

The Auditor-General
Audit Report No.50 2000–2001
Performance Audit

The National Cervical Screening Program

Department of Health and Aged Care

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of Australia 2001
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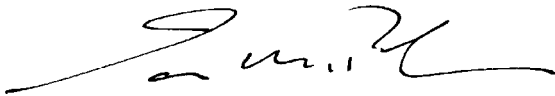
Canberra ACT
15 June 2001

Dear Madam President
Dear Mr Speaker

The Australian National Audit Office has undertaken a performance audit in the Department of Health and Aged Care in accordance with the authority contained in the *Auditor-General Act 1997*. I present this report of this audit, and the accompanying brochure, to the Parliament. The report is titled *The National Cervical Screening Program*.

Following its tabling in Parliament, the report will be placed on the Australian National Audit Office's Homepage—
<http://www.anao.gov.au>.

Yours sincerely



Ian McPhee
Acting Auditor-General

The Honourable the President of the Senate
The Honourable the Speaker of the House of Representatives
Parliament House
Canberra ACT

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Abbreviations/Glossary

AAPP	Australian Association of Pathology Practices
AHMAC	Australian Health Ministers' Advisory Council
AIHW	Australian Institute of Health and Welfare
ANAO	Australian National Audit Office
ATSIC	Aboriginal and Torres Strait Islander Commission
colposcopy	An examination of the vagina and the neck of the uterus by means of a specially designed instrument called a colposcope.
CCSER	Cervical Cancer Screening Evaluation Report
DHAC	Department of Health and Aged Care
GPs	General Practitioners
HAFD	Health Access and Financing Division (of the Department of Health and Aged Care)
HIC	Health Insurance Commission
JCPAA	Joint Committee of Public Accounts and Audit
MAB–MIAC	Management Advisory Board—Management Improvement Advisory Committee
MSAC	Medicare Services Advisory Committee
NAC	National Advisory Committee
NACCHO	National Aboriginal Community Controlled Health Organisations
NATA	National Association of Testing Authorities Australia
NCSP	National Cervical Screening Program
NHMRC	National Health and Medical Research Council
NHS	National Health Service
NPAAC	National Pathology Accreditation Advisory Council
NSIAG	National Screening Information Advisory Group
OATSIH	Office of Aboriginal and Torres Strait Islander Health
PHOFA	Public Health Outcome Funding Agreement
PPED	Primary Prevention and Early Detection Branch

RCPA QAP	RCPA Quality Assurance Programs Pty Ltd
RCPA	Royal College of Pathologists of Australasia
SPPs	Specific Purpose Payments
squamous cell carcinoma	Abnormalities of the cervical epithelium (cancer precursors) can be detected through a Pap smear test and treated successfully. Where pre-cancerous lesions cannot be detected, diagnosis of cancer at its earliest stage is the best alternative. Of the cancers detected, squamous cell carcinomas are the most common. Thus, cervical screening programs should result in a reduction in squamous cell cancer incidence and mortality.

Summary and Recommendations

Summary

Introduction

1. The National Cervical Screening Program (NCSP) was introduced as result of a 1990 report, *Cervical Cancer Screening in Australia—Options for Change*,¹ to the Australian Health Ministers' Advisory Council (AHMAC). AHMAC accepted the recommendations of the report and, in June 1992, the Commonwealth, States and Territories established a program, the 'Organised Approach to Preventing Cancer of the Cervix'. In 1995, the name of the Program was changed to the National Cervical Screening Program.

2. The structure of the Program reflects the recommendations from *Options for Change*. The Department of Health and Aged Care's (DHAC) role in the Program is to exercise leadership at the national level. In addition, the Commonwealth is the primary funder of the NCSP, through Medicare. At the core of the Program is a National Advisory Committee (NAC). This Committee was formed to provide policy advice to AHMAC. DHAC's leadership role is exercised through support for the NAC by coordinating NCSP activities with the activities of other programs administered by the department and by the provision of secretariat, project and policy development services to the NAC. The department also provides advice to the Commonwealth Minister of Health and Aged Care on cervical screening matters.

3. Under the auspices of the national Program, each State and Territory is responsible for administering various aspects of the Program at the local level, including State and Territory Cervical Cytology Registers (often known as Pap smear registers). In order to discharge their obligations under the NCSP, the States have established State Cervical Screening Programs.² In the ACT cervical screening is a component of the ACT Women's Health Program; while, in the Northern Territory, cervical screening is a component of the Northern Territory Women's Cancer Prevention Program. DHAC administers Commonwealth funding assistance to the States and Territories for their cervical screening programs provided through the Public Health Outcome Funding Agreements (PHOFAs). DHAC also administers the provision of funding

¹ Australian Institute of Health, 1991, *Cervical Screening in Australia—Options for Change*, AGPS.

² See para 2.16.

for the taking and processing of Pap smears through Medicare. Further, DHAC administers funding through Health Program Grants to certain providers for the processing of Pap smears in public and private sector pathology laboratories.

The National Cervical Screening Program

4. Cervical cancer is the fourteenth most common cancer affecting Australian women. Australian women have been screened for cervical cancer since the 1960s. Pap smears, the usual means of screening, are usually taken by general practitioners. The smears are analysed by pathology laboratories. The taking and processing of Pap smears by eligible practitioners attracts a Medicare subsidy. DHAC has informed the ANAO that the 1999–2000 Medicare expenditure on Pap smears and pathology was \$84.2 million. This does not include Commonwealth funding under the PHOFA agreements (which cannot be disaggregated, but which represented over \$5 million in 1994–95 prices); funding for national recruitment activities (representing a further \$4.8 million over the three years to 1999–2000); nor funding under the Health Program Grants. Also not included is funding provided from State and Territory sources.

5. The Program is widely accepted by women, service providers and other stakeholders. Participation in the Program has risen from an estimate of around 50 per cent of the target population in the late 1980s to 64 per cent in 1997–98.³ The age-standardised⁴ rate of cervical cancer per 100 000 women for ages 20–69 (the target group) fell from 18.0 in 1986 to 12.8 in 1996, a fall of 28.9 per cent.⁵ The age-standardised death rate from cervical cancer per 100 000 women for ages 20–69 has fallen by 40.8 per cent, from 4.9 to 2.9 over the same period.⁶ Despite these improvements, the Program still faces major challenges. For instance, data from Western Australia, South Australia, and the Northern Territory show that the age-standardised death rate for Indigenous women is about six to nine times higher than for non-Indigenous women.⁷

³ Department of Health and Aged Care 2000 *A Decade of Change: A Report on Australia's National Cervical Screening Program, 1989-1999*, Canberra, p. 8.

⁴ Age standardised rates facilitate comparisons between populations that have different age structures, for example, between youthful and aging communities.

⁵ Australian Institute of Health and Welfare, 2000, *Cervical Screening in Australia, 1997–98*, Canberra, p. 48.

⁶ *ibid*, p. 55.

⁷ *ibid*, pp. 31 and 63.

Audit objective

6. The objective of the audit was to provide an assurance to Parliament that the DHAC's administration of the National Cervical Screening Program is sound.

Scope

7. The audit focused on DHAC's administration of the National Cervical Screening Program. It also examined the links between the NCSP and other programs administered by DHAC. However, with one exception, the audit did not examine DHAC's administration of these other programs in detail. The exception was, where in order to determine whether quality assurance procedures for the processing of Pap smears were complete, the ANAO examined DHAC's oversight of pathology-industry quality assurance procedures.

8. The Health Insurance Commission's (HIC) administration of the payment of Medicare benefits for pathology services provided in relation to the NCSP was included in the scope of the audit, to the extent that it impacted on DHAC's administration of the Program.

Overall conclusion

9. The ANAO concluded that DHAC's administration of the National Cervical Screening Program is generally sound. The ANAO found that the department has a key role in the Program by providing secretariat services and other support to the NAC, which provides policy advice to AHMAC, and by supporting initiatives to further develop the Program. Some areas of DHAC's administration of the Program provide examples of good practice. Related examples are the early identification of the need to monitor the Program, the early identification of possible data sources for monitoring, and the use of an independent body to provide advice, through the Australian Institute of Health and Welfare, on performance indicators and data sources. A further example is DHAC's administration of the provision of cervical screening funding assistance to the States and Territories through Public Health Outcome Funding Agreements, which complies with the principles for sound Specific Purpose Payments program administration advocated by the Joint Committee of Public Accounts and Audit in their Report 362. On the other hand, the ANAO has identified areas for improvement in quality assurance for the analysis of Pap smears by pathology laboratories.

Key Findings

DHAC is exercising its leadership role through coordinating the activities of the NCSP with other programs administered by the department.

10. An examination of files and consultation with program managers in a number of areas in the department led the ANAO to conclude that DHAC is, on the whole, effectively coordinating the activities of the NCSP with other programs administered by the department.

DHAC is playing a positive role in ensuring that the activities of the States and Territories are coordinated.

11. State and Territory strategic and business plans have either adopted or endorsed the goals and priorities of the NCSP. The same performance indicators and performance targets are used to assess the performance of all States and Territories.

The National Advisory Committee (NAC), which provides policy advice to the Australian Health Ministers' Advisory Council, plays a key role in the success of the Program.

12. The NAC provides a venue for the views of all relevant parties to be heard, and ensures that a broadly consistent approach is adopted in key areas across Australia. Wide membership, including all States and Territories, provides a sound basis for coordinating the Program.

There is no yardstick, such as a service provision protocol with the NAC, against which DHAC could measure the provision of secretariat services to the NAC.

13. A service provision protocol would provide a yardstick by which DHAC could measure its provision of secretariat services to the NAC and its Working Groups. In addition, a service provision protocol would ensure that the NAC and Working Groups held realistic expectations of the services the secretariat could reasonably be expected to provide.

The use of independent bodies to advise on, collect and publish the information needed for policy analysis and Program monitoring is an example of good practice.

14. The ANAO considers that the identification during Program development of the need to monitor the Program and the early identification of possible data sources, combined with the use of an independent data advisory body, is an example of good practice. This

has allowed the Program to provide valid performance indicators. The Australian Institute of Health and Welfare Health Registers and Cancer Monitoring Unit, advised by the National Screening Information Advisory Group, has developed data standards that have been accepted by the NAC and the States and Territories. These standards ensure that data for performance indicators are consistent and reliable.

The outcome performance indicators published for the Program allow monitoring of performance against Program objectives.

15. There are comprehensive outcome performance indicators, with reliable annual data, available to allow an assessment of the performance of the NCSP in meeting its goals. Information on the cost of the Program is not readily available from administrative records. The Program's cost-effectiveness is assessed by periodic (approximately five yearly) rather than annual studies. These studies prepare estimates of the current cost of the Program and compare these costs with alternate policy approaches and with previous estimates of the cost of the Program. A cost-effectiveness study will be completed in 2001.

DHAC is considering further outcome and output targets for the Program, which will improve the ability to monitor outcomes.

16. At present, there is only one performance target in the PHOFAs relevant to the Program's outcome performance indicators. DHAC has advised that it is currently analysing the financial implications for Medicare of further outcome and output targets proposed by the NAC. Subject to funding availability, these indicators will be incorporated into the PHOFAs. In the interim, all States and Territories have agreed to their introduction.

It has taken nine years for the Program to mature to the stage where data for performance indicators are published for all States and Territories.

17. The NCSP was approved in 1992. The responsibility for developing Cervical Cytology Registers, which provide the data for performance indicators, was assigned to the States and Territories. The last State Cervical Cytology Register came on line in 1999. National performance data covering all States and Territories is now available and will be published for the first time in May 2001. The amount of time necessary before performance data are available on the Program in each State is partly explained by the devolved model of program implementation, wherein the States and Territories are responsible for establishment of registers with data on cervical screening.

The administration of funding assistance to the States and Territories for the NCSP through Public Health Outcome Funding Agreements (PHOFAs) complies with principles advocated by the Joint Committee of Public Accounts and Audit (JCPAA).

18. The JCPAA provided, in Report 362, a list of principles for sound Specific Purpose Payments program administration. The ANAO found that DHAC's administration of PHOFAs in respect of the NCSP complied with the JCPAA's principles.

DHAC has not prepared a risk management plan for the NCSP, either separately, or as a part of planning for the administration of the NCSP.

19. At the time of audit fieldwork DHAC did not have a risk management plan for the NCSP or for its administration of the NCSP, as required by departmental policy. The relevant division and branch plans for the financial year 1999–2000 did not identify risks. As a consequence, DHAC was unable to demonstrate that all major or significant risks to the NCSP and its administration of the NCSP have been identified, assessed, ranked, treated, monitored and reviewed. A risk management plan, consistent with good corporate governance and as required by departmental policy, would assist in the allocation of limited administrative resources.

20. DHAC, in conjunction with the NAC, has identified the following areas of the NCSP as priorities for the Program:

- recruitment—access and equity;
- early re-screening;
- new technologies; and
- quality assurance.

21. In addressing these priorities, DHAC and the NAC have addressed a number of major risks to the Program. DHAC has advised the ANAO that it had identified the need for a risk management plan (i.e. prior to the commencement of the audit), and had commenced work on its development. DHAC has informed the ANAO that a risk management plan will be developed for the NCSP during 2000–2001.

Most major elements necessary for a sound quality assurance program for pathology laboratories (including those analysing Pap smears) are in place.

22. The current pathology quality assurance system (including quality assurance for the processing of Pap smears) is the result of more than a decade of effort by the Royal College of Pathologists Australasia (RCPA), the pathology industry, the National Pathology Accreditation Advisory Council (NPAAC), the National Association of Testing Authorities

(NATA) and DHAC. In addition, impetus has also come from programs such as the NCSP, with an interest in pathology quality control. The need for quality assurance is now widely accepted within the pathology industry.

Stewardship of the pathology quality assurance system (including the analysis of Pap smears) needs to be clarified.

23. The ANAO expected to find that responsibility for stewardship of the pathology quality assurance system was clearly assigned. The ANAO was unable to identify a position or body with clear responsibility for the oversight of the pathology quality assurance system.

The HIC does not have information on the performance against quantitative standards of laboratories processing Pap smears between Medicare accreditation inspections, although this information is collected by the pathology quality assurance program.

24. To be eligible for Medicare payments (including payments for the processing of Pap smears), pathology laboratories must be accredited by the HIC. Inspections of pathology laboratories for Medicare accreditation can occur at intervals of up to three years. Information on the performance of pathology laboratories against gynaecological (cervical) cytology quantitative performance standards is published by a company⁸ associated with the Royal College of Pathologists of Australasia. However, this information does not identify individual laboratories. Access to performance information on individual laboratories by the HIC would provide an assurance that pathology laboratory quality standards were being maintained between accreditation inspections. In one State, a report from the State cervical screening registry indicated that some laboratories in that State were not meeting quantitative performance standards for the analysis of Pap smears. HIC was not aware of the availability of information on the performance of pathology laboratories against the above standards.

⁸ Quality Assurance Programs Pty Limited (QAP).

Recommendations

The highest priority recommendations are Recommendations No.3 and No.4.

Recommendation No.1
Para 2.27 The ANAO recommends that, in order to further improve the performance of the National Advisory Committee (NAC) and the National Cervical Screening Program, DHAC, in conjunction with the NAC, investigates:

- whether efficiencies might be gained by amalgamating Working Groups of the National Cervical Screening NAC with Working Groups of the BreastScreen Australia NAC that have issues in common; and
- whether current lines of communication between stakeholders, and the NAC and its Working Groups adequately meet the requirements of the NCSP and whether there are opportunities for strengthening communications.

DHAC response: Agreed.

Recommendation No.2
Para 2.34 The ANAO recommends that DHAC, in collaboration with the NAC and Working Groups, develops protocols for the provision of secretariat services to the NAC and its Working Groups, to enhance accountability for the provision of services and provide members of these groups with realistic expectations of the services to be provided.

DHAC response: Agreed.

Recommendation No.3
Para 5.33

The ANAO recommends that DHAC and the HIC explore with the pathology industry the inclusion, as a requirement for accreditation for gynaecological (cervical) cytology, a condition that data on a pathology laboratory's performance against quantitative standards is made available annually to the HIC. This would improve the Commonwealth's ability to satisfy itself that services for which it is paying are of the required quality.

DHAC response: Agreed.

HIC response: Agreed.

Recommendation No.4
Para 5.40

The ANAO recommends that DHAC, in order to achieve well-defined stewardship of the pathology quality assurance process, should take steps to assign responsibility for oversight of the process.

DHAC response: Agreed.

Audit Findings and Conclusions

1. Introduction

This chapter describes briefly the National Cervical Screening Program and the context in which it operates. It also sets out the audit's objective, approach and methodology.

