CHAPTER 6

COST-EFFECTIVENESS OF THE PROGRAM

6.1 One measure of the success of the Program will be the extent to which it delivers services in a cost-effective manner. This Chapter discusses the current funding arrangements for the Program and issues related to the cost-effectiveness of the Program, especially the extent to which it represents 'value for money'; and whether it is being delivered in the most efficient way. In relation to the delivery of services, the chapter discusses the current mix of public and private sector service delivery and the issue of the effectiveness of the current funding arrangements for the Program versus the introduction of a Medicare rebate system.

Current Funding Arrangements

6.2 Commonwealth funding for the Program for 1994-95 will be $41.8 million. The Commonwealth has also committed $236.6 million over the next five years from 1994-95 to 1998-99, to the Program. Commonwealth expenditure under the Program since its introduction is shown below:

Year	Expenditure ($million)
1990-91	1.0
1991-92	15.5
1992-93	14.9
1993-94 (est)	25.6
Other	
1992/1993 savings (screening shortfalls)	1.2
Departmental Running Costs	2.6
Offset to Medicare (biopsies not performed under the Program)	1.5
Rollover to 1994/95	2.5
TOTAL	64.8

Source: Letter from DHS&H to the Committee, dated 25 May 1994, p.1.

6.3 The table shows that Commonwealth funds totalling $64.8 million were allocated since the establishment of the Program. Of this total, $57 million was for Program costs, and $2.6 million for Departmental running costs. A further $5.2 million reflected savings in 1992-3, offsets to Medicare and rollover funds to 1994-95.

6.4 Payments to the States consist of funding for three activities:

- screening and assessment (matched and unmatched funds);
- data management (unmatched funds); and
- training (unmatched funds).

6.5 All States and the ACT have signed a participation agreement with the Commonwealth for the first phase of the Program which provides funding for the establishment or expansion of the Program. They have also entered into a cost-sharing agreement with the Commonwealth which provides funding on a 50/50 cost-shared basis (to 30 June 1994). Under this agreement, Commonwealth funding for each State/Territory is based on the projected number of women screened.[290]

Cost-effectiveness

6.6 In determining the cost-effectiveness of the Program there are two basic questions that need to be addressed – whether the screening program contributes more per dollar spent to the improvement of health than other competing uses for health resources and whether the program is being delivered in the most efficient way to achieve the desired outcomes.

1. The Screening Program - is it Value for Money?

6.7 A number of studies have addressed the issue of whether the Program represents 'value for money'. The studies have looked at the balance of benefits and risks and converted them into a quantitative value, for example, the economic cost of a life year gained or the cost of a life saved. The SECU report found that if an economic cost per life year gained of approximately $6,600-$11,000 (at 1988-89 prices) is considered acceptable value for money then mammography screening, (as subsequently implemented by the National Program), can be recommended on economic grounds.[291]

6.8 A study was subsequently undertaken by Carter et al., applying more sophisticated computer analysis to the original cost data in the SECU study.[292] The study found that the screening policy under the National Program, that is,

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290. Submission No. 114, p.8.7 (DHS&H).

291. SECU Report, *op. cit.*, p.29. The SECU data was based on information from Australian pilot projects. Assumptions in the study included a 2-year screening interval and a 70% participation rate by women aged 40-69. The concept 'cost per life year gained' is the cost of lengthening the life by one year for each patient who could otherwise have died from breast cancer. For example, for some women early detection may result in say, 30 more years of life than if undetected, for others, detection may be too late to increase the life of the patient at all. All these 'extra' years of life are added together and the result divided by the total cost of the Program.

