



**MBS Review Advisory
Committee**

**Colonoscopy Working
Group**

Draft Findings Report

August 2023

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Summary

In 2021, colorectal cancer (also known as bowel cancer) was the fourth most diagnosed cancer in Australia and had the second highest cancer mortality rate (Australian Institute of Health and Welfare, 2021). Colonoscopy is the best way to diagnose colorectal cancer. In addition to modification of lifestyle risk factors, colonoscopy can also help prevent colorectal cancer and is an important tool for managing IBD. However, current access to colonoscopy services is neither equitable or timely for many Australians, with people living in regional/remote and low-socioeconomic areas being particularly disadvantaged. In 2018–19, the rate of Medicare Benefits Schedule (MBS)-subsidised colonoscopies was:

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

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

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

In August 2022, the MBS Review Advisory Committee (MRAC) agreed to establish the Colonoscopy Working Group (CWG) to perform a post-implementation review of the 1 November 2019 changes to MBS-funded colonoscopy items. The first meeting of the CWG was held in February 2023 and has had the opportunity to review three years of data on the new MBS items.

The CWG considered that the changes to the surveillance colonoscopy items had not achieved, nor were not on track to achieve, their intended outcomes of:

- reducing the number of low-value colonoscopies performed
- addressing equity issues:
 - people living in rural/remote or low-socioeconomic areas, and Aboriginal and Torres Strait Islander populations, still have a lower rate of colonoscopies than those in metropolitan areas (AIHW, 2022).
 - high out-of-pocket costs for private colonoscopy services remain

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

NBCSP data also suggest that only 10–14% of total colonoscopy activity in Australia is occurring within the NBCSP (Worthington, et al., 2023). As such, the CWG noted that it is possible that a lot of colonoscopies performed to exclude colon cancer may be occurring outside of the NBCSP, but that currently no data linkage exists to confirm this.

Limitations remain in assessing the appropriateness of repeat colonoscopies. The CWG were concerned that the most frequent repeat colonoscopies in the 3 years since the MBS item changes came into effect were for the MBS item for the assessment of people at normal risk of colon cancer and with no diagnosis of IBD (Department of Health and Aged Care, 2023), indicating that many repeat colonoscopies could be considered low value care. More than 100,000 repeat colonoscopies were performed on people in this category in the past three years, with a large proportion of these repeats being performed by different providers over this period. The CWG were concerned that a lack of access to results of previous colonoscopy was resulting in unnecessary repeat colonoscopy for people at low or normal risk of colon cancer.

Draft recommendations

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

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

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

This recommendation would support appropriateness of colonoscopy, and aligns with [Quality Statement 9 of the Colonoscopy Clinical Care Standard](#) (ACSQHC, 2020), which states:

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

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

This includes a requirement that the applicant confirms their compliance with Quality Statement 9 for the 150 cases submitted, and that they must include evidence of compliance in their audits. Additionally, in their by-laws for accreditation to the facility, private hospitals are requested to include a requirement for compliance with Quality Statement 9, and that a copy of both the colonoscopy report and pathology report must be sent to medical records.

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

Better communication with patients about their risk of bowel cancer, modifiable lifestyle risk factors, and the appropriate use of colonoscopy should be developed (with guidance from consumer groups) by either the Cancer Council (alongside its updated [Clinical practice guidelines for surveillance colonoscopy](#)), the Department's screening branch, or Healthdirect.

Better education is also needed for GPs and proceduralists around symptoms that lead to colonoscopy referrals, and the role of new tests in informing referrals. This includes the use of faecal calprotectin for IBD; the appropriate use of FOBT in symptomatic, low-risk individuals; and guidelines for the investigation of iron deficiency among women who menstruate. The Australian Commission on Safety and Quality in Health Care could develop these resources.

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

This would promote informed decision-making by empowering both consumers (by providing absolute risk for asymptomatic people who are low risk for colon cancer) and clinicians (by supporting shared decision making) and support high-quality colonoscopy.

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

The CWG noted that a review of rural generalist training was currently underway; a greater focus on GP-endoscopist training could be incorporated in the program.

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

Recommendation requiring further consultation

Another recommendation considered by the CWG is the following:

Separate the positive FOBT indication from MBS item 32222 and limit direct access to colonoscopy to only FOBT-positive patients or those with a positive history of blood in the stool.