Portfolio outcomes

1.1 The Government⁹ has set nine outcomes for the Health and Aged Care Portfolio.¹⁰ The Department of Health and Aged Care (DHAC) pursues the achievement of these portfolio outcomes in association with other agencies in the portfolio. The portfolio outcomes are:

1. Protection and promotion of the health of all Australians and minimisation of the incidence of preventable mortality, illness, injury and disability.
2. Access through Medicare to cost-effective medical services, medicines and acute health care for all Australians.
3. Support for healthy ageing for older Australians and quality and cost-effective care for frail older people and support for their carers.
4. Improved quality, integration and effectiveness for health care.
5. Improved health outcomes for Australians living in regional, rural and remote locations.
6. Reduced consequences of hearing loss for eligible clients and a reduced incidence of hearing loss in the broader community.
7. Improved health status for Aboriginal and Torres Strait Islander people.
8. A viable private health industry to improve the choice of health services for Australians.
9. Knowledge, information and training for developing better strategies to improve the health of Australians.

⁹ The Portfolio mission and the Department of Health and Aged Care's mission statement and vision can be found in Appendix 2.

¹⁰ Commonwealth of Australia, 2000, Budget Related Paper No 1.11, *Portfolio Budget Statements 2000-01, Health and Aged Care Portfolio*.

1.2 The NCSP primarily contributes to Outcome 1. It also contributes in varying degrees to outcomes 2, 4, 5, 7, and 9. The department's Population Health Division administers two population-screening programs; the NCSP and BreastScreen Australia. Within Population Health Division, administration of these programs is the responsibility of the Primary Prevention and Early Detection Branch.

Program structure

1.3 The NCSP was introduced as result of a 1990 report, *Cervical Cancer Screening in Australia—Options for Change*,¹¹ to the Australian Health Ministers' Advisory Council (AHMAC). AHMAC accepted the recommendations of the report and, in June 1992, the Commonwealth, States and Territories established a program, the 'Organised Approach to Preventing Cancer of the Cervix'. In 1995, the name of the Program was changed to the National Cervical Screening Program.

1.4 The structure of the Program reflects the recommendations from *Options for Change*. At the core of the Program is a National Advisory Committee (NAC).¹² This Committee was formed to provide policy advice to AHMAC.¹³

¹¹ Australian Institute of Health, 1991, *Cervical Screening in Australia—Options for Change*, AGPS.

¹² Further information on the NAC can be found in Chapter 3, paras 2.21 to 2.26.

¹³ The NAC is responsible for:

- developing national policy and standards for the National Cervical Screening Program in the light of emerging issues and in line with outcomes of evidence based research and overseeing a work program to address agreed priorities;
- promoting and monitoring best practice and quality assurance across all stages of the screening pathway including the identification of areas requiring assessment or review;
- providing a focus for informed comment and debate on issues relating to cervical screening, particularly in respect of medical/technical developments, research and epidemiological evidence;
- taking a key role in monitoring the Program and providing input into evaluation; and
- overseeing and developing priorities for, and monitoring communication and recruitment strategies.

The NAC is supported by five working groups. These are:

- Policy and Cost-Effectiveness Working Group;
- New Technologies Working Group;
- Quality Assurance Working Group;
- Education, Communication and Recruitment Working Group; and
- The Aboriginal and Torres Strait Islander Women's Forum

1.5 DHAC's role is to provide leadership and support to the NCSP and the NAC by:

- providing policy development and project services to the NAC;
- coordinating NCSP activities with the activities of other programs administered by the department and with the States and Territories;
- monitoring research and evaluation undertaken on cervical cancer screening; and
- the provision of secretariat services to the NAC.

1.6 It also provides advice to the Commonwealth Minister of Health and Aged Care on cervical screening matters.

1.7 A further role for the department is the administration of funding for the Program. First, it administers the provision of funding for the taking and processing of Pap smears through Medicare. Second, it administers funding through Health Program Grants to certain States for the processing of Pap smears in public sector pathology laboratories. Third, as a part of the national Program, each State and Territory has its own cervical screening program, including a Cervical Cytology Register. DHAC administers Commonwealth funding assistance to the States and Territories for their cervical screening programs. This assistance is provided through the Public Health Outcome Funding Agreements .

The National Cervical Screening Program¹⁴

1.8 Cervical cancer is the fourteenth most common cancer affecting Australian women. Australian women have been screened for cervical cancer since the 1960s. Pap smears, the usual means of screening, are usually taken by general practitioners. The smears are analysed by pathology laboratories. The taking and processing of Pap smears by eligible practitioners attracts a Medicare subsidy. DHAC has informed the ANAO that the 1999–2000 Medicare expenditure on Pap smears and pathology was \$84.2 million. This does not include Commonwealth funding under the PHOFA agreements (which cannot be disaggregated, but which represented over \$5 million in 1994–95 prices); funding for national recruitment activities (representing a further \$4.8 million over the three years to 1999–2000); nor funding under the Health Program Grants. Also not included is funding provided from State and Territory sources.

¹⁴ A detailed description of the National Cervical Screening Program can be found in Appendix 1.

1.9 Program outcome data are published annually in *Cervical Screening in Australia*.¹⁵ The latest publication (1997–98) shows that the age-standardised¹⁶ rate of cervical cancer per 100 000 women for ages 20–69 (the target age group) fell from 18.0 in 1986 to 12.8 in 1996, a fall of 28.9 per cent. The age-standardised death rate per 100 000 women for ages 20–69 has fallen by 69 per cent, from 4.9 to 2.9 over the same period. Despite these improvements, the Program still faces major challenges. For instance, data from Western Australia, South Australia, and the Northern Territory show that the age-standardised death rate for Indigenous women is about six to nine times higher than for non-Indigenous women.

1.10 The Program's aims and national policy are:

The NCSP aims to reduce morbidity and deaths from cervical cancer, in a cost-effective manner through an organised approach to screening. The Program encourages women in the target population to have regular Pap smears and is jointly funded by the Commonwealth and the States and Territories.

The national policy provides consensus guidelines on which women need screening and how often. It states:

- 1. Routine screening with Pap smears should be carried out every two years for women who have no symptoms or history suggestive of cervical pathology.*
- 2. All women who have been sexually active should start having Pap smears between the ages of 18 to 20 years, or one to two years after first sexual intercourse, whichever is later. In some cases it may be appropriate to start screening before 18 years of age.*
- 3. Pap smears may cease at the age of 70 years for women who have had two normal Pap smears within the last five years. Women over 70 years who have never had a Pap smear, or who request a Pap smear, should be screened.*

*This policy only applies to women without symptoms that could be due to cervical pathology. Women with a past history of high-grade cervical lesions, or who are being followed up for a previous abnormal smear should be managed in accordance with NHMRC guidelines.*¹⁷

¹⁵ Australian Institute of Health and Welfare 2000, *Cervical Screening in Australia 1997–1998*, Canberra.

¹⁶ Age standardised rates facilitate comparisons between populations that have different age structures, for example, between youthful and aging communities.

¹⁷ Commonwealth of Australia, 1995, *NHMRC Clinical Practice Guidelines: the Management of Women with Screen Detected Abnormalities*, AGPS.

1.11 Essential elements of the Program include:

- women participating by attending their General Practitioner (GP) or other practitioner for two yearly Pap smears;
- processing of Pap smears in pathology laboratories to required quality standards;
- Cervical Cytology Registers (also known as Pap smear or Pap test registers) in all States and Territories to assist women to screen at two yearly intervals. The registers also track whether appropriate follow-up action to positive smears occurs. Additionally, they are the primary source of data for monitoring the achievements of the Program;
- education and recruitment programs for women and service providers; and
- a body to coordinate the Program, develop policy and standards, monitor the achievements of the Program and take remedial action where required.

Reasons for the audit

1.12 Each year, the ANAO plans a program of audits for the Health Portfolio. The ANAO decided to conduct a performance audit of the NCSP since it had not previously reviewed any preventative health program of the Commonwealth Department of Health and Aged Care.

Audit objective

1.13 The objective of the audit was to provide an assurance to Parliament that the Department of Health and Aged Care's administration of the National Cervical Screening Program is sound.

Audit scope and methodology

Scope

1.14 The audit examined DHAC's administration of the NCSP. In many areas the Program overlaps with other programs. For example, processing of Pap smears in pathology laboratories is funded through Medicare. The audit examined the links in place to ensure coordination of activities between the NCSP and the administration of Medicare, but did not go further. Similarly, the audit examined the links in place to ensure coordination between the NCSP and the activities of DHAC's Health Services Division, but does not comment on the activities of Health Services Division.

1.15 The HIC's administration of the payment of Medicare benefits for medical services provided in relation to the NCSP was included in the scope of the audit, to the extent that it impacted on DHAC's administration of the Program.

1.16 The administration of Cervical Cytology Registers and much activity to encourage women to participate in the Program are the responsibility of the States and Territories. Again, the administration of these activities was outside the scope of this audit.

Issues

1.17 The issues examined in the audit included:

- the department's leadership of the development of the Program and support to the National Advisory Committee;
- coordination of the NCSP within the department and with the States and Territories;
- DHAC's funding of the States and Territories for Program initiatives;
- data analysis and performance monitoring; and
- the actions DHAC is taking to address the risks facing the Program.

Methodology

1.18 Audit criteria, which encapsulate the auditor's expectations based on observed better practice of sound management and administration, were developed to reflect the audit's objective. The criteria included reasonable and attainable performance and control standards against which the adequacy of systems, practices, programs and administrative activities were assessed.

1.19 The main methods of inquiry were:

- review of DHAC and HIC documents; and
- interviews with officers of DHAC, HIC, State Health Departments, State cancer screening programs, NATA and the Royal Colleges of Pathologists, General Practice and Obstetrics and Gynaecology.

1.20 Fieldwork was conducted between May and September 2000 in DHAC's national office in Canberra. The audit team visited Sydney and Melbourne, and consulted officers of State Governments and stakeholders in other centres either in person or by telephone. The audit was conducted in accordance with ANAO auditing standards and cost \$318 000.

2. Program Coordination and the National Advisory Committee

This chapter examines DHAC's coordination of the NCSP. It also discusses DHAC's role in supporting the NAC.

DHAC's coordination of the NCSP

2.1 A major role for the Commonwealth identified in *Options for Change*¹⁸ and confirmed in *The Interim Evaluation Of The Organised Approach To Preventing Cancer Of The Cervix*,¹⁹ is coordinating NCSP activities with the activities of other programs administered by the department, and with the States and Territories. DHAC's approach to coordination is consistent with its leadership role in the development of Australia's health system as described in the department's corporate plan.

2.2 In examining DHAC's coordination of the NCSP the ANAO examined the adequacy of:

- the coordination of the Program with other overlapping programs in DHAC; and
- DHAC's coordination of the Program with the States and Territories.

2.3 These issues are addressed in turn.

Coordination with other areas in DHAC

2.4 The Department of Health and Aged Care has six divisions and three other major business units. Each division or business unit concentrates on one or more of the outcomes set for the Health and Aged Care Portfolio.²⁰ Individual programs, however, may contribute to a number of portfolio outcomes. The NCSP contributes to six of the nine portfolio outcomes.²¹ Coordination of the NCSP within the department is across divisions as well as within divisions.

¹⁸ Australian Institute of Health, 1991 *Cervical Screening in Australia—Options for Change*, AIH, AGPS, p. 10.

¹⁹ Commonwealth of Australia, 1995, *The Interim Evaluation Of The Organised Approach To Preventing Cancer Of The Cervix*, AGPS, Canberra, p. 1.

²⁰ Commonwealth of Australia, 2000, *Commonwealth Department of Health and Aged Care Annual Report*, National Capital Printing, Canberra, Part 2, Outcome performance reports.

²¹ See Chapter 1, para 1.1.

2.5 The complexity of the coordination task within the department for the NCSP is complicated by the high staff turnover observed in that part of the department responsible for the NCSP—in a section with a strength of four and a half people there has been a turnover of four people in less than a year. High staff turnover poses a number of risks to the Program, of which the most important is difficulty in maintaining corporate memory in relation to the Program.

2.6 Primary Prevention and Early Detection Branch (PPED), which is located within Population Health Division, administers the NCSP. One of the branch's roles is to coordinate Program activities with other areas in the department. Most coordination activity for the NCSP occurs with Health Access and Financing Division (responsible for the Medicare benefits schedule), the Office of Aboriginal and Torres Strait Islander Health (OATSIH) and Health Services Division (responsible for General Practice).

2.7 Any new project or change to an existing project can require coordination with a number of areas, not only within Population Health Division, but with other divisions within the department. One of the skills needed to coordinate activities within the department is knowing when an issue needs to be discussed with other areas and which areas to approach to gain feedback on current developments and new initiatives.

2.8 To assess the coordination of the NCSP with other programs administered by the department, the ANAO consulted managers of programs affected by the NCSP. The ANAO also discussed the coordination of the NCSP with managers in PPED and reviewed Program files. Other program managers considered that appropriate consultation between the NCSP and their programs was occurring. NCSP files examined also provided evidence of consultation, both between the NCSP and other programs and between other programs and the NCSP.

2.9 The ANAO found that, generally, effective coordination is occurring. However, the ANAO also found a few examples where PPED, in its role of providing secretariat services to the NCSP, was not consulted or not consulted early enough over issues that would have benefited from input from the NCSP.

2.10 The departmental division responsible for the NCSP does not liaise directly with the HIC in the latter's administration of Medicare payments for the taking and processing of Pap smears. Another division, the Health Access and Financing Division, liaises with the HIC on behalf of that part of the department with responsibility for the NCSP.

2.11 Given the complex environment in which the NCSP operates and high staff turnover, the ANAO expected to find written guidelines to assist staff with coordination. These guidelines would compensate for the complex environment and the loss of corporate memory associated with high staff turnover. The ANAO suggests that guidelines for coordinating activities and decisions be codified, perhaps by an aide memoir or a proforma that is completed and placed on file.

Audit finding

The ANAO found that, on the whole, DHAC is coordinating the activities of the NCSP with other programs. However, the ANAO also found examples where the NCSP was not consulted over issues that would have benefited from Program input.

2.12 As part of the audit the ANAO conducted a file search of NCSP files held by PPED. This file search revealed no fundamental problems with PPED's filing system or records management. NCSP files, particularly recent files, provide satisfactory documentation on the progress of projects. However, the ANAO had difficulty in determining from the files the events or decisions which led to projects. The ANAO observed that minutes of meetings were filed and included key points. Some stakeholders expressed concern that the minutes of meetings were not always produced in a timely fashion. The ANAO noted that some draft minutes were not supplied to meeting participants until five or six months after the meeting.

2.13 The ANAO considers that, in light of the high staff turnover in DHAC, it is crucial that the basis for projects be properly documented, as corporate memory cannot be relied upon. After discussions with DHAC, the ANAO suggests that this problem may be addressed by the cross-referencing of files.

Audit finding

There are no fundamental problems with PPED's filing system or records management. The ANAO found that NCSP projects are satisfactorily documented once a decision has been reached. However, it can be difficult to determine from the files the events or decisions which led to projects. The ANAO is of the opinion that appropriate cross-referencing of files would improve DHAC's accountability trail.

Coordination with the States and Territories

2.14 The need for coordination of the activities of the States and Territories by a central body was recognised in *Options for Change*, which states: ‘National coordination and policy development is an essential component of an organised approach to cervical cancer screening in Australia.’²² The department’s role in the Program was designed to facilitate the coordination of NCSP activities.

2.15 Facilitating factors include:

- the NAC and its Working Groups, which provide forums where matters in the States and Territories can be discussed and feedback given. The NAC strives to achieve a consensus on issues, which increases commitment to national goals and enhances coordination;
- participation in biennial NAC meetings by Commonwealth, State and Territory health department representatives, along with other stakeholders. The health department representatives are expected to keep their State constituents informed of decisions and developments that take place in these forums. This leads to a sharing of information and enhanced coordination between the national Program and State and Territory programs;
- biennial Program managers meetings held in conjunction with NAC meetings. DHAC had not been attending these meetings. However, in more recent times this situation has changed with DHAC now invited by the States and Territories to participate. DHAC has accepted this invitation; and
- DHAC activities, directly in working with the States and Territories and, indirectly, through supporting the NAC and its working parties.

2.16 The ANAO has obtained copies of the business plans for each State and Territory cervical screening program. The ANAO found that, in order to discharge their obligations under the NCSP, the States have established State Cervical Screening Programs. In the ACT cervical screening is a component of the ACT Women’s Health Program, while in the Northern Territory cervical screening is a component of the Northern Territory Women’s Cancer Prevention Program. An examination of State and Territory plans showed that they were in accord. In all cases, their plans either adopted or endorsed the goals and priorities of the NCSP. The same performance indicators and performance targets are used to assess the performance of all States and Territories.²³

²² Australian Institute of Health, 1991 *Cervical Screening in Australia—Options for Change*, AIH, AGPS.

²³ Performance indicators and performance targets are discussed in Chapter 3.