292. R. Carter et al., 'Cost-Effectiveness of Mammographic Screening in Australia', *Australian Journal of Public Health*, vol. 17, No.1, 1993, p.42.

screening women aged 40-69 years every two years, has an average cost-effectiveness of $20,300 per life gained which is comparable to many other uses of health care resources. The study concluded that screening all women aged 50-69 years every 2 to 3 years is 'reasonable value for money'.[293] The study noted that 'a properly conducted breast cancer screening program could be cost-effective by current standards, and certainly more cost-effective than quite a number of health programs currently being funded in Australia'.[294]

6.9 One submission also provided estimates of the cost-effectiveness of the Program. The RACS, Section of Breast Surgery estimated that, based on the cost of the Program in NSW, the cost per life saved is $167,000.[295] The College noted that if the benefits of mammographic screening provide less than a 30 per cent reduction in mortality and if participation is significantly less than 70 per cent, the cost per life saved will increase substantially.

6.10 Using the same reduction in mortality but with a participation rate of 50 per cent, the College estimated that the cost per life saved would increase to $235,000. The College argued that 'it is difficult to justify' continued funding for the Program based on this cost-benefit analysis.[296] These data indicate, that if the Program fails to achieve a 70 per cent participation rate and/or the reduction in mortality is less than anticipated, for much the same costs overall (that is, with facilities and staff in places) then the average cost of the Program will increase substantially.

6.11 Evidence received by the Committee indicated that little quantitative data are available on the overall cost-effectiveness of the Program. DHS&H stated in its submission that it is expected that valid estimates of average and marginal costs for each program component will only be possible after some years when it can be expected that 'economies of scale' will be realised and the Program is at 'steady state' operation (that is, fully operational and screening at maximum planned capacity).[297]

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293. *ibid.*

294. *ibid.*, p.49.

295. *Transcript of Evidence*, p.1328 (RACS, Section of Breast Surgery). This estimate was based on a 30 per cent reduction in mortality and a 70 per cent participation rate amongst eligible women in NSW. Note: the figure quoted, i.e. $167,000, is the cost per life saved and not the cost per life year saved as cited in the SECU study.

296. *ibid.*, p.1329.

297. Submission No.114, p.9.7 (DHS&H). DHS&H stated that at the current stage of implementation, the start-up and other fixed costs would distort cost analysis. In the longer term, capital costs are annualised (that is, averaged out over a period of time), and this bears little relationship to the patterns of actual expenditure currently being experienced within the National Program.

6.12 The Department also noted that it is not anticipated that a detailed economic analysis will be possible except as part of the longer term evaluation of the Program. A specific analysis will, however, be made of remote area costs from available expenditure data, and an attempt will be made to compare the cost-effectiveness of the various models of service delivery which have been adopted within the Program. The evaluation, in the long term, may also attempt to assess the relative efficiency of delivering a population-based screening program through the coordinated, controlled model recommended by the SECU Report or through some other model.[298]

6.13 DHS&H provided some information to the Committee on the rural and remote area costs associated with the Program. The Department noted that a detailed study of remote area costs is currently being undertaken. The Department stated that preliminary results indicate that the additional cost of service delivery in rural and remote areas is estimated to be $20 per woman screened.

6.14 The factors contributing to the additional costs in rural and remote area service provision were identified by the Department as:

- the specific costs of operating mobile services in rural/remote areas (living away allowances and travel expenses, film courier expenses, van towage expenses, costs of transporting an assessment team to the mobile);
- rural/remote area capacity utilisation constraints stemming from climate, terrain, down-time;
- mobile service design factors (providing an expert breast assessment service to remote areas; film processing on board); and
- 'learning curve' issues associated with running a mobile in rural/remote areas, particularly with respect to planning and implementing an effective service.[299]

6.15 The States generally indicated that the Program would be cost-effective, at least in the longer term. Several States, including Victoria and Queensland, noted that the initial costs associated with establishing the screening Program have been relatively high.[300] BreastScreen noted that these high start-up costs were due to the investment in infrastructure development (for example, purchase of radiology equipment, and data system hardware), and other capital costs associated with establishing new Services. The States indicated, however, that cost reductions will occur when the Program is fully implemented over subsequent years as economies of scale will be achieved through much higher throughput of women screened (i.e.

298. Submission No.114, p.9.7 (DHS&H).

299. Additional information from DHS&H to the Committee, dated 18 February 1994, pp.1-2.

300. *Transcript of Evidence*, p.951 (Queensland Department of Health); p.1118 (BreastScreen).

increasing numbers of women using the Services).

