Brief
Cervical Screening Changes

Purpose

To brief the Department of Health on key considerations of the proposed changes to the National Cervical Screening Program from the perspective of NCOPP public pathology members.

Background

Changes to the current 2 yearly Pap test screening program are scheduled for 1 May 2017. These changes follow MSAC recommendations and see the replacement of conventional 2 yearly pap smears with 5 yearly Human Papillomavirus tests (HPV) with reflex Liquid Base Cytology (LBC).

Critical Issues

MBS item changes

- Two new items for HPV and LBC tests are required to be introduced to the Medicare Benefits Schedule (MBS).
- The proposed MBS fees in the MSAC outcomes document, being $30 for HPV and $19.45 for LBC, are too low and do not cover the costs of providing the tests.
- The new HPV and LBC items must be exempt from coning.
- The GP/Nurse Practitioner pap smear consultation item should be amended to reflect the changes and appropriate specimen collection method (e.g. in a liquid based medium).
- The de-listing of the MBS items for the existing cervical cancer screening test should occur after a 6 month period accompanied by a robust communication campaign led by the Department of Health to GPs/Nurse Practitioners and the public about the change.
- There are two competing technologies in LBC (Thin Prep and Sure Path). The use of a particular technology over another should not be mandated as this could result in providers being placed at a competitive disadvantage as new technology is costly and time consuming to introduce (due to retraining, re-credentialing, new quality assurance practices and relisting tests with NATA etc.).
- HPV must be a standalone item and thus excluded from items 69494, 69495, 69496, 69316, 69317, 69319 and their associated/referred item numbers. This will ensure that the costs of the HPV tests are covered by a fee, which is important to ensuring access to the tests. Having a separate item also ensures that screening of other sexually transmitted diseases are not compromised and activity data can be reconciled with that sent to the appropriate register.

Costings

The change to practice means that LBC will be a diagnostic as opposed to a screening test. This entails additional costs associated with scientific and pathologist review.

As the consumable cost of a HPV test generally exceeds $25, the proposed $30 fee is insufficient. While bottom up costing is the preferred approach, some laboratories have reported difficulty in costing the test as it is dependent on the costs of new kits and automation which is currently unknown. As such, reference could be made to Item 69496 $43.05 as the HPV test will be a complex multiplex test looking for three different types of HPV (16 and 18 and "other" high risk types), and require appropriate internal controls/human DNA test. There is a concern that manufacturers of HPV test kits will alter the price of their kits to reflect the MBS fee rather than the cost of the kits plus appropriate margin.

There is no justifiable reason to have a separate public and private Patient Episode Initiation (PEI) fee. There should be the same PEI fee attached to the new items for both the public and private pathology sector.

Ph +61 2 9431 8672 | Fax +61 2 9431 8677 | www.ncopp.org.au
PO Box 576 Crows Nest NSW 1585 Australia | ncopp@ncopp.org.au | ABN 93 439 259 975

NCOPP has received the following costing data from members (note: this is cost data and is not inclusive of a margin and not reflective of MBS benefit percentages):

	Cost	
Pathology Provider	HPV	LBC
Public Pathology 1	$30.00	$82.00
Public Pathology 2	$26.08	$53.72
Public Pathology 3	$44.23	$59.39
Public Pathology 4	Refer to page 1, paragraph 5	$69.47
Public Pathology 5	$49.60	$44.10

Workforce changes

There have not been significant workforce changes within public pathology organisations as a result of the Department of Health announcement of the adoption of MSAC cervical screening recommendations. Workload has been increasing in SA and parts of NSW by 20% and 33% respectively, however this may not be directly attributable to the announcement of the change.

NCOPP members have plans to manage the change internally. These include a range of measures such as focusing on meeting the requirements of increasing non-gynecological cytology activity, natural attrition and position description modifications, and taking the lead in the adoption of new technology (e.g. digital imaging such as Ki-67 digital counting).

A concerning issue since the announcement has been the reduction in cytology educational opportunities. Teaching tutorials have reduced along with the willingness of academic staff to continue or start rotations in cytology at some universities. Attraction and retention of scientists to the cytology profession is likely to be problematic into the future at the same time as an increased proportion of complex cases will be seen in the public sector. Likewise it will be difficult to sustain training, examination and continuing education infrastructure. A Department of Health funded training program with incentive payments for host organisations and creation of training positions may be appropriate in the future once the cytology workforce has been appropriately sized to accommodate the change. In the short term, fee subsidisation and incentives for cytology training capped to reflect the size of the workforce required to meet the change going forward, would assist in retention of appropriate numbers of staff.

Due consideration should be given implications of the Commonwealth funding redundancy packages for displaced staff.

Recommendation

It is recommended that the Department of Health introduce MBS items for HPV and LBC in line with the above considerations. It is recommended that the Department liaise with the Australian Society of Cytology to review the provision of training in light of the change.

Jenny Sikorski, CEO NCOPP, 17 April 2015