2.17 The ANAO found instances of joint initiatives between the States/Territories and Commonwealth that assist national coordination. An example is the national education campaign that has been running since 1993. This campaign aims to encourage women across Australia to undergo screening regularly.²⁴ DHAC is playing an important role in ensuring that the activities of the States and Territories are coordinated.

2.18 The ANAO is aware of high staff turnover in DHAC (mentioned earlier), which, in the opinion of many of the stakeholders interviewed (including State and Territory program managers), was adversely affecting coordination between the Commonwealth and the States and Territories. Issues raised included:

- Commonwealth officers lacking knowledge of State and Territory program content;
- effort put into building up relationships between States/Territories and the Commonwealth is lost every time Commonwealth staff move on;
- it is difficult to know who in the Commonwealth to contact about issues of concern or interest; and
- the high staff turnover affects the stability of the NCSP, in that an appropriate level of technical knowledge is not maintained by Commonwealth staff. This can impede the Commonwealth's ability to identify and work productively on problems as they arise.

2.19 The ANAO found the State and Territory strategic and business plans examined to be a useful source of information on State and Territory activities. These plans have the potential to further facilitate a coordinated approach to cervical screening. At present, DHAC does not obtain copies of State and Territory plans. DHAC has advised the ANAO that, under the PHOFAs (see Chapter 3), the focus is on outcomes and deliverables rather than inputs and processes. DHAC has advised that there is no requirement in the PHOFAs for the States and Territories to provide copies of State plans to the Commonwealth.

2.20 It would be beneficial if DHAC were to have access to such plans, or appropriately modified versions of them, to be better informed of the strategies being adopted by the States and Territories. While this is a matter of decision by the States and Territories, such access would facilitate Commonwealth officers' understanding of Program priorities and issues at State and Territory level and their ability to work productively with the States and Territories.

²⁴ More information on joint initiatives can be found in Commonwealth of Australia, 2000, *A Decade of Change, A Report on Australia's National Cervical Screening Program, 1989–1999*, Canberra.

Audit finding

The ANAO found that the National Cervical Screening Program was coordinated across the States and Territories. DHAC was facilitating coordinated State and Territory programs, both directly and through its activities in supporting the NAC. An exchange of State and Territory plans between States and with DHAC would further facilitate coordination and the department's ability to work productively with the States and Territories.

DHAC and the National Advisory Committee (NAC)

2.21 The Australian Health Ministers' Advisory Council (AHMAC) Cervical Cancer Screening Evaluation Steering Committee recommended, in its 1991 Report, that an organised approach to cervical screening be adopted.²⁵ It went on to say that:

Under the auspices of an appropriate national body, a National Cervical Cancer Screening Advisory Committee should be established and that the Committee should be supported by a secretariat. The Report stated that it envisaged that the National Cervical Cancer Screening Advisory Committee would play a key role in ensuring that the views of all relevant parties are heard, and that a broadly consistent approach in key areas is adopted across Australia.

2.22 The NAC was established in line with recommendations from the AHMAC report.²⁶ It reports to and provides policy advice to AHMAC. The current NAC has 18 members, including representatives from the Commonwealth, all States and Territories and seven non-government members. The non-government members are appointed as expert individuals rather than as official representatives or delegates of their professional associations. They have been selected because of their personal expertise and their strong links to their professional communities. These experts include a pathologist, a GP, an epidemiologist, a gynaecologist and a health economist. There is also a consumer representative and a representative for Indigenous women.

2.23 There are five working groups supporting the current NAC, each with designated areas of responsibility. These working groups are comprised of government and non-government stakeholders and others with relevant expertise and experience. They report regularly to the NAC with advice and recommendations for action.²⁷ The Commonwealth

²⁵ Australian Institute of Health, 1991, *Cervical Screening in Australia—Options for Change*, AIH, AGPS, pp. 10 and 118.

²⁶ The Terms of Reference for the NAC and the working groups can be found in Appendix 3.

²⁷ See Appendix 3 and Chapter 1. Para 1.5 for further information on NCSP working groups.

provides funding for the operations of the NAC and for research under the auspices of the NAC. Priorities for the use of budgeted funds are decided jointly by the NAC and DHAC.

2.24 The ANAO asked DHAC and stakeholders for their views on whether the current NAC was working effectively. Overall, DHAC and stakeholders felt that the NAC was successful in providing a forum where new initiatives and developments could be discussed. They also stated that it provided a forum for the States and Territories to provide input into NCSP matters nationally. Those interviewed also saw the NAC as facilitating coordination throughout the NCSP.

2.25 While stakeholders expressed their support of the NAC, some felt that there might be value in looking at alternative methods of operating the NAC and its Working Groups. The following examples were given:

- Some of those interviewed considered that it might be possible to merge the Cervical Screening Policy Review and Cost Effectiveness Working Group with the BreastScreen Monitoring and Evaluation Working Group. Both the NCSP NAC and BreastScreen NAC have a Working Group responsible for communication and education. Such a merger could address issues of possible duplication.
- Some stakeholders expressed a wish for enhanced lines of communication with the NAC and its Working Groups. This would facilitate:
 - the receipt by stakeholders of current information on the Program including on new projects and proposals;
 - the provision of feedback from stakeholders to the NAC and its Working Groups that may assist the Program in meeting its objectives; and
 - well informed stakeholders committed to the Program and its goals.

2.26 *Options for Change* envisaged the NAC as a core component of an organised approach to cervical screening in Australia. The ANAO, after consultation with stakeholders and an examination of audit evidence, considers that the NAC has contributed effectively to a coordinated and coherent Program by providing a vehicle for:

- informed policy;
- a consensus on policy and direction;
- a coordinated Program; and
- acceptance of the Program by women and service providers.

DHAC, by establishing and supporting the NAC in a manner consistent with its leadership role, has contributed to the success of the Program.

Audit finding

The ANAO found that DHAC, stakeholders, NAC and NAC working group members supported the current NAC. Notwithstanding, the ANAO considers that there might be some value in DHAC, in conjunction with the NAC, reviewing alternative methods of operating the NAC and its working groups to ensure that the structure continued to evolve in line with present and future requirements of the NCSP.

Recommendation No.1

2.27 The ANAO recommends that, in order to further improve the performance of the National Advisory Committee (NAC) and the National Cervical Screening Program, DHAC, in conjunction with the NAC, investigates:

- whether efficiencies might be gained by amalgamating working groups of the National Cervical Screening NAC with working groups of the BreastScreen Australia NAC that have issues in common; and
- whether current lines of communication between stakeholders, and the NAC and its Working Groups adequately meet the requirements of the NCSP and whether there are opportunities for strengthening communications.

DHAC's response

2.28 The department agrees to this recommendation. The Department of Health and Aged Care has for some time (and prior to the commencement of the audit) been considering the amalgamation of working groups of the Breast and Cervical Screening Programs, to ensure effective utilisation of limited departmental resources.

2.29 The department considers that current strategies for communication with the NAC and its Working Groups are adequate and make effective use of limited resources. However, the department will consult with the NAC and its Working Groups on whether they need to be improved.

Secretariat services provided by DHAC to the NAC

2.30 The need for the NAC to be supported by secretariat services is detailed in *Options for Change*.²⁸ This report identified the Commonwealth Department of Community Services and Health²⁹ as the appropriate body

²⁸ Australian Institute of Health, 1991, *Cervical Screening in Australia—Options for Change*, AIH, AGPS, p. 10.

²⁹ Now Health and Aged Care.

to provide these services. The provision of secretariat services is a key role for the department in supporting the NAC. As stated earlier in this Chapter, the ANAO observed a high staff turnover in that part of the department which provides secretariat services to the NCSP NAC. Many of the stakeholders interviewed were concerned by the high staff turnover. They felt that it impeded the ability of the secretariat to provide services to the NAC and its Working Groups in a timely fashion. Stakeholders also commented that much of the less tangible knowledge that comes with participation in the Program over time (such as staff building up an understanding of Program history and culture) was also adversely affected by high staff turnover. The ANAO concurs with these views and considers that the high staff turnover is likely to be adversely affecting DHAC's provision of secretariat services to the NAC.

2.31 The department advised ANAO that it acknowledged that there had been staff turnover over the past twelve months, and that high turnover can make retaining corporate history more difficult. However, the department does not consider that the level of turnover had impacted negatively on the performance of the Program, stating that representatives of the NAC frequently commented on the increase in project activity being undertaken in comparison with previous years.

2.32 Other concerns expressed by NAC and Working Group members in interviews included:

- minutes being disseminated later than the stakeholders felt was appropriate; and
- the secretariat and the department unable to implement projects within a time frame, which meets the expectations of the NAC and of Working Group members.

2.33 The ANAO did not sight a service provision protocol in place between DHAC and the NAC and its Working Groups for the provision of secretariat services. Such an agreement would provide the NAC and its Working Groups with realistic expectations of the services the secretariat could reasonably be expected to provide to the NAC and Working Groups. In addition a service provision protocol would provide a yardstick by which DHAC could measure its provision of secretariat services to the NAC and Working Groups.

Audit finding

The ANAO found that a service provision protocol between the NAC, working groups and DHAC, for the provision of secretariat services, would ensure that the NAC and its working groups held realistic expectations of the services the secretariat can reasonably be expected to provide. In addition, a service protocol would provide a yardstick by which DHAC could measure its provision of secretariat services to the NAC and working groups.

The ANAO found high staff turnover in DHAC is likely to have hindered the delivery of quality secretariat services to the NAC and its working groups.

Recommendation No.2

2.34 The ANAO recommends that DHAC, in collaboration with the NAC and Working Groups, develops protocols for the provision of secretariat services to the NAC and its Working Groups, to enhance accountability for the provision of services and provide members of these groups with realistic expectations of the services to be provided.

DHAC's response

2.35 This recommendation is agreed. The arrangements for the NACs for the Breast and Cervical Screening Programs will be reviewed at the end of their terms of appointment. The development of protocols for the provision of secretariat services to the NAC and its Working Groups will be considered in that context.

3. Performance Monitoring and Program Funding

This chapter examines the performance indicators and data available to DHAC for monitoring the performance of the NCSP, determining effective strategies and techniques, identifying problem areas and developing responses. The chapter also examines the department's administration of funding assistance to the States and Territories.

The need for monitoring

3.1 The need to monitor the Program and the need for data was recognised in *Options for Change*,³⁰ which states:

Monitoring the performance of the various components of the screening pathway in relation to the resources employed is fundamental to an organised approach. This monitoring applies to recruitment, Pap smear taking and reporting, and the management of women with abnormal Pap smears. This will enable resources to be used to most effectively, identify problem areas requiring particular attention and determine effective strategies and techniques which could be widely adopted. Such monitoring requires a budget and recognition of the central importance of the data collected to show that the screening Program is accountable for its use of limited dollars.

Performance indicators

3.2 Outcome 1 of the Health and Aged Care Portfolio is:

To promote and protect the health of all Australians and minimise the incidence of preventable mortality, illness, injury and disability.

3.3 The aim of the NCSP, which is consistent with the outcome, is:

To reduce morbidity and deaths from cervical cancer, in a cost-effective manner through an organised approach to screening.

³⁰ Australian Institute of Health, 1991, *Cervical Screening in Australia—Options for Change*, AIH, AGPS Canberra, p. 33.

3.4 The annual performance indicators for the NCSP are:

Indicator 1: Participation rate for cervical cancer screening

Indicator 2: Early re-screening

Indicator 3: Low-grade abnormality detection

Indicator 4: High-grade abnormality detection

Indicator 5: Incidence of micro-invasive cervical cancer

Indicator 6: Incidence of squamous, adenocarcinoma, adeno-squamous and other cervical cancer

Indicator 7: Mortality

3.5 The Australian Institute of Health and Welfare prepares the data for these indicators using information from the State and Territory Cervical Cytology Register and other sources. The Commonwealth uses the national performance indicators to assess the performance of the States and Territories against targets in the Public Health Outcome Funding Agreements (PHOFAs) (discussed later in this chapter). Program performance targets are also discussed later in this chapter.

3.6 The first indicator³¹ provides information on the success of the NCSP in reaching the target population. The second provides information on adherence to the Program policy of two yearly screening intervals for women whose previous Pap smear showed no abnormalities. Indicators 3 and 4 give information on the detected incidence of abnormalities (precancerous lesions). Indicators 5 and 6 are indicators of morbidity, while Indicator 7 is an indicator of the death rate from cervical cancer. These performance indicators also allow an assessment of the Program's contribution to Outcome 1.

3.7 The only part of the NCSP goal not covered by annual performance-indicators is 'cost-effective'. Information on the cost of the Program is not readily available from administrative records. As a result the cost-effectiveness of the Program is assessed by cost-effectiveness studies conducted at approximately five yearly intervals. The performance indicator for cost-effectiveness is 'cost per life year saved'. The results of the two cost-effectiveness studies completed can be found in *Options for Change*³² and *The Interim Evaluation*.³³ A third study is scheduled for completion in June 2001.

³¹ Full definitions of these indicators can be found in Australian Institute of Health and Welfare 2000, *Cervical Screening in Australia 1997–98*, Canberra, pp. 3–4.

³² Australian Institute of Health, 1991, *Cervical Screening in Australia—Options for Change*, AGPS, Canberra, pp. 73–93.

³³ Commonwealth of Australia, 1995, *The Interim Evaluation of the Organised Approach to Preventing Cancer of the Cervix*, AGPS, Canberra, p. 73.

3.8 This study will be the first cost-effectiveness study completed since the PHOFAs³⁴ were entered into. The ANAO suggests that DHAC, in conjunction with the NAC, review intervals between future cost-effectiveness studies.

Administration costs

3.9 The budget for administration of the NCSP is \$262 000 for 2000–2001, with another \$219 000 to support the NAC and NCSP activities. This is less than 0.5 per cent of the estimated cost of Program and is not a significant cost element. It should be noted that Commonwealth staffing allocated to the Program has reduced in recent years, with not all of the four and a half positions being filled. Part of the staff reduction is explained by funding assistance to the States and Territories for cervical screening programs now being administered through the PHOFAs.

Audit finding

There are adequate and valid outcome performance indicators available to allow Parliament and stakeholders to assess the performance of the NCSP in contributing to Outcome 1 of the Health and Aged Care Portfolio and in meeting its goals.

Cervical Cytology Registers

3.10 The primary source data for monitoring the performance of the NCSP is the eight State and Territory Cervical Cytology Registers. The Commonwealth provides funding assistance for the registers through the PHOFAs (discussed later in this chapter). A Cervical Cytology Register is a computerised database of the results of Pap smears, together with basic identifying data about the women and their referring doctors.³⁵ Each State and Territory has established and maintains its own register. Registers perform two main functions:

- a service function to facilitate women attending for appropriate screening and treatment; and
- an epidemiological/monitoring function to assist in data collection and the monitoring and evaluation of the Program.

³⁴ Discussed later in this chapter.

³⁵ Department of Health and Aged Care 2000 *A Decade of Change: A Report on Australia's National Cervical Screening Program, 1989–1999*, Canberra, p. 22.

3.11 State and Territory ownership of the registers is a strong factor in their commitment to the NCSP. It is 'their' program, not some remote entity run by the Commonwealth. A strong local component provides local knowledge that assists a Cervical Cytology Register to provide a reminder service, particularly if there has been a change of address.

3.12 The first Cervical Cytology Register commenced operations in Victoria in 1989. New South Wales commenced in July 1996 and Queensland in February 1999. The commencement of the New South Wales register led to data becoming available for more than 80 per cent of the NCSP target population and the publication of national data became feasible. Full national data will be available for the first time in 2001 for the year 1999–2000. Data for individual States or Territories is available from the commencement date of each register. Note that State and Territory privacy legislation prevents the supply of data on individuals to other States, DHAC or other Commonwealth bodies.

3.13 Data that is consistent between States facilitates the production of national performance indicators and comparisons between States. There is an NCSP minimum data set and a set of definitions (data guide) for each national performance indicator. Some States, when developing their Cervical Cytology Register, used the Victorian register as a base. Hence a number of States have the same basic registry software. Other States have locally developed registers.

3.14 The results of Pap smears are provided to the registers by pathology laboratories. Women may elect not to have their personal data included on Cervical Cytology Registers. However, the percentage who do so is very small, of the order of 1 or 2 per cent. Data from Cervical Cytology Registers provides reliable information on the performance of the Program in each State and Territory.

Audit finding

Pap smear registers, which are the major source of data for national performance indicators, provide reliable data for these indicators.

3.15 DHAC uses data from the Cervical Cytology Registers for research as part of policy analysis and development. Examples include using the findings of:

- a State funded research project;
- a research project initiated by the NAC, agreed to and funded by the Commonwealth, and conducted by the AIHW or other contractor; and
- a Commonwealth funded research project conducted by one or more States.

Audit finding

DHAC uses data from the Pap smear registers for research to assist policy analysis and development.