6.16 BreastScreen noted that 'in Victoria, steady state capacity will result in screening over 220,000 women per annum. Achievement of this high participation rate will result in the maximum use of capped funds which will see the unit cost of providing BreastScreen services fall accordingly'.[301]

6.17 The ultimate test of the effectiveness of the Program will be the extent to which it has led to a reduction in breast cancer mortality. DHS&H noted that a recent analysis of the combined results of five randomised controlled trials in selected overseas countries have demonstrated a statistically significant reduction in mortality of about 30 per cent in the women aged 50-69 invited for screening.[302]

6.18 One witness noted, however, that it will prove difficult to demonstrate that the Program has been effective in Australia in terms of a reduction in mortality. The witness noted that the benefits of mammographic screening have to be measured by the difference in mortality between a screened population and a control group (that is, an unscreened population group). This cannot be done in Australia because it is not a population-based program in that there is no control population against which to compare the results in the group that has been screened. In Australia, there is the additional problem of extensive de facto screening in the existing health care system. Due to these factors, the witness noted that it will be difficult to obtain a clear answer to the question of whether mammographic screening has been beneficial or not.[303]

6.19 Overseas studies have shown benefits of up to 60 per cent in terms of reductions in mortality from screening programs. These studies have been carefully conducted population-based controlled trials. Populations were identified in several geographic areas and invited to attend for screening and the mortality in these populations was compared with the mortality from breast cancer over the same period of time in populations which had not been invited for screening. In the populations which had not been invited for screening, the incidence of de facto screening or other mammographic examination was also low.[304]

6.20 The Committee notes also that the morality of population-based controlled trials would need to be considered, in that the 'control' population would be denied access to the probable benefits of a screening program.

Future Funding

6.21 Evidence to the Committee indicated that continuity of funding is needed for

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301. *Transcript of Evidence*, p.1118 (BreastScreen).

302. Submission No.114, p.9.2 (DHS&H).

303. *Transcript of Evidence*, p.1343 (RACS, Section of Breast Surgery).

304. *ibid.*, pp.1343-4.

the Program's future development. For example, the Western Australian Health Department indicated that the joint funding agreement should be extended to at least June 1996 to allow for the full implementation of the Program in that State.[305] Prior to the announcement in the 1994-95 Budget, funding for the Program was guaranteed only until June 1994.

6.22 The Committee believes that on-going funding should be guaranteed so that the Program can be effectively implemented throughout Australia. In this regard, the Committee welcomes the announcement in the 1994-95 Budget of the Commonwealth's commitment of $236.6 million over the next five years to the on-going implementation and expansion of the Program.

Conclusions

6.23 The Committee recognises that any detailed and systematic attempt to assess the cost-effectiveness of the Program must necessarily be conducted over the longer-term, especially when the Program becomes fully operational. The Committee, however, considers that a detailed cost-benefit analysis of the Program should form part of any on-going evaluation of the Program as it is an important means by which the benefits of the Program, in a quantifiable way, can be demonstrated. The collection of uniform data by the States and Territories is also an important prerequisite in determining the Program's cost-effectiveness.

6.24 The Committee, however, notes that the cost-effectiveness of the Program in a purely economic sense is only one measure of the overall effectiveness of the Program. Even measures of economic cost-effectiveness involve subjective judgements and often the measures themselves may be open to question. Any attempt to assess the overall effectiveness of the Program must take into account factors other than purely economic ones, including the effect of the Program on mortality rates, community values and other non-quantifiable, quality-of-life issues.

Delivery of Services

6.25 The cost-effectiveness of the Program also needs to address the issue of whether services are being delivered in the most efficient manner. In the following sections issues relating to the mix of public/private services and the provision of a Medicare rebate are addressed.

