural and low-socioeconomic populations

The CWG noted that the populations with the highest risk of developing, and likelihood of dying from, bowel cancer (those who live in remote or low-socioeconomic areas or are from Aboriginal and Torres Strait Islander populations) are the least likely to have colonoscopies. This is likely due to a lack of available workforce and the potential for out-of-pocket costs.

The CWG considered that a way to remove a barrier for priority populations was to allow direct access to colonoscopy following a positive FOBT or for those with a positive history of blood in the stool, providing they had not had a recent colonoscopy. This would mean that they would not have to pay to consult with an endoscopist prior to colonoscopy.

The CWG also noted that the NBCSP now facilitates the ability for GPs to order and issue program kits directly to patients, with the aim of increasing uptake in the program by under-or-never screeners, with a focus on Aboriginal and Torres Strait Islander people and people living in rural and remote locations. This option is additional to the existing ability of GPs being able to interact with the National Cancer Screening Register to check patients screening status and request a kit be sent to their nominated mailing address. Based on advice of a healthcare provider,

this may also support more patients who are receiving regular colonoscopies to opt out or defer from the NBCSP.

The NBCSP is an area of focus as the CWG recognises that population screening programs involve uncovering diseases early in asymptomatic people when treatment is most effective. Data show that people with a positive FOBT result can often face difficulties accessing timely colonoscopy services within the public health system. This access challenge is especially difficult for people in rural, remote, and low-socioeconomic areas, where accessing and affording specialist consultation is challenging. It is known that 70% of colonoscopies are performed in the private sector, and without private health insurance, most patients incur significant out-of-pocket costs (Department of Health and Aged Care).

The CWG noted that the NBCSP has a hot-zone policy that is managed through the scheduling of invitations to be sent in the cooler months of the year for relevant postcodes. This means that there are postcodes where invitations are limited to a 3–6-month window per year.

The CWG considered that another possible way to promote uptake in disadvantaged areas was to offer bulk-billing incentives. However, the CWG acknowledged that changes to the colonoscopy MBS items alone would be insufficient to overcome the other cost barriers from non-privately insured patients and may result in cost shifting.

Lack of patient communication

The CWG were concerned about the lack of communication to patients about pathways outside of bowel screening, particularly for those not included in the NBCSP surveillance group (for example, premenopausal females).

The CWG noted that MBS item usage data show that post-menarche, premenopausal females continue to have many more colonoscopies than their male counterparts of the same age (Department of Health and Aged Care). The CWG were concerned that other causes of iron deficiency anaemia, such as heavy menstrual bleeding or diet, may not be appropriately considered in these females, and that they are possibly being referred for low-value colonoscopy procedures. The CWG considered that there needs to be clear guidance around the evaluation of bowel symptoms and iron deficiency in younger females, but that this was an issue that could only partly be solved through MBS items. This guidance could be developed by the Australian Commission on Safety and Quality in Health Care.

The CWG considered that it was important to provide people with information that gives a balanced message, rather than messaging that may increase patient anxiety. Therefore, the CWG considered that information on bowel cancer rates per population should be better communicated to the public, to inform younger people about their absolute risk of bowel cancer and build public understanding of appropriate clinical screening intervals. Such resources could be developed by clinicians and organisations such as the Cancer Council, the Department's

screening branch or Healthdirect using readily available data from the Australian Institute of Health and Welfare, and be guided by consumer groups.

The CWG also considered it important that patients are informed that a wait time of up to 120 days between a positive FOBT and colonoscopy is not associated with poorer clinical outcomes, even if cancer is present (and there is no evidence of worsening prognosis) (Cancer Council Australia). Regarding this, the updated Colonoscopy CCS could also include that hospitals must report any patients who have waited more than 120 days for a colonoscopy.

Multiple claims for MBS item 32222

When the Implementation Liaison Group discussed the changes to colonoscopy MBS items in 2018, it recommended a once-a-day service interval on repeats claimed under MBS item 32222. While the CWG noted that it is likely that some low-value colonoscopies are being billed to this item, it is currently not possible to determine the number of claims for each indication under this item, making further analysis into the specific use difficult.

The CWG considered that it may be useful to separate the first indication (positive FOBTs) from the rest of the indications, as this would allow:

- measurement of the number of colonoscopies being performed for that indication
- a request to be included in the item explanatory notes that the result be reported back to the National Bowel Cancer Screening Register
- restriction on the number of repeats
- direct access to be encouraged for that indication (within an explanatory note), which could incentivise its use in disadvantaged populations (the CWG acknowledged this would require improving GP education around symptoms that lead to colonoscopy referrals).

The CWG noted that, in the 3 years since implementation of the item changes, more than 100,000 claims for MBS item 32222 were for repeat colonoscopies. The median spacing between repeat colonoscopies was approximately 12 months. Further, the vast majority of repeat claims for item 32222 were by different endoscopists (than the initial claim). There is concern that unnecessary, repeat colonoscopies are being performed because of a lack of available information on recent results. A contributing factor could be open access services that do not require this information to be provided.

The CWG considered that a possible way to improve this would be to require the uploading of both colonoscopy and pathology reports to a patient's My Health Record (where one exists). The CWG considered that, as an initial step, the explanatory note TN.8.152 could be amended to request that all colonoscopy reports and pathology results be uploaded to My Health Record. The Department could then explore how to mandate this within 3 years, which would allow providers enough time to acquire appropriate software.

The CWG considered that the faecal calprotectin test, which was made available on the MBS in November 2021 via MBS items 66522 and 66523, could be further utilised as a first line test prior to referring for colonoscopy in appropriate patient cohorts. Claims for MBS item 66522 have rapidly increased since introduction, but their impact on colonoscopy referrals in Australia is not yet fully understood.

Information gaps and barriers to implementation

Missing information from MBS data

For MBS items covering several indications, such as MBS item 32222, it is difficult to know from MBS data alone why the service was provided. This makes it difficult to draw definitive conclusions on whether there have been improvements in high-value colonoscopy.

The CWG considered that it should be possible to link the performance of iron or elastase studies in the previous 3–6 months with a colonoscopy, and if there is admission data, any colonoscopies done within 6–12 months after a surgical procedure. This may assist in understanding why MBS item 32222 is being claimed. Furthermore, if these data were to be broken down by demographic, it may provide evidence of a high frequency of iron studies followed by colonoscopy in females who menstruate.

The CWG noted that the most common repeat colonoscopies have been claimed through MBS item 32222, and that a large proportion of repeat claims for item 32222 were by a different provider to the initial claim. This raises a concern that the repeat colonoscopies were performed because the second (or subsequent) provider was not able to obtain, or did not inquire about, a patient's complete history, but this has not been confirmed.

How colonoscopies are funded in Australia

The CWG considered that there are 8 categories for how colonoscopies are funded in Australia. These are:

1. public hospitals with public patients as inpatients
2. public hospitals with private patients as inpatients
3. public hospitals with outpatients
4. private hospitals
5. patients who pay the full out-of-pocket costs
6. Department of Veterans' Affairs

And potentially through

7. transport accident compensation
8. workers compensation.

The first 4 categories cover the vast majority of colonoscopy in Australia. Data from 2021–22 show that, within these 4 categories, over 70% of colonoscopy are performed in private hospitals, and the vast majority are as same day procedures.

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