3.16 A characteristic of Commonwealth/State programs is that a national program is not complete until all States and Territories have implemented the major dimensions of the program. In the case of the NCSP, it took four years from the time the Program was approved until registers were operational in sufficient States and Territories to warrant the publication of national data. It has taken over six years to establish Cervical Cytology Registers in all States and Territories. The machinery (discussed later in this chapter) to process and publish performance data from the registers was established within one year of sufficient registers being operational to warrant the publication of national data. To summarise, it will have taken nine years from the Program's beginning in 1992 until 2001 for national performance data, based on all State and Territory registers, to be published. The amount of time necessary before performance data are available on the Program in each State is explained by the devolved model of program implementation, wherein the States and Territories are responsible for establishment of registers with data on cervical screening.

DHAC's use of Medicare data

3.17 Another important source of data is derived from Medicare payments. The Pathology table in the Medicare Benefits Schedule (MBS) has a separate item for processing Pap smears where the previous Pap smear was normal. Information available includes, for each woman, the time between tests, service supplier behavior patterns (e.g. average time between tests by a particular service provider) and postcode data. The results of Pap smears are not available from Medicare data. Note that, although the Medicare data supplied includes an identifier which allows DHAC to track individuals, information which would allow DHAC to identify individuals, such as names and addresses, is not available.

3.18 Much of the data available from Medicare duplicates data available from Cervical Cytology Registers. In addition, Medicare data provides information on Commonwealth payments through Medicare for the processing of Pap smears. Medicare data are readily available to DHAC, whereas the provision of data to DHAC from Cervical Cytology Registers has to comply with the provisions of State and Territory privacy legislation and is not so readily available to DHAC. Medicare data are available to DHAC within 24 hours of the transactions being processed

by the HIC. Although Medicare data covers most Pap smears in Australia, it does not include Pap smears funded through Health Program Grants or by State Governments. In summary, Medicare data provides a useful tool for DHAC to monitor trends on and to analyse issues concerning the processing of Pap smears in private sector laboratories.

3.19 DHAC, in conjunction with the NCSP NAC, has identified high early re-screening rates as a Program priority area.³⁶ DHAC is using Medicare data received from the HIC, combined with cervical cytology register data and social marketing research to estimate the extent of early re-screening, determining which sectors of the target population are presenting early and why. The information gained from the exercise will be used to inform and educate practitioners about appropriate screening practice.

3.20 Another example of the use of Medicare data to develop policy for the NCSP, is DHAC's work with the Royal Australian and New Zealand College of Obstetricians and Gynaecologists to develop standards for colposcopies.³⁷ A concern that arose during development was access to colposcopy services for rural and remote women. DHAC used Medicare data to examine the locations where colposcopies are performed by GPs, to help build practical NCSP guidelines for colposcopies.

Other data sources

3.21 The Program conducts Commonwealth-funded surveys to collect information required to develop informed responses to issues when this information is not available from primary data sources. Examples³⁸ are the survey of general practitioners attitudes to early re-screening, and research into the motivations of women who regularly re-screen early, conducted in 1999.

DHAC sponsorship of data collection by the AIHW

3.22 DHAC, through a Memorandum of Understanding with the Australian Institute of Health and Welfare (AIHW), has funded a Health Registers and Cancer Monitoring Unit. The Unit, established in July 1997,

³⁶ See Chapter 4.

³⁷ A colposcopy is an examination of the vagina and the neck of the uterus by means a specifically designed instrument called a colposcope.

³⁸ Blue Moon Research & Planning in, Department of Health and Aged Care 2000 *A Decade of Change: A Report on Australia's National Cervical Screening Program, 1989–1999*, Canberra, p. 20.

monitors and reports on the performance of the NCSP.³⁹ The Unit is advised by the National Screening Information Advisory Group⁴⁰ (NSIAG) (established in November 1997) and works closely with the NCSP NAC and its working parties. A key function of the Unit is to provide advice to the NAC on current and proposed performance indicators and issues concerning the provision of the data required for these indicators.

3.23 Major outcomes since the establishment of the Unit have been the development of the seven cancer screening program performance indicators, (described earlier in this chapter) including a definition of each indicator and identification of the data to be provided by the States and Territories. Further achievements include the preparation and publication of the 1996–97 and 1997–98 reports, and the preparation of the 1998–99 report. NSIAG has prepared advice for the Unit (and indirectly for the NAC) on the development of triennial performance measures to report on issues that are not covered by the core annual national monitoring indicators, and are of importance to monitor over a longer period. The first of these indicators recommended for publication is cervical cancer incidence rates by Socio-Economic Indexes for Areas (SEIFA) index.

3.24 A further triennial indicator, which has been given priority, is Indigenous status. Information from three States and territories indicates that mortality from cervical cancer amongst Indigenous women is six to nine times higher than for non-Indigenous women.⁴¹ The Program is taking action to reduce the incidence of and mortality from cervical cancer amongst Indigenous women (see Chapter 4). However, information on Indigenous status is required in order to assess the success of these actions.

³⁹ Australian Institute of Health and Welfare, 2000, *Annual Report 1999–2000*, AIHW, Canberra, p. 28.

⁴⁰ NSIAG's terms of reference are to:

- confirm data items to be collected and the indicators generated from them;
- develop and implement a schedule and format for the provision of data by the States and Territories to the AIHW;
- develop and implement a reporting format and timetable for the AIHW to report to the Commonwealth, States and Territories;
- identify processes for the distribution of national performance reports by the AIHW;
- assist with the evaluation of performance measures; and
- review the provision of data by the States and Territories to the AIHW after 12 months.

⁴¹ Australian Institute of Health and Welfare 2000, *Cervical Screening in Australia 1997–98*, Canberra, pp. 62 and 63.

3.25 At the moment Indigenous status is not collected by the registers, even in States where the enabling legislation allows it. As a consequence the success of national policies targeting Indigenous women cannot be assessed. DHAC is working with the NAC and the States and territories to identify methods of successfully collecting Indigenous status.

3.26 The terms of reference for NSIAG reflect the original need to determine the initial performance indicators required for the NCSP and to establish the supporting data collections. Now that these are being published, the ANAO suggests that NSIAG's terms of reference be revised to reflect the maturity of NCSP performance indicators. DHAC have advised that as NSIAG is a body that advises the AIHW, this is a matter for the AIHW. The department will refer this matter to the AIHW for its consideration.

Audit finding

The ANAO considers that the early identification of the need to monitor the Program and the early identification of possible data sources, combined with the use of an independent data advisory body is an example of good practice. This, coupled with the use of the AIHW, has allowed the Program to provide valid, reliable performance indicators. It has also allowed the early identification of areas where further performance information and performance indicators are required.

Performance targets

3.27 The PHOFAs, discussed later in this Chapter, include performance targets. Only one of these performance targets relates to the seven annual performance indicators described at para 3.4.⁴² DHAC has advised that the NAC has agreed to further quantitative performance targets. These are:

- that, by 2003, the incidence of invasive squamous cervical cancer⁴³ among women aged 20–69 years be 5.7 per 100 000 women;
- that, by 2003, mortality from cervical cancer among women aged 20–69 years be 1.8 per 100 000 women;
- that, by 2002–2003, participation among eligible women aged 20–69 years be 70 per cent or greater and participation among eligible women aged 50–69 years be 65 per cent or greater; and
- that, by 2003, not more than 30 per cent of women who receive a negative Pap smear report are re-screened before 21 months.

⁴² The target is 'Increase participation by women aged 20-69 years in biennial screening'.

3.28 DHAC has advised that it is currently analysing the financial implications of the new targets for Medicare. Subject to funding availability, these indicators will be incorporated into the PHOFAs. In the interim, all States and Territories have agreed to their introduction.

Reporting

3.29 *Breast and cervical cancer screening in Australia 1996–97*⁴⁴ was the first annual report containing performance indicators for the NCSP. For 1997–98 separate reports have been prepared for the NCSP and BreastScreen Australia. The NCSP report is entitled *Cervical Screening in Australia 1997–98*,⁴⁵ published in August 2000. Although the AIHW had a draft of the report available in November 2000, the report for 1998–99 is not scheduled for publication until May 2001. Timely publication would increase the usefulness of these reports and the ANAO suggests that DHAC, in conjunction with the NAC, endeavour to publish cervical screening reports as soon as possible. The reports are also available on the AIHW web site.⁴⁶

3.30 The reports are prepared from data supplied by the State and Territory Cervical Cytology Registers. Note that supply of this data is a condition of Commonwealth assistance under the PHOFAs.

Audit finding

Annual reports on the performance of the National Cervical Screening Program are published in print and on the AIHW web site.

Public Health Outcome Funding Agreements

3.31 Commonwealth financial assistance to States and Territories for the NCSP is provided through a broadbanded funding arrangement, the bilateral PHOFAs.⁴⁷ The first round of PHOFAs covered the period 1997–98 to 1998–99. Second round agreements cover the five-year period, 1999–2000 to 2003–2004.

⁴³ Of the several types of cervical cancer, squamous cell carcinoma is the most commonly seen. Squamous cell carcinoma of the cervix is usually preceded by non-malignant abnormalities. These abnormalities once detected through a Pap smear test may be treated successfully. The ability of these cancer precursor abnormalities to be detected and treated ensure this cancer is suited to a screening program.

⁴⁴ Australian Institute of Health and Welfare 1998, *Breast and cervical screening in Australia 1996–97*, Canberra.

⁴⁵ Australian Institute of Health and Welfare 2000, *Cervical Screening in Australia 1997–98*, Canberra.

⁴⁶ www.aihw.gov.au

⁴⁷ See www.health.gov.au/pubhlth/about/phofa2000/index.htm for the agreements with each State and Territory and for reports on performance against the agreements.

3.32 Under the PHOFAs Commonwealth assistance for the following eight Commonwealth/State programs has been broadbanded into a single Agreement with each State and Territory:

- National Drug Strategy;
- HIV/AIDS Matched Funding Program;
- BreastScreen Australia;
- National Cervical Screening Program;
- National Childhood Immunisation Program;
- National Women's Health Program;
- Alternative Birthing Program; and
- National Education Program on Female Genital Mutilation.

3.33 The Joint Committee of Public Accounts (now the Joint Committee of Public Accounts and Audit) found in Report 342 that the administration costs for small Specific Purpose Payments (SPPs), particularly for the smaller States and Territories, were out of proportion to the actual value payment received by the State.⁴⁸ The Committee recommended:

Commonwealth departments administering SPPs should investigate the possibility of broadbanding existing SPPs within their portfolios. The broadbanding should be considered on the basis of retaining the objectives and performance indicators of the original SPPs but pooling Commonwealth funding. Service providers should have the flexibility to use the pooled funds as they see fit to meet the new combined objectives.

3.34 The Joint Committee of Public Accounts and Audit further discussed the broadbanding of SPPs in Report 362. The Committee noted that⁴⁹ *'The Commonwealth has also been exploring the possibility of broadbanding a number of public health programs funded under separate SPPs'*. The Committee supported *'...recent initiatives aimed at merging smaller SPPs and streamlining SPP program elements'*. The Committee provided in Report 362 a list of principles for sound SPP program administration.⁵⁰ Fieldwork has led the ANAO to conclude that the PHOFAs, as they relate to the NCSP, have characteristics consistent with the JCPAA's recommendations.

⁴⁸ Joint Committee of Public Accounts 1995, *Report 342—The Administration of Specific Purpose Payments: A Focus on Outcomes*, Parliament of the Commonwealth of Australia, p. 95.

⁴⁹ Joint Committee of Public Accounts and Audit 1998, *Report 362—General and Specific Purpose Payments to the States*, Parliament of the Commonwealth of Australia, p. 52.

⁵⁰ *ibid*, pp. 57–58.

3.35 Report 342 recommended that *'Service providers should have the flexibility to use the pooled funds as they see fit to meet the new combined objectives.'* One of the principles from Report 362 is 'streamlined accountability'. The PHOFAs financial acquittal process meets both these objectives.

3.36 The financial acquittal information required is simple and has only three lines as follows:

- Commonwealth funding assistance for broadbanded programs;
- total expenditure on broadbanded programs; and
- the difference between these two figures.

3.37 If the total expenditure equals or exceeds Commonwealth assistance, acquittal is complete. If total expenditure does not exceed Commonwealth funding the State is required to repay the unused Commonwealth funding. A State may carry over unused funds in intermediate years, but must repay any unused Commonwealth funds at the end of the agreement. This financial acquittal process is both simple and flexible.

3.38 Under the arrangements States and Territories are free to determine the funds to be allocated to each of the broadbanded programs, in accordance with the recommendation from Report 342.

3.39 Primary accountability for State and Territory performance for the NCSP is through the seven outcome performance indicators described earlier in this Chapter. PHOFA performance targets and performance indicators are discussed further below.

3.40 A consequence of broadbanding Commonwealth financial assistance over a group of programs is that expenditure on each program in a State or Territory is no longer available from administrative records held by the Commonwealth. If this information is required, for instance for a cost-effectiveness study, DHAC must obtain it separately from the States.

3.41 Further, the concept of the funding for each program comprising a distinct Commonwealth and State contribution is no longer valid. Each State has a pool of funds, composed of Commonwealth financial assistance and State funding, which it allocates between the broadbanded programs in order to achieve the required outcomes. There is no requirement to distinguish what component of the funding of a program is derived from Commonwealth assistance and what component is contributed by the State.

Audit finding

DHAC's provision of funds for the NCSP to the States and Territories complies with the recommendation for broadbanding from JCPA Report 342 and the principles in JCPAA Report 362.

3.42 There are three levels of performance indicators for the NCSP under the PHOFAs. These are:

- shared indicators—reported on by the Commonwealth using data from existing sources;
- annual and alternating indicators—these are consistent across jurisdictions and are designed to be collected with minimal resource impact; and
- State specific indicators—these indicators are determined by mutual agreement between the Commonwealth and each State and Territory.

3.43 The shared indicator for the NCSP is '*Mortality due to cervical cancer per 100 000 estimated resident female population for the target group range (20–69) and all women*'. The target is '*Increased proportion of women aged 20–69 years participate in biennial screening*.' The information used to assess performance against this target is derived from the State and Territory Cervical Cytology Registers and is published in *Cervical Screening in Australia*.⁵¹

3.44 The PHOFAs require the Commonwealth to provide an annual performance report on the shared performance indicators no later than 12 weeks after the end of the financial year. After consultations and discussions with States the report is made publicly available via the Internet.

3.45 By the same date each State is required to provide the Commonwealth with an annual performance report against the annual performance indicators specified in the PHOFAs. The Commonwealth and the State are to jointly review progress against the performance indicators set out in individual State performance reports. After consultations and discussions with each State this report is made publicly available via the Internet.

3.46 At the time of preparation of this report, the 1997–98 and 1998–99 performance reports were available on the Internet.

⁵¹ Australian Institute of Health and Welfare, 2000, *Cervical Screening in Australia 1997–98*, Canberra, is the second annual report for the National Cervical Screening Program.

Audit finding

The Parliament and the public have ready access to reliable and up-to-date information about Commonwealth funding assistance to State and Territory cervical screening programs through the PHOFAs and information on progress against the performance targets specified in the PHOFAs.

3.47 An annual performance outcome specified in the PHOFAs is the supply of *'high quality data to monitor and evaluate the implementation of the NCSP'*. The performance required is *'that information is provided annually to the AIHW for reporting against the seven national cervical cancer screening monitoring indicators'*⁵². The target is *'complete and timely reports against the indicators are supplied as required, to the AIHW.'*

Audit finding

The PHOFAs include a requirement for the States and Territories to supply the basic data for each of the seven NCSP performance indicators.

⁵² Described at the beginning of this chapter.

4. Risk Management

This chapter examines DHAC's management of risks to the National Cervical Screening Program. It also examines ongoing actions taken to achieve Program priorities, which address a number of major risks to Program and portfolio outcomes.

Program risk

4.1 At the time of audit fieldwork DHAC did not have a systematic approach to the identification and management of risk in place for the NCSP. For instance, the division and branch business plans for the financial year 1999–2000 do not discuss risk and there was no lower level business plan. There was not a risk management plan for the Program as part of a sound corporate governance framework.

4.2 DHAC's procedural rules state:

The process of managing risk involves:

- *establishing the context associated with program goals and activities;*
- *identifying the risks (including identifying the likelihood and consequences associated with each risk);*
- *analysing the risks;*
- *assessing and prioritising the risks;*
- *treating the risks (including a cost/benefit analysis of the treatment options); and*
- *continually monitoring and reviewing the risks and treatments.*

4.3 The department's procedural rules also state that management responsibility includes '*ensuring that appropriate supporting documentation of risk management processes and outcomes is maintained*'.

4.4 DHAC has provided documentation from a half-day discussion session on risk management held in December 1999, at which risks to the NCSP were identified. However, there has been no further action to assess, rank or treat the risks. As mentioned earlier, the division and branch plans for the financial year 1999–2000 do not discuss risk. As a consequence, at the time of audit fieldwork, DHAC was unable to demonstrate that major risks to the NCSP and its administration of the NCSP have been identified, assessed, ranked, treated, monitored and reviewed. In the absence of such a consolidated approach to risk, the department was not in a position to show that the limited resources available for administration of the NCSP were being used to best effect.