Mix of Public and Private Services

6.26 Screening and assessment services may be located in either the private or public sectors. The SECU Report argued that these services could be established within either sector at the discretion of the States and Territories. The Report noted that the keys to obtaining optimal performance from a screening program are training, quality assurance and monitoring, accreditation and the funding mechanisms, not whether the service is located in the public or private sector. The

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305. *Transcript of Evidence*, p.160 (Health Department of Western Australia).

report noted:

> Since no particular benefits arise from a screening program being located wholly in the public or private sectors, there is no reason to recommend that a screening program be located wholly either in the public or private sectors. The expertise and facilities which would be required by a screening program currently reside in both the public and private sectors and it is likely that a screening program would involve both sectors. Such an approach also has the advantage that it maximises the use of currently deployed resources.[306]

6.27 In line with the recommendations of the SECU Report, the Program has left the determination of the public/private mix of services to the individual States/Territories. Currently, screening and assessment services are located in both the public and private sectors in NSW, Victoria, Queensland, Western Australia and Tasmania, while they are wholly located in the public sector in South Australia and the Australian Capital Territory.[307] All States, however, utilise private sector practitioners in the provision of services.

6.28 The Accreditation Guidelines provide that screening and assessment services, located in either the public or private sectors, must meet the same accreditation guidelines in order for the Service to qualify for funding under the Program.[308]

6.29 The Committee received evidence during the inquiry of the cost advantages of permitting mammography services to be provided by existing private radiological practices. One submission argued that many of the facilities, including expensive mammography equipment, used by the Program are simply a duplication of private facilities that already exist throughout Australia.[309] It was argued that, to an extent, existing mammographic facilities are under-utilised at present. It was also argued that in urban areas especially, high quality private mammographic services already exist and many of these facilities are more conveniently located than the fixed centres established under the Program.[310] However, the submission did not address the problem of access to mammographic services in rural areas and the Committee believes that without the establishment of public services in these areas under the auspices of the National Program, screening services, would in all likelihood, be denied to women in these areas.

6.30 In Queensland, in particular, it was argued that there has been little attempt

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306. SECU Report, *op. cit.*, p.87.

307. Submission No. 114, p.6.3 (DHS&H).

308. Accreditation Guidelines, *op. cit.*, p.3.

309. *Transcript of Evidence*, pp.1331-2 (RACS, Section of Breast Surgery).

310. *Transcript of Evidence*, p.1316 (RACS, Section of Breast Surgery).

to integrate and coordinate the services of existing private radiology practices with the Program in that State.[311] It was argued that the failure to involve these private sector facilities has significantly delayed the implementation of the Program in Queensland.[312] The Queensland Department of Health commenting on these assertions argued that they have undertaken negotiations with at least two private sector facilities with a view to involving them in the Program in Queensland.[313] The Committee was advised that a private radiology service in Cairns has been contracted to the Program as the fixed screening and assessment facility for the Peninsula and Torres Strait Regional Health Authority and commenced screening operations in March 1994. Plans are also well advanced for the Wesley Breast Clinic in Brisbane to provide screening as part of the Program.[314] The Committee was advised that the Wesley Hospital Board has approved the Hospital's participation in the Program.[315]

6.31 It was stated during the inquiry that several States, including New South Wales and Victoria, already successfully use a mix of facilities in the public and private sectors. The NSW Health Department[316] and the Tasmanian Breast Screening Service[317] both stated that a positive feature of the Program in their respective States has been the involvement of the private sector in both screening and assessment. In Tasmania, utilisation of the private sector for the provision of screening and assessment services has enabled the Service to increase the accessibility of the Service to women, while keeping establishment costs to a minimum.[318]

6.32 One witness emphasised that it was more important to ensure standards of quality essential to achieving the aims of the Program, irrespective of whether the service was provided in the public or private sector.[319]

> The performance standards relating to equipment, data collection and the expertise of the service providers have already been defined by the

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311. *Transcript of Evidence*, p.1483 (RACR, Queensland Branch).

312. *Transcript of Evidence*, p.1481 (RACR, Queensland Branch). See also *Transcript of Evidence*, p.1015 (Dr Noble).

313. *Transcript of Evidence*, p.980 (Queensland Department of Health).