The CWG considered whether the inclusion of a requirement for an initial consultation with an endoscopist for people without a positive FOBT or blood in stool would improve equity of access to colonoscopy for people in rural/remote and low-socioeconomic areas by reducing the number of unnecessary colonoscopies performed and therefore improve the capacity of the workforce to undertake more targeted procedures. However, it was noted this is a complex area and changes to direct access colonoscopy provision could have negative consequences including increased costs for some consumers. The CWG considered that all other requests for colonoscopy should be accompanied by a relevant medical history, documentation, and be reviewed by an endoscopist to assess suitability for the procedure.

Further discussion is required around the requirement for consultation for other indications within MBS item 32222 and the CWG welcomes comments on whether these considerations will improve high-value care and equity.

The CWG also invites further suggestions on how to improve equity of access to colonoscopy for people in rural/remote and low-socioeconomic areas who receive a positive FOBT as part of the NBCSP. The NBCSP is an area of focus as the CWG recognises that screening programs involve uncovering diseases in asymptomatic people, and there is a lack of support for follow-up (including in the long term) for those who have positive FOBTs as part of the NBCSP. This lack of follow-up support is especially difficult for people in rural/remote and low-socioeconomic areas, where accessing and affording specialist consultation is very challenging – it is known that 70% of colonoscopies are performed in the private sector, and without private health insurance, the majority of patients incur significant out-of-pocket costs (DOHAC, 2023).

Abbreviations

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

Preamble

Medicare Benefits Schedule Continuous Review

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

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

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

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

Medicare Benefits Schedule Review Advisory Committee

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

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

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

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

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

Medicare Benefits Schedule Continuous Review Guiding Principles

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

a) The MBS:

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

b) Service providers of the MBS:

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

c) Consumers of the MBS:

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

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

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

Government consideration

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

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

Colonoscopy Working Group

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

The CWG met on 4 occasions: Friday 3 February, Wednesday 22 March, Thursday 20 April and Thursday 22 June 2023.

Background to the post-implementation review

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

The aims of the revised structure were to:

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

Changes to MBS colonoscopy items

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

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

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

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

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

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

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

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

Post-implementation review

This is the first post-implementation review (PIR) of the 1 November 2019 changes to colonoscopy MBS items.

The Department of Health and Aged Care (the Department) has developed a framework that guides PIRs of changes that have arisen from the MBS Review Taskforce and from MRAC recommendations. PIRs are used to determine if the changes have met their clinical intent and how the MBS items are being used in practice.

PIRs follow a 3-step model:

1. gather datasets
2. analysis by the Department and prepare PIR report for review by the MRAC
3. recommend and implement corrective actions, if necessary.

PIRs are usually conducted 24 months after implementation of a change, although some items may require more or less time to gather the necessary data to inform a robust review. In most instances, this PIR has used MBS data from 36 months following the implementation of the changes.

Colonoscopy Working Group findings

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

Population

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

The CWG considered that many repeat colonoscopies continued to be performed for seemingly inappropriate purposes, largely within MBS item 32222; in the 3 years since the MBS item changes (November 2019—November 2022), over 100,000 people had repeat colonoscopies under item 32222, with a large proportion of these repeats being performed by different endoscopists (DOHAC, 2023).

The CWG also considered that increased prevalence of iron deficiency in young women had contributed to an increased number of colonoscopies being performed in this population. The rate of colonoscopy among women aged 15–54 years was up to double that of men of the same age; outside of this age range, rates of colonoscopy were only 10% higher among women compared to men (DOHAC, 2023). Clear guidance around the investigation and management of iron deficiency in pre-menopausal women is needed to assist with addressing this issue, especially as heavy menstrual bleed is under recognised and potentially a driver of inappropriate referral to an endoscopist. As women who menstruate may present with bowel cancer (AIHW, 2022), it is important that practitioners consider the possibility of this, noting that risks associated with complications of colonoscopy, such as perforation, should be considered as for all patients referred for the service. However, the CWG also noted that this group may be more likely to present with other symptoms or blood tests requiring further investigation, so this was a complex area.

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

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

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

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

Intervention

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

Along with the gap in colonoscopy rates for different populations, the CWG noted that there was a lack of communication with patients about how the item changes affected their colonoscopy intervals, which caused stress to some patients.

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

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

The CWG also noted anecdotal evidence that patients were concerned about being asked to come back for a separate procedure because clinicians may not perform a gastroscopy and colonoscopy with polypectomy on the same day, due to the financial impact of the multiple operation rule. However, the CWG noted

that this was not reflected in the data, as less than 0.01% of colonoscopies had a gastroscopy in the following 6 months.