4.5 The department advised that major risks to the Program were previously identified and were in the course of being treated prior to the commencement of the audit.

4.6 An example of the potential benefits of a systematic approach to risk management is new technologies (see para 4.38). All new technologies have costs and benefits to users, practitioners and the Commonwealth. Further, overseas evidence may not be relevant in the Australian context. A formal risk analysis of a new technology would allow an estimate of the potential costs and benefits to the Program. This knowledge would assist decisions on the allocation of resources to research the introduction of the new technologies to Australia.

4.7 For example, a new technology that has not been subjected to a Medical Services Advisory Committee⁵³ (MSAC) assessment and is not listed for Medicare eligibility could still be widely adopted by women. This may lead to risks to the Program. Discussions with stakeholders provided an example where the manner in which the new technology is promoted may lead to a perception that technology used in the NCSP is outdated and by implication unreliable. This is an example where a risk analysis by DHAC would provide an assessment of potential risks and costs to the Program of the new technology and would assist in determining whether the risk should be addressed and in devising strategies to address the risk.

4.8 The department has advised that it is highly cognisant of these risks. The MSAC processes address these risks in regard to the listing of new medical services on the Medicare Benefits Schedule. Further, the department is currently developing, in conjunction with the medical professions and the States and Territories, models for the introduction of 'Horizon Scanning' in Australia. This activity involves the identification of prospective new technologies that may be introduced in the medium term. Those that may have significant impact in terms of health priorities, health outcomes, safety, cost and similar aspects are identified and prioritised. Strategies are developed to conduct further research on, or manage the introduction into the health system of these prioritised new technologies.

4.9 The ANAO noted that the Departmental Secretary, in April 2000, wrote to senior staff stating that he wanted them to review their approach to the consideration of management of risks. In particular, he expected that future unit business plans will specifically identify and integrate risk management strategies with the strategies for addressing business priorities and achieving the required outcomes.

⁵³ See para 4.42.

4.10 DHAC has informed the ANAO that a risk management plan will be developed for the NCSP during 2000–2001.

Audit finding

At the time of audit fieldwork, DHAC's approach to the management of risk to the NCSP and DHAC's administration of the NCSP did not comply with the department's own procedural rules. As a consequence, DHAC is not in a position to show that significant risks to the NCSP have been identified, assessed, ranked, treated, monitored and reviewed. DHAC has informed the ANAO that a risk management plan will be developed during 2000–2001.

4.11 DHAC has, in conjunction with the NAC, identified the following areas of the NCSP as priorities:

- recruitment—access and equity;
- early re-screening;
- new technologies; and
- quality assurance.

4.12 The NCSP has working groups in place to address each priority area. These working groups report directly to the NAC. In addressing these priority areas, DHAC and the NAC have addressed a number of the major risks to the Program. The strategies that have been established by the NAC and DHAC to address priority areas are set out later in this Chapter. A more detailed account can be found in the recent publication, *A Decade of Change*.⁵⁴

Recruitment—access and equity

4.13 Health and Aged Care portfolio outcomes to which the NCSP contributes include:

- protection and promotion of the health of all Australians and minimisation of the incidence of preventable mortality, illness, injury and disability;
- improved health outcomes for Australians living in regional, rural and remote locations; and
- improved health status for Aboriginal and Torres Strait Islander people.

4.14 Lack of access to the NCSP and inequitable access are risks to the Program's contribution to these portfolio outcomes.

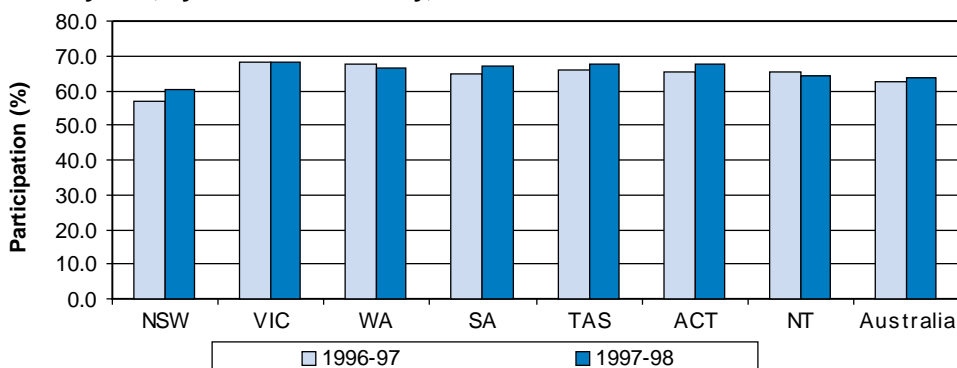
⁵⁴ Commonwealth of Australia, 2000, *A Decade of Change, A Report on Australia's National Cervical Screening Program, 1989–1999*, Canberra.

NCSP recruitment activities

4.15 NCSP national guidelines state that routine screening with Pap smears should be carried out every two years for women who have no symptoms or history suggestive of cervical pathology. The screening performance indicator shows 36 per cent of women are screening less often than the two yearly policy requires.

Chart 4.1

Participation in the National Cervical Screening Program by women aged 20–69 years, by State and Territory, 1996–97 and 1997–98



Note: 1. The Queensland Pap Smear Register commenced February 1999; therefore no Queensland data are available.

Source: *Cervical Screening in Australia 1997–1998*.⁵⁵

4.16 While there is variation in participation rates between States and Territories, the participation rate for all States and Territories for which data are available lies between 60 and 70 per cent.

4.17 The NCSP is increasing the participation levels of women through a two-pronged approach. The Commonwealth is developing and implementing national education campaigns while the states are undertaking local activities targeting the needs of specific groups. The Program has identified five groups of women who are known to under-screen. These include women who:

- are from Aboriginal and Torres Strait Islander backgrounds;
- are from some culturally and linguistically diverse backgrounds;
- live in rural or remote areas;
- are more than 60 years old; and
- have a low socio-economic status.⁵⁶

⁵⁵ Australian Institute of Health and Welfare, 2000, *Cervical Screening in Australia, 1997–98*, Canberra, pp. 34–35.

⁵⁶ *ibid*, p. 13.

4.18 DHAC supports two working groups that focus on increasing the participation of under-screening women. These working groups are:

- the Education, Communication and Recruitment Working Group; and
- the Aboriginal and Torres Strait Women's Forum.

4.19 National recruitment activities include general recruitment activities and recruitment activities aimed at specific target groups. An example of a general recruitment activity is the second national education campaign, launched in 1998. This Commonwealth funded campaign was designed to address barriers to participation identified by qualitative research conducted in 1996.

4.20 National projects aimed at particular groups of women known to under-screen are described below.

Aboriginal and Torres Strait Islander women

4.21 Discussions in *Options for Change*⁵⁷ indicate that the Program has been aware of the need to increase participation for Indigenous women since its inception. Primary responsibility for improving rates of cervical screening amongst Aboriginal and Torres Strait Islander women lies with the States and Territories. Improvement of screening rates amongst Indigenous women is a requirement of funding assistance to the States and Territories through the PHOFAs, with a target of:

Pap smear coverage rates among Aboriginal and Torres Strait Islander females aged 20–69 years is the same as coverage rates in the non-Aboriginal and Torres Strait Islander community by 2001.

4.22 An examination of State and Territory cervical screening plans (provided by seven of the eight States and Territories) shows that Indigenous women have been identified as a priority target group. These plans also show that action has been taken to increase participation in the Program by Indigenous women. Actions by the States and Territories to increase recruitment amongst Indigenous women all involve consultation and cooperation with Aboriginal health groups and Aboriginal communities. There is a strong intent to encourage communities to take ownership of the cervical screening initiatives aimed at their communities.

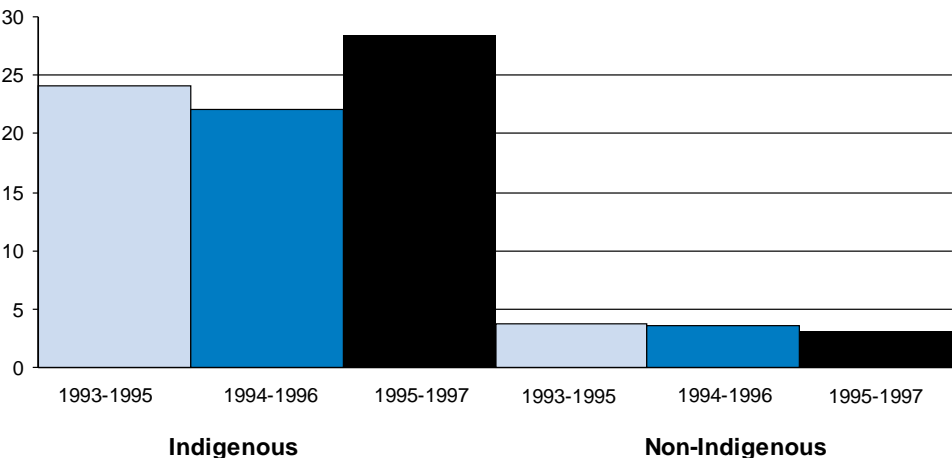
4.23 However, despite these activities, data included in *Cervical screening in Australia 1997–1998* (reproduced in Chart 4.2) indicated that Aboriginal and Torres Strait Islander women were between six to nine times more

⁵⁷ Australian Institute of Health, 1991, *Cervical Screening in Australia—Options for Change*, AIH, AGPS, Chapter 9.

likely to die from cervical cancer than non-Indigenous women. In response to these figures the NCSP NAC established the Aboriginal and Torres Strait Women’s Forum which met for the first time in April 2000. The forum has been established as a working group of the NCSP NAC and reports directly to the NAC.

Chart 4.2

Age Standardised Death Rates⁵⁸ for Cervical Cancer, by Indigenous and Non-Indigenous Status, SA, WA, NT, 1993–95 to 1995–97



Notes: 1. Deaths per 100 000 women.
2. At the time of this report, only South Australia, Western Australia and the Northern Territory had Indigenous death registration data considered by the AIHW to be of a publishable standard.
Source: *Cervical Screening in Australia, 1997–1998*.⁵⁹

4.24 As part of the provision of health services to Indigenous peoples, the Commonwealth has entered into Framework agreements with each State and Territory, the Aboriginal controlled health organisation in each State and Territory and the Aboriginal and Torres Strait Islander Commission. Under these agreements a State Forum has been established in each State and Territory. The role of each Forum, as set out in the Framework Agreement, is threefold; namely to decide on key issues about regional planning, to contribute to policy and planning development and to evaluate implementation of the Framework Agreement. Membership of a Forum includes representatives from DHAC, the State or Territory Department of Health, the State affiliate of the National Aboriginal Community Controlled Health Organisation (NACCHO) and the Aboriginal and Torres Strait Islander Commission (ATSIC).

⁵⁸ Aged standardised rates facilitate comparisons between populations that have different age structures, for example between youthful and aging communities.
⁵⁹ Commonwealth of Australia, 2000, *Cervical screening in Australia, 1997–1998, National Cervical Screening Program*, AIHW, pp. 62–63.

4.25 At the request of the ANAO, DHAC canvassed their State and Territory staff who attend the State Forums. These staff report that cervical screening has not been discussed at Forum meetings. DHAC has advised that it is intended that the Aboriginal and Torres Strait Women's Forum will advise if, and when, issues should be raised in the overarching Aboriginal Health Forums. In the first instance issues will be directed to the NCSP NAC, as the Aboriginal and Torres Strait Women's Forum reports directly to the NAC.

4.26 DHAC's Office for Aboriginal and Torres Strait Islander Health has advised the ANAO that the Framework Agreements are signed by the partners to the Health Forums of each State and Territory Health department, the local affiliate of the National Aboriginal Community Controlled Health Organisation (NACCHO), the Aboriginal and Torres Strait Islander Commission and the Commonwealth. The Agreements do not deal with specific issues at this level but rather with overall principles in Aboriginal Health. They oversight regional planning processes within the particular jurisdiction, determining priorities according to local needs. Cervical screening would be raised through these regional planning processes as considered appropriate by the membership (taking into consideration the sensitive nature of 'women's business' issues).

4.27 Accordingly, it is appropriate for the NCSP to consider these sensitive issues through the Program structures rather than through the higher level Health Forums in each State and Territory. The Aboriginal and Torres Strait Islander Women's Forum, as a working party of the NCSP NAC, is the most appropriate way to develop strategies to improve participation in cervical screening by Indigenous women.

Women from culturally and linguistically diverse backgrounds

4.28 In 1998 a Commonwealth strategy was launched to target 32 language groups of women. This strategy is known as the CALD strategy (women from culturally and linguistically diverse backgrounds). The aims identified in the strategy were:

For women:

- *to increase awareness of the benefits of screening;*
- *to generate positive attitudes towards cervical screening; and*
- *to increase intentions for women to have Pap smears every two years.*

For health care providers:

- *raise awareness of the key role they play in informing women; and*
- *increase intentions to have Pap smears every two years.*

Women living in rural and remote areas

4.29 Women living in rural and remote areas face unique problems in that it is often difficult for them to access a general practitioner for cervical screening.⁶⁰ Additionally, in rural and remote Australia, there is a shortage of female general practitioners. Surveys indicate that the gender of the general practitioners is a barrier to screening, as many women prefer to consult a female.⁶¹

4.30 DHAC has advised that the Rural Women's GP Service has been established to improve rural women's access to female general practitioners. This Service, which is administered the Australian Council of the Royal Flying Doctor Service, will deliver female general practitioner services to rural communities and larger remote centres where there is currently little or no access to a female doctor.

4.31 DHAC, in conjunction with the Education, Communication and Recruitment Working Group, is examining other national options to improve access for rural and remote women. One option is the use of nurse practitioners and health workers as smear takers, in areas where general practitioners are not available. There is a constraint on this option in that pathology services to process Pap smears are eligible for Medicare payments only if ordered by a medical practitioner. Where a Pap smear is taken by a nurse practitioner or other health worker who is not under the supervision of a medical practitioner, payment for the processing of the Pap smear has to be through methods other than Medicare.

4.32 The 2001–2002 Budget set aside additional funds for GPs to increase NCSP participation rates, particularly by targeting women who are unscreened or under-screened.

Audit finding

The ANAO found that DHAC, in conjunction with the NCSP NAC, has identified lack of access and equitable access as priority areas for the Program.

DHAC, in conjunction with the NAC, by identifying priority groups of women for whom access needs to be improved, is addressing the risks to the Program's success and the Program's contribution to Health and Aged Care portfolio outcomes.

⁶⁰ Commonwealth of Australia, 2000, *A Decade of Change, A Report on Australia's National Cervical Screening Program, 1989–1999*, p. 13.

⁶¹ Australian Institute of Health, 1991, *Cervical Screening in Australia—Options for Change*, AIH, AGPS, Chapter 9.

Early re-screening

4.33 The NCSP aims to ‘reduce morbidity and deaths from cervical cancer in a cost-effective manner.’ *A Decade of Change*⁶² states:

Unnecessary early re-screening is a significant issue for the Program. Data from the Australian Institute of Health and Welfare show that 47 per cent of women are re-screening early. Early re-screening occurs when a woman has a further Pap smear within a 24-month period, despite the result of the previous screen being negative. It is appropriate for women who have had screen detected abnormalities to re-screen at an earlier interval. But when a woman has had a negative smear and has no history of abnormal cervical cytology, the national policy recommends a further Pap smear after two years.

4.34 High levels of early re-screening place a significant burden on all parties. Women undergo an unnecessary and invasive medical procedure, and general practitioners have less time to spend on other patients or issues. The cost to the Program is potentially significant, particularly in terms of scarce funding which may be better directed elsewhere, such as to women who are under-screened.⁶³

4.35 To address this problem, DHAC has funded two research projects aimed at understanding more about reasons for over-screening. The first project focussed on the attitudes of general practitioners towards the NCSP two yearly screening policy.⁶⁴ It identified current levels of knowledge of the biennial screening policy by GPs, explored acceptance of the two yearly policy both in principle and in practice, and recommended that if DHAC adopted an education strategy for GPs, it should:

- be backed by medically based evidence on the statistics and incidence of cervical cancer and those most at risk;
- address the misinformation on cervical cancer and those at risk;
- clearly support the two yearly time frame; and
- provide evidence based Australian research on the screening procedure.

⁶² Commonwealth of Australia, 2000, *A Decade of Change, A Report on Australia's National Cervical Screening Program, 1989–1999*, p. 20.

⁶³ *ibid.*

⁶⁴ Blue Moon Research & Planning in *ibid.*, p. 20.