314. Additional information from the Queensland Department of Health to the Committee, dated 25 February 1994, p.3.

315. Advice to the Committee from the Queensland Department of Health, dated 16 May 1994.

316. *Transcript of Evidence*, p.380 (New South Wales Health Department).

317. *Transcript of Evidence*, p.1767 (Tasmanian Breast Screening Service).

318. *ibid.*, p.1761.

319. *Transcript of Evidence*, p.1048 (St Andrew's Breast Clinic, Brisbane).

National Program. It would seem to be a reasonable proposal that any dedicated service, whether in the public or the private sector, should be able to be assessed by the multi-disciplinary panel already established for that purpose in each State.[320]

6.33 Evidence presented to the Committee suggested that the quality control of radiological services in private practice is equal to that of public screening and assessment units.[321] However, other evidence suggested that it may be difficult to ensure that the high standards of quality control demanded by the Program could be replicated in the private sector. One submission noted that private sector diagnostic and management quality is 'variable' whereas the Program offers an integrated, highly specialised and high quality diagnostic service.[322] Another submission noted that monitoring the quality of service and maintaining the necessary records poses great difficulties in private practice. The submission noted that many private practitioners are 'disinclined to operate according to, and to provide records for, programs imposed upon them'.[323] It was, however, noted that it is important to use the high standard of expertise that is currently available in the private sector.[324]

6.34 The Committee considers that screening and assessment services need not be wholly located in either the public or private sectors. The Committee believes, however, that all such services, whether they be in the private or public sectors, should meet the same stringent requirements for accreditation by the Program set down in the Accreditation Guidelines. The Program's aim should be to provide high-quality and accessible services throughout the country and where services are able to be provided by the private sector, such services should be part of the National Program. The Committee believes, however, that such services should not operate in competition with accredited services.

Recommendation

The Committee RECOMMENDS:

16. That the Program avoid any duplication in the provision of screening services, but that it utilise both the private and public sectors in the provision of screening services subject to all services meeting the guidelines for accreditation established by the National Program.

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320. *ibid.*, p.1049.

321. *Transcript of Evidence*, p.1341 (RACS, Section of Breast Surgery).

322. *Transcript of Evidence*, p.785 (Dr Rickard). See also Submission No. 90, pp.3-4 (Dr Warren).

323. Submission No. 25, p.4 (Anti-Cancer Council of Victoria).

324. *Transcript of Evidence*, p.427 (New South Wales Health Department).

Medicare Rebate

6.35 Under the Program, funding of mammography screening and assessment is independent of the Medicare rebate system.[325] The SECU Report argued that funding screening mammography through the Medicare system would be a less effective means of ensuring a comprehensive, high quality and cost-effective national approach to the early detection of breast cancer. The Report noted, that while an administratively simple option, requiring only a minor change to the Medicare Benefits Schedule (MBS), it 'fails to effectively target the appropriate categories of women and has the potential to maximise costs'.[326]

6.36 Evidence presented to the Committee[327] suggested that the current arrangements are the most cost-effective means of providing a screening program. One witness noted that the effect of the Program being funded through the MBS fee-for-service would have serious cost and other implications:

> One can have a Medicare rebate for an individual process such as taking and reading film. One could conceive of a rebate for the entire process ... But one can see problems there, and one of the key issues in rebates would seem to me ... the incentives that operate in those fees. If one was to have a global fee for taking a woman, once she had fronted up for screening, all the way through the entire process, it is possible that that could lead to under-investigation ... just as a rebate for every individual step along the way has the potential to lead to over-investigation ... one has to look at the incentive effects of rebates and see what implications they have for the health of the people that are going through, for the likelihood that they are going to be investigated when they may or may not need it, and also for the cost to the public purse broadly.[328]

6.37 One submission provided data on the additional cost of introducing a fee-for-service approach to funding. The submission estimated that the additional cost of funding the Program via MBS would be $20 million per annum higher than using the current system. (It was estimated that the cost of the current arrangements is $68.6 million per annum, whereas funding under MBS would be $89 million per annum). There would also be additional financial costs imposed on women from the fee for service approach through the Medicare gap payment. Under

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325. Medicare benefits are payable for diagnostic mammography for women who present to their doctor with symptoms or indications of malignancy in the breast, or with a family history of breast cancer. For rebate purposes, diagnostic mammography is required to be rendered by a specialist in diagnostic radiology and the patient is referred with a specific request for the procedure. See Submission No. 114, p.8.3 (DHS&H).