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

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

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

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

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

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

Comparator

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

- improving communication with patients
- better engaging General Practice and Primary Care in bowel screening and the assessment of people with iron deficiency and anaemia
- incentivising clinicians (including endoscopists, anaesthetists and nursing staff) to work in disadvantaged areas. This may include supporting existing

programs and organisations that encourage proceduralists to visit these areas (e.g. [CheckUP](#)).

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

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

Outcomes

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

Assessment of main issues

Total colonoscopy items

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

- the ability of providers to directly refer patients for colonoscopy
- a lack of clarity around time frames for follow-up colonoscopies based on the findings of the current colonoscopy.

The CWG considered that the NBCSP may be contributing to inappropriate repeat colonoscopies for people with normal results from an initial colonoscopy. Despite many people not requiring a repeat colonoscopy for 10 years, the NBCSP routinely sends out bowel cancer screening kits 4 years after a colonoscopy. Furthermore, the [NBCSP patient information booklet](#) suggests that people who do not want to skip a screening round can request a repeat FOBT 2 years after a colonoscopy. The CWG considered that there needs to be better education of, and communication with, patients and GPs on appropriate intervals for repeat colonoscopy.

Inequity of access for rural and low-socioeconomic populations

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

The CWG considered that a way to remove a barrier for priority populations was to allow direct access to a colonoscopy following a positive FOBT. This would mean that they would not have to pay to consult with an endoscopist prior to colonoscopy.

The CWG also noted that the NBCSP is now distributing kits to GPs, with the aim of increasing uptake in the program for Aboriginal and Torres Strait Islander patients. As part of these changes, GPs can now interact with the National Cancer Screening Register. This may support more patients who are receiving regular colonoscopies to be removed from the National Cancer Screening Register, thereby reducing inappropriate investigations.

The CWG noted that the NBCSP has a hot-zone policy, where invitations are scheduled to be sent in the cooler months of the year for relevant postcodes. This means that there are postcodes where invitations are limited to a 3–6-month window per year. The CWG considered that the temperature issue with the kits was not well known among GPs or patients, so there should be an education campaign and increased communication about the NBCSP's hot-zone policy.

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

Lack of patient communication

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

The CWG noted that MBS item usage data show that post-menarche, pre-menopausal women continue to have many more colonoscopies than their counter-parts of the same age (DOHAC, 2023; Services Australia, 2023). The CWG were concerned that other causes of iron deficiency anaemia such as heavy menstrual bleeding or diet may not be appropriately considered in these women, and that they are possibly being referred for low-value colonoscopy procedures. The CWG considered that there needs to be clear guidance around the evaluation of bowel symptoms and iron deficiency in younger women, but that this was an issue that could only partly be solved through MBS items. This guidance could be developed by the Australian Commission on Safety and Quality in Health Care.

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

Multiple claims for MBS item 32222

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

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

- measurement of the number of colonoscopies being performed for that indication
- a request to be included in the item explanatory notes that the result be reported back to the National Cancer Screening Registry
- restriction on the number of repeats

- direct access to only be given to that indication, which could incentivise its use in disadvantaged populations.

However, more information was needed on the potential benefits and unintended consequences of doing this.

The CWG also recalled that, several years ago, the MBS item for FOBT covered 2 tests: chemical testing, which detects upper-gastrointestinal bleeding; and the immunoassay, which detects lower-gastrointestinal bleeding. These were available for patients with clear evidence of melena or iron deficiency who require testing for both upper- and lower-gastrointestinal bleeding. To support the NBCSP through GPs, the chemical testing was removed from the MBS item, so laboratories no longer perform this test. However, this means that the current item covers all positive FOBTs, whether they are performed as part of the NBCSP or not. The CWG considered that this could be addressed by having 2 FOBT items: one for screening that requires the results for screening to be uploaded to the National Cancer Screening Registry, and one for clinical evidence of blood loss or investigation of bowel symptoms in young people.

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

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

Information gaps and barriers to implementation

Missing information from MBS data

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

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

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

How colonoscopies are funded in Australia

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

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

And potentially through

7. transport accident compensation
8. workers compensation.

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

The CWG noted that there is currently a compliance project underway that is focusing on public hospitals charging back to Medicare, with colonoscopy being a key issue. It is expected that a lot of data will come from this project that may assist the CWG in its current assessment.

Consultation and feedback review process

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

All feedback provided through consultation processes is considered.

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