4.36 The second project was aimed at understanding the attitudes and motivations of women re-screening early following a negative screen.⁶⁵ The recommendations included action:

- *to increase women's confidence to screen at the appropriate intervals; and*
- *to support general practitioners who currently advise their patients to screen at two yearly intervals.*

4.37 The Commonwealth is also analysing Medicare data and data from State and Territory Cervical Cytology Registers to assist in the identification of the reasons for early re-screening. Tasmania has undertaken an analysis of re-screening patterns using data from the Tasmanian Cervical Cytology Register. The outcomes of these research projects will provide a basis for the development of strategies, at a Commonwealth, State and Territory level, to deal with unnecessary early re-screening.

Audit finding

The ANAO found that DHAC, in conjunction with the NCSP NAC, is taking an appropriate leadership role in initiating research on the extent of over-screening and developing strategies to reduce early re-screening. This action is addressing the risk posed by early re-screening to the success of the Program in achieving its goals.

New technologies

4.38 DHAC, in conjunction with the NCSP NAC, has identified the marketing and introduction of untried new cervical screening technologies as a risk to the Program and to women. DHAC supports a New Technologies Working Group which reports to the National Advisory Committee. The working group is responsible for:

- *considering the potential and actual impact to the Program of new technologies; and*
- *establishing minimum criteria that should be satisfied before a new technology is approved by the NCSP. Minimum criteria include product and cost effectiveness in the context of a population health program.*

⁶⁵ *ibid.*

4.39 Apart from potential benefits, new technologies pose the following risks to the Program:

- having a comparatively effective and cost-effective test for cervical screening available to women, that is not being utilised;
- having a comparatively less effective or less cost-effective test for cervical screening that is being used; and
- pressure from manufacturers to provide Medicare cover for a test which, in the Australian context, is not as cost-effective as the standard Pap smear.

4.40 New technologies can also result in women paying for services, not covered by Medicare, which do not offer substantially better protection than standard services. DHAC has advised that it is a Government objective to promote access to safe, effective and cost-effective medical services. Nonetheless patient freedom of choice to access other services remains, and it is not Commonwealth policy to seek to influence these individual choices so long as the services meet regulatory standards required by, for example, the Commonwealth Therapeutic Goods Administration or State Governments.

4.41 The *Health Insurance Act 1973* excludes payment of Medicare benefits for health screening services except where Ministerial directions have been issued to enable benefits to be paid. The NCSP is the only screening program where Medicare covers pathology costs.

4.42 It is Commonwealth policy that all potential new listings for Medicare benefits are considered for safety, effectiveness and cost-effectiveness prior to listing. Assessments are carried out by the Medical Services Advisory Committee, established in 1998. The MSAC adopts an evidence-based approach in advising the Minister for Health and Aged Care on, among other things, the circumstances under which public funding should be supported for new medical services. Applications to the MSAC⁶⁶ can be made by the medical industry, medical profession or other parties.

4.43 If the MSAC accepts an application for assessment, a supporting committee is appointed to consider the application and report back to the MSAC. Members of supporting committees can be MSAC members, co-opted members or members nominated by professional bodies or

⁶⁶ Further information on the MSAC's terms of reference, membership, and applications and assessment processes and related activities can be found at its Internet site—www.health.gov.au/haf/msac

stakeholder organisations. Appointments to supporting committees are made by the MSAC. New technologies affecting the NCSP must be subject to recommendations for public funding by the MSAC, and the Minister must endorse these recommendations, before they attract Medicare benefits. However, new technologies that do not attract Medicare benefits can be introduced without assessment by the MSAC. To date, no new technologies have been referred to MSAC by the NCSP.

4.44 Notwithstanding, there is an increasing amount of new technology that is available to be applied to the testing of Pap smears. Also relevant is that, as mentioned earlier in this chapter, DHAC has informed the ANAO that it is developing mechanisms for 'Horizon Scanning' within the health system more broadly. This involves proactive identification, prioritisation and, where necessary, review of new medical technologies that may have significant effects in terms of safety, health outcomes or costs.

Audit finding

DHAC, in conjunction with the NCSP NAC, has recognised that the introduction of new technologies, while having potential benefits, may also pose potential risks to the Program and has a New Technologies Working Group in place.

Quality Assurance

4.45 The guidelines for managing cervical screening programs, published by the World Health Organisation,⁶⁷ emphasise the importance of quality control and quality assurance to a cervical screening program. Considerable progress has been made to ensure that the NCSP has sound quality assurance practices in place throughout the screening pathway. An early example is *Making the Pap Smear Better*,⁶⁸ which set the scene for many later developments.

⁶⁷ A.B. Miller, 1992, *Cervical cancer screening programmes Managerial Guidelines*, World Health Organisation, Geneva.

⁶⁸ Commonwealth Department of Health, Housing, Local government and Community Services, 1993, *Making the Pap Smear Better, Report of the Steering Group on Quality Assurance in Screening for the Prevention of Cancer of the Cervix*, AGPS.

4.46 Within the Program, DHAC supports the NAC's Quality Assurance Working Group whose roles include:

- monitoring quality assurance outcomes for the Program;
- reviewing findings from current quality assurance projects and making recommendations to the National Advisory Committee;
- coopting technical experts in the field where necessary to provide advice, and identify areas where laboratory adherence to performance standards require improvement;
- identifying methods to improve quantitative and qualitative measures of quality in Pap smears and make recommendations to the National Advisory Committee; and
- examining and recommending opportunities to standardise histopathology nomenclature and reporting of cervical pathology.

4.47 Membership of the Quality Assurance Working Group includes representatives from the Commonwealth and the States and Territories and members included for their expertise in pathology and cytology quality assurance.

General Practitioners

4.48 GPs take around 80 per cent of all Pap smears in Australia and play a vital role in the Program. Not only are GPs in an ideal position to encourage women to participate in the Program, but they also provide the necessary referral and support to women with screen detected abnormalities.⁶⁹ The potential areas of risks to the Program associated with GPs include:

- non-compliance with NCSP screening policy;
- unsatisfactory quality of Pap smears; and
- unsatisfactory quality for women of the smear taking experience.

4.49 It is clear that the Program is providing GPs with information and training so that they may continue to improve the quality of service to women and increase participation rates. Commonwealth and State initiatives include:⁷⁰

- a handbook, *Screening for the Prevention for Cervical Cancer*;
- national guidelines for the management of women with screen detected abnormalities;

⁶⁹ Commonwealth of Australia, 2000, *A Decade of Change, A Report on Australia's National Cervical Screening Program, 1989–1999*, p. 6.

⁷⁰ *ibid*, p. 9.

- a laminated quick reference guide;
- the use of interpreters and women's health nurses in some States to augment GP's services and to ensure that they are better able to meet the needs of all Australian women in a sensitive and culturally appropriate manner;
- the establishment of State and Territory based registers and reminder systems, which have been valuable in improving screening rates and providing education and practice-based support; and
- the provision of funding by the Commonwealth, through the Divisions of General Practice Program and the National Health and Medical Research Council, to encourage GPs to work with other health professionals to improve the quality of service delivery at the local level.

4.50 In addition, the Commonwealth and representatives of GPs have recently signed an agreement encouraging GPs to undertake population health activities such as cervical screening.

4.51 DHAC has identified future challenges as:

- ensuring that GPs' clinical practice is evidence-based;
- identifying women who do not undergo screening or who unnecessarily re-screen early, and encouraging behaviour change in these groups;
- incorporating appropriate new technologies into general practice; and
- coping with the medico-legal uncertainties associated with screening.

Audit finding

The ANAO found that DHAC, in conjunction with the NCSP NAC, is working to improve GPs' compliance with screening protocols and policy.

Quality processing of smears

4.52 It is important that the reading of Pap smears in pathology laboratories is of a high standard. If the precursors to cervical cancer are missed (false negatives), treatment which will reduce the chance of a woman contracting cervical cancer will not be offered. If a negative smear is mis-read as positive the woman will be subjected to further tests. Further, if there is confidence in the quality of the reading of Pap smears, longer screening intervals will be more acceptable, which will in turn lead to a more cost-effective Program.

4.53 Quality assurance procedures in Australian pathology laboratories are discussed in detail in Chapter 5.

Colposcopy

4.54 The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, with funding assistance provided by DHAC, has developed standards for colposcopy.⁷¹ The first iteration of these standards was published in April 2001 and will be used on a voluntary basis by medical practitioners taking colposcopies. DHAC has recognised the need for ongoing review of the standards and is seeking to ensure that all women are able to access high quality colposcopy services.

Histopathology

4.55 The Quality Assurance Working Group of the NAC has initiated a project to collect information on histopathology practices, as the first step in developing protocols for the examination and reporting of biopsies as part of the management of abnormal Pap smears.

Audit finding

Since the beginning of the organised approach to screening for cancer of the cervix in 1992, the Program has recognised quality assurance as a priority. DHAC, in conjunction with the NCSP NAC, has initiated strategies to ensure that quality assurance processes are developed and implemented. The Program concentrated initially on quality in taking and processing Pap smears, but is now turning its attention to quality assurance in procedures later in the screening pathway, such as colposcopy and histopathology.

Other risks

4.56 Service providers and consumer representatives consulted reported that consumers held misconceptions about the scope of the Pap smear. These misconceptions included:

- there is only one type of cervical cancer and the Pap smear will always identify any abnormalities;
- a Pap smear will show all cancers of the reproductive system; and
- a Pap smear can be used to effectively diagnose sexually transmitted diseases.

⁷¹ A colposcopy is an examination of the vagina and the neck of the uterus by means a specifically designed instrument called a colposcope.

4.57 Because of the misconceptions some women were not reporting symptoms of other reproductive disorders to their doctors, in the belief that the Pap smear had given them a clear bill of health. In light of these comments, the ANAO suggests that DHAC review the priority afforded to this area of risk, to ensure that women are better informed about the scope of the Pap smear and the need to report symptoms to their doctor. DHAC have advised that these misconceptions were previously identified by social marketing research commissioned by DHAC on behalf of the NAC.

5. Quality Assurance of Pap Smear Analyses

This chapter examines the quality assurance system for pathology laboratories in Australia as it relates to the analyses of Pap smears. In particular, it examines overall stewardship of the system and the ability to monitor the performance of individual laboratories against performance standards.

Overview

5.1 Pathology quality assurance has three components: standards, accreditation against standards and monitoring of performance against standards. The body responsible for setting standards for pathology laboratories is the National Pathology Accreditation Advisory Council (NPAAC). The Health Insurance Commission (HIC) is responsible for the accreditation of pathology laboratories for the payment of Medicare benefits and for ensuring that laboratories are continuing to meet accreditation requirements. The accreditation requirements incorporate the standards set by NPAAC. Under an agreement with the HIC, the National Association of Testing Authorities (NATA) assesses and accredits medical testing (pathology) laboratories in Australia. The NATA accreditation program has been developed in conjunction with the Royal College of Pathologists of Australasia (RCPA).

5.2 Since accurate pathology analysis can be fundamental to successful diagnosis and treatment of medical conditions, the quality assurance of that analysis is very important. The current quality assurance system is the result of a decade or more of effort by the RCPA, the pathology industry, NPAAC, DHAC, HIC, NATA and programs with an interest in pathology quality control such as the NCSP.⁷² The need for quality assurance is now widely accepted within the pathology industry and the foundations of a sound system are in place. Commonwealth legislation regarding pathology is the subject of a current review.⁷³

5.3 Much of the following discussion is about the quality assurance of all kinds of pathology tests, not just of Pap smears. That is because the analysis of Pap smears is conducted within similar constraints as that of other pathology tests.

⁷² For further information on gynaecological (cervical) quality assurance see Commonwealth of Australia, 2000, *A Decade of Change, A Report on Australia's National Cervical Screening Program 1989–1999*, Paragon Printers, Canberra.

⁷³ For further information see www.health.gov.au/haf/branch/dtb/reviewpath.htm

Standards

5.4 NPAAC was established in 1979. The present Council is constituted under subsection 9(1) of the *National Health Act 1953*, Order No.1 of 1997,⁷⁴ and reports to the Commonwealth Minister for Health and Aged Care. The Council has the following functions:⁷⁵

- (a) to consider and make recommendations to the Commonwealth, the States and Territories about:*
 - (i) developing policy for accreditation of pathology laboratories;*
 - (ii) introducing and maintaining uniform standards of practice in pathology laboratories throughout Australia;*
 - (iii) adopting coordinated legislation and administrative action in providing pathology services;*
- (b) to initiate, promote and coordinate educational programs about pathology laboratory practice; and*
- (c) at the request of the Minister, a State Minister or a Territory Minister—to provide advice about the accreditation of a particular pathology laboratory.*

5.5 NPAAC has developed standards and requirements relevant to the processing of Pap smears.⁷⁶ In addition, NPAAC is developing guidelines to address new technologies and standards to improve quality systems in medical laboratories.⁷⁷

⁷⁴ National Pathology Accreditation Advisory Council Order No.1 of 1997.

⁷⁵ For further information see www.health.gov.au/haf/branch/dtb/npaac.htm

⁷⁶ These include:

- *Requirements for Gynaecological (Cervical) Cytology (1997); and*
- *Standards for Pathology Laboratories (1998).*

A further relevant NPAAC publication is *Criteria for Assessment of External Quality Assurance Programs*. Volume 2, published in 1996, includes criteria for cytology.

⁷⁷ Examples are:

- *Guidelines for the use of Fluid Based Collection Systems and Automated and Semi-Automated Screening Devices in the Practice of Gynaecological (Cervical) Cytology (Consultation Draft March 2000); and*
- *Draft Guidelines for Quality Systems in Medical Laboratories (First Draft July 2000).*

5.6 NPAAC has two standing committees, the Laboratory Standards and Education Committee (LSE) and the Planning and Liaison Committee (PAL).⁷⁸ The first is the operational committee of the NPAAC and is concerned with establishing working parties and sub-committees to draft standard and guideline documents. The second committee is responsible for liaison with other accreditation bodies, advising the NPAAC on publicity aspects related to accreditation of pathology services and the dissemination of information on NPAAC and the accreditation system.

5.7 There are a number of sub-committees working on specific issues. The relevant sub-committee for the NCSP is the Gynaecological (Cervical) Cytology Sub-committee. To ensure liaison between this sub-committee and the NCSP Quality Assurance Working Group a member of each is also a member of the other.

5.8 In 1996 the Department of Health and Aged Care published *Performance Standards for Australian Laboratories Reporting Cervical Cytology*. These standards were developed by the Working Party on Quality Assurance in Cervical Cytology, established under the aegis of the NCSP NAC.

5.9 NPAAC *Requirements for Gynaecological (Cervical) Cytology* include a requirement that;

8.1.1 Laboratories must be enrolled, participate and remain in an external quality assurance program (QAP) complying with NPAAC criteria.

8.1.2 The external QAP will include assessment against outcome standards which are quantitative performance measures as agreed between the Commonwealth (National Cervical Screening Program) and the QAP from time to time.

5.10 The quantitative performance measures are those contained in *Performance Standards for Australian Laboratories Reporting Cervical Cytology*. Compliance with 8.1.2 (above) became mandatory from 1 July 1999.

5.11 Section 23DNA of the *Health Insurance Act 1973* empowers the Minister to determine the principles to be used in approving or refusing an application for accreditation under the Act. Determinations under this section are disallowable instruments under Section 46A of the *Acts Interpretation Act 1901*. A requirement of these principles is that pathology laboratories comply with NPAAC guidelines.

⁷⁸ See www.health.gov.au/haf/branch/dtb/npaac

Audit finding

There is a structure in place to develop, promulgate and maintain standards for pathology laboratories including for the analyses of Pap smears. There is provision to ensure coordination between the NPAAC and the NCSP in developing standards for gynaecological (cervical) cytology.

Accreditation

5.12 Section 16A of the *Health Insurance Act 1973* requires pathology laboratories to be accredited under the Act to be eligible for Medicare payments for the services they provide. Section 23 DN of the Act empowers the Minister for Health and Aged Care (or delegate) to approve premises as an accredited pathology laboratory. There is a deed in place between the HIC and NATA. Under this deed NATA has agreed to conduct inspections of pathology laboratories and to report to the HIC, to enable the HIC to provide assistance to the Minister in approving premises as accredited pathology laboratories.

5.13 The NATA accreditation process is an outcome of the NATA/RCPA medical testing accreditation program. Under this program, teams of experienced pathologists and scientists, led by a NATA officer, inspect pathology laboratories. The laboratories are measured against several standards.⁷⁹ The HIC's involvement in pathology quality assurance results from its responsibilities under Section 23 DN of the *Health Insurance Act 1973*, and its responsibilities to ensure that Medicare payments to pathology laboratories are made in accordance with the Act. The HIC has controls in place to ensure that payments for pathology services as a whole are made in accordance with legislation. These controls are audited as part of the ANAO's audit of the Commission's financial statements.