326. SECU Report, *op. cit.*, p.78.

327. *Transcript of Evidence*, p.693 (Dr Fett); p.168 (Health Department of Western Australia).

328. *Transcript of Evidence*, pp.692-3 (Dr Fett).

this approach there is also likely to be a GP referral for the original visit, and then at least one, and possibly more for any further specialist investigations, significantly increasing the cost of the program.[329] The submission concluded that:

> Funding the program under fee for service is quite unlikely to improve outcomes for women, but is likely to substantially increase the cost of the program. We are concerned, therefore, that a move away from the program funding approach will compromise both efficiency and effectiveness of this significant national initiative.[330]

6.38 However, the cost-effectiveness of present arrangements was questioned by some witnesses. One witness argued:

> There have been doubts raised about the cost-effectiveness of both systems in various aspects of health care. ... If the Medicare system is effective for other diseases in a cost-effective sense, it could be cost-effective for this [program].[331]

6.39 The Committee notes, however that while the cervical cancer screening program, which is funded under Medicare, has been an effective screening tool for cervical cancer, it has not been cost-effective. A report analysing the Program found that there has been 'insufficient coverage of the target population resulting in significant under-screening of some subgroups of the population' and while cervical cancer screening has been a growth area in the health system 'much of the current effort is poorly directed and cost-inefficient'. [332]

6.40 It was also claimed that if the Medicare rebate system were available for screening mammography it would make the Program more accessible to increased numbers of women than is currently the case.[333]

6.41 Other witnesses, however, mentioned other advantages of retaining the present system. One witness, arguing that a Medicare rebate should not be available for screening mammography, noted that 'I do not think there is any other way to have quality control ... adequately done'.[334]

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329. Submission No. 134, pp.2-6 (Monitoring and Evaluation Reference Group).

330. *ibid.*, p.1.

331. *Transcript of Evidence*, p.1304 (RACS, New South Wales State Committee).

332. AIH, *Cervical Cancer Screening in Australia: Options for Change*, AGPS, Canberra, 1991, pp.3-4.

333. *Transcript of Evidence*, p.1304 (RACS, New South Wales State Committee).

334. *Transcript of Evidence*, p.538 (Australian Society of Breast Physicians).

6.42 It was noted that extending the Medicare rebate for screening would make quality control difficult, especially as it involves many more private providers of services. One witness raised the following scenario:

> How do you know that the accredited radiologist is reading films that day? His partner might be reading films that day, and so on. It is too difficult to police, and I think the quality control would be just about impossible. The only way to get volume through and for people to have experience is in a centre where there is very good quality control.[335]

6.43 One submission noted that funding through the MBS would lead to fragmentation of the screening/follow-up process between various providers and a tendency for unnecessary procedures; central elements of monitoring, evaluation, accreditation and limitation of numbers of services would be extremely difficult to manage; there would be no method for controlling charges to women with serious implications for access for women and for recruitment rates; and there would be difficulties associated with establishing and monitoring call and recall systems. The funding approach also has the potential for maximisation of procedures. This has cost implications and increases the number of invasive investigations to which women may be subject. The MBS fee-for-service approach also introduces a charge for women, which may discourage participation in the Program.[336]

6.44 Some witnesses considered that data collection would be compromised if Medicare rebates were introduced. One witness argued:

> If there are Medicare rebates introduced for the individual elements of the program, that greatly weakens the opportunity to collect those data. It also has the potential to significantly reduce the continuity of clinician involvement at every stage ... The spectre that the Medicare rebate raises is that there is a rebate for taking and reading a film and a rebate for assessment and a rebate for a biopsy and a rebate for treatment, and all of those different bits then become independent. They could be done by different people; the individual clinicians do not have a feel for the implications of their decisions at various points, and it becomes much more difficult to put the data together. It is not the best way to save women's lives for the money invested.[337]

6.45 Some witnesses,[338] however, suggested that it would be feasible to introduce a Medicare rebate system at accredited screening and assessment centres with appropriate quality control mechanisms in place. One witness noted that 'the

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335. *ibid.*

336. Submission No. 134, pp.3-4 (Monitoring and Evaluation Reference Group).

337. *Transcript of Evidence*, p.691 (Dr Fett).

338. *Transcript of Evidence*, p.1296 (RACS, New South Wales State Committee); p.794 (Dr Rickard).

bottom line is quality and ... how you pay for it is not really the big issue; it is how you are going to ensure that you can get quality as the outcome'.[339]

6.46 Concern is expressed during the inquiry by several witnesses that the Medicare system was being used for de facto or opportunistic screening by many women.[340] One witness expressed concerns about this practice in the following terms:

> There are a great number of women in Australia who are having mammograms, and although the Medicare benefit is designed for people with a specific range of problems there are a number of people without those problems who are having mammograms, and that is opportunistic screening. It is appropriate that screening be done with quality control ... There may not be very serious concerns about quality in most of the private and public practices that are involved in mammographic work, but there may be some and that is why quality control is appropriate. Opportunistic screening, without recording of details, allows us to have no idea of what the end result of the screening process might be.[341]

6.47 A representative of the Health Insurance Commission (HIC) advised the Committee that in relation to the extent of de facto mammography screening under Medicare the Commission had 'no hard data at all about the extent to which screening may be occurring under the Medicare program'.[342] However, data provided to the Committee by the Commission showed that the number of Medicare rebated mammography services showed some decrease in Queensland, South Australia and the Australian Capital Territory since 1990-91, although it increased in the other States.[343]

6.48 A representative of the Commission acknowledged that one factor involved could be that de facto screening decreased in those States and the ACT over the period as the screening program was being progressively implemented.[344]

6.49 The Committee believes that it is important that de facto screening not continue under Medicare. This would compromise the achievement of a high quality screening service as de facto screening is being provided without organised quality

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339. *Transcript of Evidence*, p.794 (Dr Rickard).

340. *Transcript of Evidence*, p.540 (Australian Society of Breast Physicians); p.1016 (Dr Noble).

341. *Transcript of Evidence*, p.1298 (RACS, New South Wales State Committee).

342. *Transcript of Evidence*, p.1422 (HIC).

343. *ibid.*, pp.1410F,1415. There was, however, an increase in services in Queensland from 1991-92 to 1992-93.

344. *ibid.*, p.1442.

control or specific targeting of the women most at risk. The Committee recognises that it is difficult for GPs not to provide mammography services where a woman requests a mammogram. The Committee believes, however, that more should be done to inform women about the difference between diagnostic and screening mammography.

6.50 The Committee also considers that GPs should be encouraged to provide those services only where it is necessary for adequate medical care of the patient concerned. The HIC advised the Committee that 'occasionally practitioners may apply a liberal interpretation to the item description [for mammography], particularly the 'symptoms or indications of malignancy found on examination of the patient' by a medical practitioner'.[345]

Conclusion

6.51 The Committee considers that on the basis of the evidence presented to it, funding for screening mammography needs to be provided independently of the MBS fee-for-service system.

6.52 The Committee believes that the present system provides a more cost-effective system than the alternative funding approach under Medicare. The current system also ensures a rigorous approach to quality control and data collection that would be difficult if screening and assessment services were provided on an ad hoc basis through individual providers. The Committee believes that a move away from the current funding approach would compromise both the efficiency and effectiveness of the Program.

Recommendation

The Committee RECOMMENDS:

17. That the funding of screening mammography under the Program continue to be independent of Medicare fee-for-service schedules.

345. *ibid.*, p.1410G.