Audit finding

There are provisions in place to ensure that pathology laboratories are accredited both by NATA and the HIC. The HIC has controls in place to ensure that payments for pathology services are only made to accredited laboratories.

⁷⁹ These include:

- National Pathology Accreditation Advisory Council (NPAAC) *Requirements for Gynaecological (Cervical) Cytology*;
- Other NPAAC requirements;
- Gynaecological cytology performance standards; and
- ISO/IEC Guide 17025 (1999).

The Pathology Quality and Outlays Agreement

5.14 The Pathology Quality and Outlays Agreement is a cooperative agreement between the Commonwealth Government and the two peak pathology professional bodies—the Australian Association of Pathology Practices (AAPP) and the Royal College of Pathologists of Australasia (RCPA)—to manage pathology expenditure under the Medicare benefits arrangements. It represents a three-year partnership from 1 July 1999 to 30 June 2002, which has been recently extended a further two years to 30 June 2004. Pathology expenditure in 1999–2000 was \$1 086 million, of which about \$25 million (2.3 per cent) was for pathology tests on Pap smears.

5.15 An important objective of the Agreement is to improve quality in pathology testing, use and practice. The Quality Use of Pathology Program is designed to support cooperation between requesting doctors and pathologists to develop and demonstrate best practice in pathology ordering, use and practice. One of the objectives of the program is to reduce pathology expenditure by improving the ordering practices of doctors and eliminating unnecessary tests.

5.16 Another program, the Quality of Testing Initiative will:

support efforts aimed at exploring a range of testing related issues in a rapidly changing environment. Activities will focus on both processes and outputs of pathology testing. They will cover support of the work of the NPAAC in developing standards relevant to current and future laboratory needs, and the pathology profession in developing systems to identify early testing problems.

5.17 Two Committees established by the Agreement are relevant to pathology quality assurance. These are the Pathology Consultative Committee and the Quality Use of Pathology Committee. The terms of reference for these Committees do not include responsibility for the oversight of the pathology quality assurance process.

5.18 The primary quality focus in the Pathology Quality and Outlays Agreement is on improving the quality of pathology ordering within the context of the clinical management of the patient. Notwithstanding, there are sufficient references in the Agreement to indicate that the quality of processes in pathology laboratories is encompassed by the Agreement. However, oversight of the quality assurance process is not a specific responsibility of any of the committees established under the Agreement. DHAC have advised that the Pathology Consultative Committee, at its meeting of 19 October 2000, noted the need for urgent attention in the area of poor laboratory performance.

Audit finding

The Pathology Quality and Outlays Agreement includes a 'quality of testing initiative.' However, oversight of the quality assurance process is not a specific responsibility of any of the committees established under the Agreement.

Monitoring of performance against standards

Monitoring

5.19 Quality assurance implies a desired quality level and testing to ensure that product of the desired quality level is reaching the consumer. NATA accreditation inspections are the method of testing used in the Australian pathology quality assurance process. NATA accreditation is granted for periods of up to three years, depending on NATA's assessment of the laboratory.

5.20 To maintain accreditation laboratories are required to report annually on their performance against quantitative performance standards to the RCPA Quality Assurance Programs Pty Ltd (the RCPA QAP). DHAC has advised that the RCPA QAP undertakes regular monitoring of laboratory performance against standards between NATA inspections. The RCPA QAP publishes data on performance against standards each year.⁸⁰ This data does not identify individual laboratories but does show the number of laboratories not meeting standards. The RCPA QAP also provides laboratories with certificates confirming participation in an external quality assurance program.

5.21 NATA only has access to a laboratory's performance data during an accreditation inspection. Between inspections NATA has no access to information on the performance of individual laboratories and is unable to monitor their performance. As the only information available to the HIC is contained in NATA accreditation reports, the HIC is also unable to monitor the performance of individual laboratories, including the performance of laboratories analysing Pap smears.

⁸⁰ RCPA Cytopathology Quality Assurance Program, *Performance Standards for Australian Laboratories Reporting Cervical Cytology, 1999—Data for January 1 to December 31, 1998*.

5.22 The results of Pap smears are reported to Cervical Cytology Registers. By aggregating this information by laboratory, registers are also able to monitor a laboratory's performance against standards. However, in many States when women agree to their data being placed on the register, monitoring the performance of laboratories is not a specified use of this data. Under privacy legislation, this places limitations on the use of register data to monitor the performance of pathology laboratories. Cervical Cytology Registers only contain data on women resident in their State. Some laboratories have interstate business, which is a possible limitation on the use of register data to monitor laboratory performance.

5.23 In one State, a report from the State registry indicated that some pathology laboratories in that State were not meeting performance standards. However, because of privacy concerns, managers in the State cervical screening programs were unable to identify for themselves, or others, the laboratories not meeting performance standards. HIC was not aware of this information.

5.24 One of the roles of the NCSP Quality Assurance Working Group is to monitor quality assurance outcomes for the Program. A review of the minutes of meetings of the Working Group confirms that it is monitoring outcomes. The Working Group's review of the 1999 RCPA QAP report identified problems in monitoring the performance of pathology laboratories processing Pap smears and discussed possible solutions.

Compliance action

5.25 The NCSP Quality Assurance Working Group, as a sub-committee of the NCSP NAC, is an advisory body. Neither the Working Group nor the NAC has authority to take action to assist or compel non-complying laboratories to meet standards. Nor do they have sufficient information to identify laboratories whose performance warrants action.

5.26 NATA can refuse accreditation or refuse to renew accreditation for a laboratory that does not comply with standards. Before taking this step NATA will advise the laboratory of the measures needed to meet accreditation standards and will normally give the laboratory time to take the necessary corrective action. Where a laboratory has been refused NATA accreditation, NATA will advise the HIC of its action. A laboratory that has been refused NATA accreditation but still has accreditation under the *Health Insurance Act 1973* remains eligible for the payment of Medicare benefits on the services it provides until that accreditation is revoked.

5.27 The Minister (or delegate) can revoke accreditation under the *Health Insurance Act 1973*. Section 23DN empowers the Minister (or delegate) to revoke accreditation. Where there is a decision to revoke accreditation, subject to the *Administrative Appeals Tribunal Act 1975*, application may be made to the Administrative Appeals Tribunal for review of the decision to revoke by or on behalf of a person whose interests are affected by the decision.

5.28 As mentioned earlier, NATA accreditation is granted for periods of up to three years. The only body in a position to monitor the performance of individual laboratories between NATA inspections is the RCPA QAP. DHAC has advised that this is an issue concerning NPAAC. At the meeting of 31 October 2000 the NPAAC Executive noted that '*An area for investigation concerns the response to poorly performing participants, enrolled in the RCPA Quality Assurance programs.*' After this meeting NPAAC wrote to the RCPA QAP to ascertain what steps and procedures were undertaken with respect to persistent poor performance of participating laboratories.

5.29 Section 23DNA empowers the Minister to determine the principles to be used in approving or refusing an application for accreditation. Determinations under this section are disallowable instruments under Section 46A of the *Acts Interpretation Act 1901*. One principle requires laboratories to participate in an external quality assurance program. Laboratories are required to provide the HIC with an annual certificate of participation. A certificate is required for each area of pathology for which the laboratory is accredited. Note that if there is a dispute about accreditation, the Minister can also ask NPAAC for advice on the accreditation of a particular pathology laboratory.

5.30 Section 23DNA could be used to include as a requirement for accreditation for gynaecological (cervical) cytology a condition that data on a pathology laboratory's performance against the quantitative performance standards is made available annually to NATA through the RCPA QAP. NATA would provide the HIC with a report on non-complying laboratories with recommended action. As this data is already provided to the RCPA QAP, provision of the data by the RCPA QAP would minimise the administrative burden on pathology laboratories. This would improve the Commonwealth's ability to satisfy itself that services for which it is paying are of the required quality.

5.31 This measure would be most likely to be successful if it were negotiated with and accepted by the pathology industry. Establishing the measure would require consultation between the RCPA, the AAPP, NATA, DHAC and the HIC. It is the Department of Health and Aged Care that formulates policy proposals and seeks to gain industry acceptance on policy issues, and DHAC could be expected to take a lead role in the negotiations.

5.32 The ANAO has examined the pathology quality assurance process as it applies to the analysis of Pap smears. The ANAO has not examined in detail the quality assurance process for other areas of pathology. Accordingly, the recommendation below is directed only to gynaecological (cervical) cytology. However, the principle that the accreditation authority (HIC) should monitor pathology laboratory performance against quantitative performance standards has general application across all types of pathology analysis where quantitative performance standards exist.

Audit finding

RCPA Quality Assurance Programs publishes information on the performance of pathology laboratories against gynaecological (cervical) cytology standards. However, this information does not identify individual laboratories. The ability of pathology laboratories to meet gynaecological (cervical) cytology quality standards is tested by NATA as part of the NATA/RCPA quality assurance program. NATA inspection reports are used by the HIC to determine accreditation under the Health Insurance Act 1973. NATA inspections can be up to three years apart, with no information available to NATA or the HIC to monitor the performance of laboratories between inspections. The quality assurance program would provide more effective reassurance on quality standards if NATA and the HIC between NATA inspections could monitor the performance of individual laboratories.

Recommendation No.3

5.33 The ANAO recommends that DHAC and the HIC explore with the pathology industry the inclusion, as a requirement for accreditation for gynaecological (cervical) cytology, a condition that data on a pathology laboratory's performance against quantitative standards is made available annually to the HIC. This would improve the Commonwealth's ability to satisfy itself that services for which it is paying are of the required quality.

DHAC's response

5.34 The department agrees with this recommendation and recognises that it would be valuable to have information on the performance of laboratories in the periods between inspections by the National Association of Testing Authorities, Australia and the Royal College of Pathologists of Australasia (NATA/RCPA). As noted in the report, the National Pathology Accreditation Advisory Council (NPAAC) wrote to the Royal College of Pathologists of Australasia Quality Assurance Program (RCPA QAP) in late 2000. This letter raised a number of issues, including processes currently in place to address consistent under-performance by laboratories in quality assurance programs. The board of the RCPA QAP is currently considering these issues. The department will continue to take a lead role in working with relevant parties to facilitate provision of this data to the HIC.

HIC's response

5.35 The HIC agrees with the general thrust of this recommendation. Accordingly, the HIC is currently working with DHAC, the lead government agency, and the RCPA QAP to streamline reporting arrangements and improve annual reporting mechanisms already in place. The HIC recommends that Approved Pathology Laboratories be required to demonstrate satisfactory performance in the quality assurance program prior to continued accreditation.

Stewardship of the Pathology Quality Assurance Program

5.36 Table 5.1 summarises the roles of participants in the complicated quality assurance process for gynaecological (cervical) cytology, and shows whom they are responsible to. Many of the bodies noted in the Table are responsible to the Commonwealth Minister for Health and Aged Care and are subject to ministerial direction. However, the RCPA QAP and NATA do not report to the Minister and are not subject to ministerial direction.

Table 5.1**Participants in Pathology Quality Assurance**

Participant	Responsible for	Responsible to
NPAAC	Setting and promulgating standards and guidelines	Minister for Health and Aged Care
RCPA QAP	RCPA external quality assurance program	RCPA
NATA	Testing the performance of pathology laboratories against standards	Memorandum of understanding with Commonwealth that NATA is preferred accreditation authority. To HIC through deed of arrangement.
HIC	Accreditation of pathology laboratories under <i>Health Insurance Act 1973</i>	Minister for Health and Aged Care Operates within the bounds of policy set by the Department of Health and Aged Care and the service level agreement between the department and the HIC
NCSP Quality Assurance Working Group	Monitoring system performance against standards Providing advice to NPAAC on new or revised standards	AHMAC, through the NCSP NAC Minister for Health and Aged Care, through Primary Prevention and Early Detection Branch of the Department of Health and Aged Care
Pathology Consultative Committee (Pathology Agreement)	Overseeing the Pathology Quality and Outlays Agreement	Minister for Health and Aged Care Pathology Industry
Quality Use of Pathology Committee (Pathology Agreement)	Overseeing the development and implementation of a range of quality initiatives in pathology	Minister for Health and Aged Care Pathology Industry

5.37 With five or more committees or organisations involved in the quality assurance process, the ANAO expected to find that responsibility for stewardship of the process was clearly assigned. However, none of the bodies shown in Table 5.1 has an overall responsibility for gynaecological (cervical) cytology quality assurance or for the pathology quality assurance process as a whole. The ANAO has been unable to identify a position with clear responsibility for the oversight of the pathology quality assurance process, or committee with responsibility for advising on the oversight of the pathology quality assurance process.

5.38 Without clearly defined responsibility for oversight of the pathology quality assurance process and authority to address any identified deficiencies:

- activities of participants in the process may not be properly coordinated;
- accountability for the process as a whole is not possible;
- risks to the success of the process may not be identified and addressed;
- the quality of services provided to women and their doctors may not reach the required standards; and
- the benefits possible from an organised approach to cervical screening may be reduced.

5.39 Clearly assigned responsibility for stewardship may require a new committee, or an extension to the terms of reference of an existing committee. This audit is focussed on the National Cervical Screening Program. The examination of gynaecological (cervical) cytology quality assurance has been designed to provide an assurance that there is a satisfactory quality assurance process in place or to identify gaps and make recommendations for improvement. However, the finding of a lack of clear responsibility for oversight of the pathology quality assurance process applies generally to all types of pathology. Accordingly, the recommendation is couched in general terms.

Audit finding

The ANAO has been unable to identify a position or body with clear responsibility for the oversight of the pathology quality assurance process.

Recommendation No.4

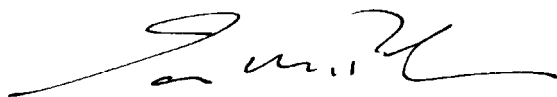
5.40 The ANAO recommends that DHAC, in order to achieve well-defined stewardship of the pathology quality assurance process, should take steps to assign responsibility for oversight of the process.

DHAC's response

5.41 The department agrees with this recommendation and recognises the need for a committee to provide oversight of the pathology quality assurance process. Given the current role of NPAAC in developing and reviewing standards for pathology laboratories, it may be appropriate for the terms of reference of this body to be extended to include oversight of quality assurance processes. The department will investigate the assignment of responsibility for the quality assurance process to NPAAC as a matter of priority.

New Zealand—the Gisborne Ministerial Inquiry

5.42 The report of a Ministerial Inquiry in New Zealand (Report of the Ministerial Inquiry into the Under-Reporting of Cervical Smear Abnormalities in the Gisborne Region⁸¹) was published on 10 April 2001. The Inquiry concerned the reading of abnormalities in cervical smears in the Gisborne region prior to March 1996. The report identifies a number of systemic problems with the New Zealand National Cervical Screening Program. There are differences between the Australian and New Zealand approaches; for instance, in the period covered, quality assurance was compulsory in Australian laboratories reading cervical cytology but not in New Zealand laboratories. Despite these differences, the ANAO considers that there would be value in a review of the quality assurance component of the Australian program in the light of the findings of the New Zealand Inquiry and other overseas experience. DHAC have advised that the issues identified by the New Zealand Ministerial Inquiry and issues raised in cervical cytology in comparable countries such as the USA and the United Kingdom will be considered as part of its ongoing monitoring and review processes.



Canberra ACT
15 June 2001

Ian McPhee
Acting Auditor-General

⁸¹ The report can be found at www.csi.org.nz

Appendices

Appendix 1

The National Cervical Screening Program⁸²

Cervical cancer

1. Cancer of the cervix is the fourteenth most common cancer in Australian women. One in 156 Australian women will develop cancer of the cervix in their lifetime. Cervical cancer⁸³ affects the cells lining the cervix, which is the lower part of the womb or uterus as it joins the inner end of the vagina. Like other cancers, cervical cancer is a disease where normal cells change, begin to multiply out of control and form a growth or tumour. If not caught early enough, the disease can spread to other parts of the body. The main symptoms of cervical cancer are unusual bleeding from the vagina, and sometimes an unusual vaginal discharge. However, these symptoms do not always indicate that pre-cancerous changes are taking place. The Pap smear, which is described in more detail below, is an effective means of identifying whether unusual symptoms indicate that further examination and treatment is required.

2. A cervical cancer can take 10 or more years to develop, but before this the cells may show pre-cancerous changes. These early changes can be detected by a Pap smear. With early treatment, there is an excellent chance of a full recovery. There are two levels of severity of these pre-cancerous lesions, low-grade abnormalities and high-grade abnormalities, with the higher-grade lesions more likely to develop into cancer.

3. The Pap smear is the most common way to detect pre-cancerous changes, which rarely cause any symptoms. The test involves a doctor inserting a speculum into the vagina and gently scraping the surface of the cervix. This process collects cells that are transferred onto a slide or into a special liquid, which is then sent to a pathology laboratory for assessment. Pap smears are offered by general practitioners, gynecologists, family planning clinics, hospital outpatient clinics and in some circumstances, nurse practitioners or other health workers.

⁸² A detailed description can be found in *A Decade of Change* (Commonwealth of Australia, 2000, *A Decade of Change A Report on Australia's National Cervical Screening Program 1989–1999*).

⁸³ This description of cervical cancer is taken from *Cervical Screening in Australia 1997–1998* (Australian Institute of Health and Welfare, 2000, *Cervical Screening in Australia 1997–1998*, Canberra, Appendix A: Cervical Cancer: *symptoms, detection and treatment*).

4. If the Pap smear suggests a pre-cancerous change, a doctor is able to look directly at the cervix by inserting an instrument called a colposcope into the vagina. Using a special stain the doctor can highlight any suspicious areas, pre-cancerous or cancerous. The doctor will then take a tissue sample (a biopsy) of the suspicious area for further examination by the pathologist.

5. Pre-cancerous changes are relatively easy to treat and curable in nearly all cases. The type of treatment offered to the woman depends on whether the type of change observed is low- or high-grade, the woman's age and general health, whether she wants to have children, and her preferences.

6. There is a range of treatments for pre-cancerous changes, including cryosurgery (freezing), cauterisation (burning also called diathermy), laser surgery, or loop or cone biopsies. In a small number of instances a hysterectomy may be necessary, especially if changed cells are found inside the opening of the uterus and the woman does not want to have children in the future.

7. For invasive cancer, cone biopsy or hysterectomy is generally performed. If the cancer cells are only detected on the surface of the cervix, it may be treated by a cone biopsy. If it has invaded more deeply into the cervix, a hysterectomy is generally performed. In advanced cases, a radical hysterectomy is needed to remove the cervix and uterus along with a margin of tissue around the cervix and lymph nodes from the pelvis. Radiotherapy is sometimes used as well as surgery, and for more advanced cases it may be used on its own.

Background to the Organised Approach to screening for Cervical Cancer⁸⁴

8. Australian women have been screened for cervical cancer since the 1960s. Since then, Pap smears have been the usual means of screening women for changes that may indicate pre-cancerous developments. Pap smears are usually taken by general practitioners, with the resulting Pap smears read by pathology laboratories. The taking and processing of Pap smears by eligible practitioners attracts a Medicare subsidy.

⁸⁴ Centre for Health Program Evaluation and University of Melbourne, 1995, *Victorian Evaluation of the Commonwealth/State Program 'The Organised Approach to Preventing Cancer of the Cervix, The Organised Approach—Who's Organising?'* and A Joint Commonwealth/State Initiative Managed by the Western and Central Sydney Area Health Service, *New South Wales Cervical Screening Program Strategic Directions (1996–1999)*.

9. Mortality from cervical cancer decreased during the 1970s and 80s due to the finances expended by Commonwealth, State and Territory governments and the efforts of medical practitioners. Notwithstanding, it was believed more could be achieved. Prior to 1991, while 90 per cent of squamous⁸⁵ cervical cancer was preventable through screening, only about 50 per cent of potential cases were being prevented. This fact prompted Australian Health Ministers to commission a Commonwealth-funded evaluation of existing services and possible alternative and improved service provision through targeted pilot projects. This evaluation culminated in the Australian Health Minister's Advisory Council (AHMAC) Cervical Cancer Screening Evaluation Report (CCSER).

10. The CCSER reported that significant elements of an organised screening pathway for cervical cancer did not exist in Australia. In addition, the report suggested that optimal impact was not being achieved for a number of reasons. These included:

- lack of an agreed screening policy, including a target age group and re-screening interval and insufficient efforts to increase uptake among all women at risk;
- poor access by women to service providers of choice;
- other barriers to screening, ranging from negative attitudes to screening to simply forgetting;
- absence of fail-safe systems to follow-up women with abnormalities;
- lack of agreement on appropriate management; and
- the absence of a national framework to monitor and co-ordinate recruitment, recall, management of abnormalities and quality assurance.

11. AHMAC received the report in late 1990 and invited the Commonwealth to conduct discussions on the recommendations. The responses, which came out of these discussions, were set down in the document *Cervical Cancer Screening an Organised Approach*. In this document, the importance of the following elements were identified:

- Screening women at two yearly intervals. Screening should commence at age 20 or within one to two years of first sexual intercourse,

⁸⁵ Of the several types of cervical cancer, squamous cell carcinoma is the most commonly seen. Squamous cell carcinoma of the cervix is usually preceded by non-malignant abnormalities. These abnormalities once detected through a Pap smear test may be treated successfully. The ability of these cancer precursor abnormalities to be detected and treated ensure this cancer is suited to a screening program. (*Important causes of ill-health in Australia, in Australia's Health, 1996, The fifth biennial health Report of the Australian Institute of Health and Welfare, AGPS, p. 71*).

whichever is the later and finish when the women reaches age 70, if she has a history of normal Pap smears.

- The development of a comprehensive communication strategy to explain the policy on screening to service providers and women.
- Formal recruitment and recall plans for identifying target population groups, particularly those assessed as being under-screened, such as older and Aboriginal women, and identifying appropriate strategies for recruitment and recall with an indicative time frame.
- Appropriate goals, including participation rates and process targets, and reduction in morbidity and mortality from cervical cancer.
- Monitoring and evaluation of State and Territory programs, by States and territories, and development of broad strategies for accomplishing stated goals.
- The possible establishment of cervical cytology registries in States and Territories.
- Quality assurance for test taking, test reading and notification of results.

12. Based upon these principles, the Organised Approach to Preventing Cancer of the Cervix was established in June 1992 by the Commonwealth, States and Territories. The approach encapsulated 11 internationally recognised elements of the cervical cancer-screening pathway. These elements are set out below:

- Recruitment
- Pap smear taking
- Pap smear reporting
- Notification of Pap smear results
- Management of women with abnormal Pap smears
- Quality Assurance and Monitoring
- Accreditation
- Policy
- Coordination
- Funding
- Education and Research.

13. In 1994 an evaluation of the Organised Approach to the Prevention of Cancer found that the number of women participating in screening had risen alongside a reduction in the total number of Pap smears taken due to compliance with two yearly screening protocols. It was noted, however, that the greatest increase in participation occurred in the women

under 35 years. This group was also known to be a lower risk than women over 35. Consequently, the evaluation recommended that the Commonwealth implement strategies which target older women, rural women and hard to reach groups such as Aboriginal women and women from non-English speaking backgrounds.

Participation in the National Cervical Screening Program

14. The National Cervical Screening Program is a population screening program. The Program aims to reduce the incidence of morbidity and mortality from cervical cancer, in a cost-effective manner through an organised approach to screening.⁸⁶

15. The NCSP has achieved a small but consistent increase in participation rates among the target population of women aged 20–69, throughout Australia. During the period from 1992–1994, an estimated 61 per cent of women were screened. Between 1996–1997, 62.4 per cent of women were screened. During 1997–1998, records show that 63.9 per cent of women were screened. This has resulted in 90 273 more women being screened in the latter period. In 1997–1998 more than 2.7 million Australian women had Pap smears. In 1997 alone, this led to around 25 000 pre-cancerous abnormalities being detected.

The National Advisory Committee

16. An organised approach to cervical cancer screening requires a mechanism to ensure that all steps along the screening pathway are appropriately managed. In Australia, the mechanism used is the National Advisory Committee (NAC) and its Working Groups. The NAC provides AHMAC with policy advice on cervical screening and supplies a forum for debate and discussion on policy, recruitment, quality assurance, pathology reporting and other relevant matters. The NAC has five working groups:

- Quality Assurance Working Group;
- Education, Communication and Recruitment Working Group;
- Policy Review and Cost-Effectiveness Working Group;
- New Technologies Working Group; and
- Aboriginal and Torres Strait Women's Forum.

⁸⁶ Commonwealth of Australia, 2000, *A Decade of Change, A Report on Australia's National Cervical Screening Program, 1989-1999*, p. 7.

17. The National Advisory Committee and its Working Groups are discussed in Chapter 2.

18. Commonwealth and States and Territory responsibilities are separated out as follows:

- The Commonwealth is responsible for the overall direction of the NCSP, including:
 - quality assurance,
 - monitoring and review of the national Program;
 - Medicare payments to medical providers for Pap smear taking and reading of Screen-Detected Abnormalities;
 - funding assistance to the States and Territories through the Public Health Outcome Funding Agreements; and
 - the accreditation and registration of pathology laboratories for eligibility for Medicare payments for the reading of Pap smears.
- States and Territories are responsible for:
 - funding of State and Territory activities, with funding assistance from the Commonwealth;
 - regional co-ordination and delivery of the Organised Approach, including:
 - * the development of screening recruitment programs for women;
 - * the operation of Pap smear registries;
 - * operation and funding of cancer registries; and
 - * delivery of relevant medical services in public hospitals under Australian Health Care agreements.

Appendix 2

Health and Aged Care – Portfolio Mission

The services provided by the Health and Aged Care portfolio are delivered through nine portfolio outcomes.⁸⁷

The Department of Health and Aged Care (DHAC) pursues the achievement of the portfolio outcomes in association with other agencies in the Portfolio: the Health Insurance Commission, Australian Hearing Services, the Aged Care Standards Accreditation Agency, the Private Health Insurance Administration Council, the Private Health Insurance Ombudsman, the Professional Services Review Scheme, the Australian New Zealand Food Authority, the Australian Institute of Health and Welfare and the Australian Radiation Protection and Nuclear Safety Authority.

The Portfolio of Health and Aged Care has a diverse set of responsibilities, but throughout there is a common purpose, which is reflected in the department's mission statement.

Mission

To lead the development of Australia's health and aged care system

By:

- providing expert policy advice, analysis and other services to the Government;
- consulting and collaborating with State and Territory governments, professional organisations, industry groups and consumers;
- promoting healthy living and communicating information about health and aged care services;
- managing the Commonwealth's health and aged care programs to ensure the provision of quality, cost effective health care; and
- safeguarding health, safety and equity, in a way that imposes minimal regulatory burden.

⁸⁷ Commonwealth of Australia, 2000, Budget Related Paper No. 1.11, *Portfolio Budget Statements 2000–01, Health and Aged Care Portfolio*, p. 7.

Vision

The vision for the department and the Portfolio is:

A world class health and aged care system for all Australians

The nine specific outcomes the Government has set for the Portfolio are:

1. Protection and promotion of the health of all Australians and minimisation of the incidence of preventable mortality, illness, injury and disability.
2. Access through Medicare to cost-effective medical services, medicines and acute health care for all Australians.
3. Support for healthy ageing for older Australians and quality and cost-effective care for frail older people and support for their carers.
4. Improved quality, integration and effectiveness for health care.
5. Improved health outcomes for Australians living in regional, rural and remote locations.
6. Reduced consequences of hearing loss for eligible clients and a reduced incidence of hearing loss in the broader community.
7. Improved health status for Aboriginal and Torres Strait Islander people.
8. A viable private health industry to improve the choice of health services for Australians.
9. Knowledge, information and training for developing better strategies to improve the health of Australians.

The Portfolio's success in achieving this vision will be reflected in part by the achievement of the following broad health and aged care service targets, which are measured biannually by the Australian Institute of Health and Welfare:

- continued improvements in life expectancy for both males and females over time;
- further reductions in infant mortality rates over time;
- improved life expectancy, health expectancy and infant mortality rates for Aboriginal and Torres Strait Islanders so that they are comparable with the general population; and
- improved life expectancy, health expectancy and infant mortality rates for low income Australians so that they are comparable with the general population.

Appendix 3

Terms of Reference – National Advisory Committee and Working Groups

National Cervical Screening Program

National Advisory Committee

The National Advisory Committee for the National Cervical Screening Program has the following responsibilities, to:

1. develop national policy and standards for the National Cervical Screening Program in the light of emerging issues and in line with outcomes of evidence based research and oversee a work program to address agreed priorities;
2. promote and monitor best practice and quality assurance across all stages of the screening pathway including the identification of areas requiring assessment or review;
3. provide a focus for informed comment and debate on issues relating to cervical screening, particularly in respect of medical/technical developments, research and epidemiological evidence;
4. take a key role in monitoring the Program and provide input into evaluation; and
5. oversee and develop priorities for, and monitor communication and recruitment strategies.

In undertaking the tasks identified in the terms of reference the Committee may from time to time form such working parties as are required to progress particular initiatives.

Policy and Cost-Effectiveness Working Group

The role of the Policy and Cost-Effectiveness Working Group is to:

1. review national policy in the light of recent evidence and emerging issues;
2. assess the capacity to monitor the outcomes of the Program in relation to infrastructure and information systems;
3. consider financial implications of current and potential screening practices, make assessments and propose options for development;
4. coopt technical experts in the field where necessary to provide advice;
5. monitor program performance outcomes and consider an evaluation strategy for the National Advisory Committee; and
6. make recommendations to the National Advisory Committee.

New Technologies Working Group

The role of New Technologies Working Group is to:

1. consider changes in technology and their actual and potential impact on cervical screening and make recommendations to the National Advisory Committee;
2. consider and respond to reports that evaluate the new technologies in cervical screening such as the AHTAC report;
3. coopt technical experts in the field where necessary to provide advice;
4. liaise with the appropriate professional bodies to provide guidance and support to service providers who need to address issues related to cervical screening methodologies within the context of relevant ethical and medico-legal issues;
5. monitor the usage of new technologies in cervical screening;
6. establish minimum criteria on scientific evidence and cost effectiveness that should be satisfied for new technologies; and
7. consider the cost implications of the new technologies for women and for the Program.

Quality Assurance Working Group

The role of the Quality Assurance Working Group is to:

1. monitor quality assurance outcomes for the Program;
2. review findings from current quality assurance projects and make recommendations to the National Advisory Committee;
3. coopt technical experts in the field where necessary to provide advice, and identify areas where laboratory adherence to performance standards require improvement;
4. identify methods to improve quantitative and qualitative measures of quality in Pap smears and make recommendations to the National Advisory Committee; and
5. examine and recommend opportunities to standardise histology nomenclature and reporting of cervical pathology.

Education, Communication and Recruitment Working Group

The role of the Education, Communication and Recruitment Working Group is to:

1. provide advice to the National Advisory Committee for the National Cervical Screening Program about education, communication and recruitment activities to ensure that they are consistent with the national policy of the National Cervical Screening Program;
2. provide a consultation mechanism within existing networks of related community and professional organisations to ensure education, communication and recruitment activities are performed in the most effective manner;
3. assist in the coordination of State and Territory strategies to underpin national campaigns to ensure that campaign messages are reinforced for maximum effect; and
4. coopt technical experts in the field where necessary to provide expertise with regard to the accuracy, currency and appropriateness of proposed education messages and/or recruitment initiatives.

Aboriginal and Torres Strait Islander Women's Forum

The role of the Aboriginal and Torres Strait Islander Women's Forum is to:

1. provide advice to the National Advisory Committee of the National Cervical Screening Program;
2. make recommendations to the National Advisory Committee;
3. provide a consultation mechanism within existing networks of related community and professional organisations to ensure education, communication and recruitment activities are performed in the most effective manner;
4. propose options for directions and priorities for National Cervical Screening Program activities for the Indigenous community; and
5. coopt expertise where necessary to provide advice.

Appendix 4

Relevant Reviews and Evaluations

1. The following reviews and evaluations have been conducted in relation to the Australian National Cervical Screening Program.
 - Australia Health Ministers' Advisory Council Cervical Cancer Screening Evaluation Steering Committee (1991), *Cervical cancer screening in Australia: options for change*, Australian Government Publishing Service, Canberra.
 - Department of Health, Housing, Local Government and Community Services (1993), *Making the Pap Smear Better, Report of the Steering Group on Quality Assurance in Screening for the Prevention of Cancer of the Cervix*, Australian Government Publishing Service, Canberra.
 - Department of Human Services and Health (1995) *The Interim Evaluation of the Organised Approach to Preventing Cancer of the Cervix, 1991–1995, Report of the Evaluation Steering Committee, May 1995*, Australian Government Publishing Service, Canberra.
 - The Centre for Health Program Evaluation, University of Melbourne (1995) *The Organised Approach—Who's Organising? Victorian Evaluation of the Commonwealth/State Program 'The Organised Approach to Preventing Cancer of the Cervix'*, funded by the Victorian Department of Health and Community Services.
 - Department of Health and Aged Care (2000), *A Decade of Change, A report on Australia's National Cervical Screening Program 1989–1999*, Paragon Printers, Australasia.
2. There is also an annual report by the Australian Institute of Health and Welfare (AIHW), which reports the performance of the NCSP against agreed key performance indicators.
 - AIHW, (2000) *Cervical screening in Australia 1997–98*, National Capital Printing, Canberra.
3. The following audit report, conducted in relation to the UK Cervical Screening Program, was used to assist in planning the audit.
 - Comptroller and Auditor General (UK) (1998), *The Performance of the NHS Cervical Screening Programme in England*, National Audit Office.

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