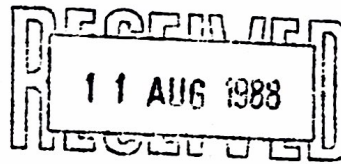


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9th August, 1988

Dr. Robin Marks
Anti-Cancer Council of Victoria,
1 Rathdowne Street,
CARLTON SOUTH VIC. 3053

Dear Robin,

Enclosed please find the final report of the VCG(S) Working Party. I apologize for the delay, however, it was necessary to incorporate some late changes suggested by some Working Party members.

Thank you very much for all the time and effort you put into the Working Party and the report!

Yours sincerely,

Sandy Gifford

Sandy Gifford
Chairperson

Nigel,

*CERVIX
FILE*

*Herewith the final
version.*

RM

**REPORT OF THE VICTORIAN
CYTOLOGY (GYNAECOLOGICAL) SERVICE
WORKING PARTY**

**CONVENED BY: THE WOMEN'S HEALTH
POLICY AND PROGRAMMES UNIT,
HEALTH DEPARTMENT VICTORIA**

JULY 1988

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REPORT OF THE VICTORIAN CYTOLOGY (GYNAECOLOGICAL) SERVICE

WORKING PARTY

1. INTRODUCTION

1.1 Background

Cancer of the cervix is one of the few cancers that can be largely prevented if detected and treated in its pre-invasive stage. The Papanicolaou (Pap) smear is an inexpensive and relatively non-invasive screening test that can be used to identify women at risk of developing cervical cancer and who need further follow-up and investigation. Despite the availability of the Pap smear, 350 women in Australia die each year from the disease. The majority of these deaths can be prevented (appendix A).

Prevention of mortality and morbidity of cervical cancer depends on an effective, and low cost public health screening program consisting of four key components: accessibility to appropriate screening services in community and primary care settings, high quality and efficient laboratory services for analyzing smears, an epidemiologic data base or registry for evaluation, and treatment and follow-up services for women at risk.

Victoria and Queensland are the only states to maintain a publicly funded laboratory service. Victoria thus has the advantage of being able to develop a comprehensive and high quality public health screening program for the early detection of cervical cancer. The majority of smears in other states are processed in the private sector. Recent policy developments at both the State and National level make it timely to review the role and function of Victoria's laboratory service, the Victorian Cytology (Gynaecological) Service. This is essential in order to ensure that there is an appropriate infra-structure to carry out new public health initiatives for women in relation to cervical cancer.

The Victorian Cytology (Gynaecological) Service (VC(G)S) was established in 1965 to provide a laboratory service to examine cervical smears taken from Victorian women. The overall goal of the VC(G)S is to provide a high quality and cost efficient laboratory and monitoring service for cytological specimens. In this regard, the VC(G)S provides a crucial public health service to women in Victoria in the early detection of cervical cancer:

1. Within a public health framework, the VC(G)S provides rigorous follow-up of all women with abnormal smears;
2. The VC(G)S is cost efficient, with each smear costing approximately \$7.76, compared with a Commonwealth rebate of \$15.65. The AMA recommended fee is currently set at \$20.50 (appendix B);
3. The VC(G)S has established a comprehensive data base which has allowed for epidemiological research and monitoring of cervical cancer and its associated risk factors.

Since the establishment of the service, the uptake of cervical screening has increased from 4,112 per 100,000 eligible women per year (4%) in 1965 to 19,700 per 100,000 eligible women (20%) in 1987¹. The VC(G)S examines and reports on 75% of all smears taken in Victoria. Several recent developments have made it necessary to examine the current and future role and function of the VC(G)S.

- The Commonwealth and State Governments have given priority to developing public health policies and programmes for cervical cancer screening. Cancer of the cervix is one of the few cancers that can be prevented if abnormalities are detected in their early stages. An effective public health programme has the real potential of reducing the mortality and morbidity due to the disease;
- Cervical screening has been given priority as a public health issue and is being actively addressed by all state governments.

1. *An "eligible" woman is defined as a women who has ever been or is sexually active and who has not had her cervix removed.*

- In April 1987, the Anti-Cancer Council of Victoria convened a working party to develop a policy for cervical cancer screening. The Working Party identified as a major barrier to developing a State-wide campaign, the difficulties that the VC(G)S would have in responding to the increased demand for their services;
- Due to increased awareness among primary health care providers of the benefits of the Pap smear, there is an increasing demand for the services of the VC(G)S. This is making it difficult for the VC(G)S to continue to provide a high quality and prompt service;
- Due to economic constraints the health sector is being asked to be more accountable for the use of resources.
- Policy changes are currently taking place concerning accountability mechanisms of health services to consumers. It is therefore timely to review the composition of the current Board of Management of the VC(G)S with a view to ensuring greater consumer representation.

In August 1987, the Women's Health Policy and Programmes Unit, Health Department Victoria, convened a Working Party to examine the current and future role of the VC(G)S in relation to the above issues.

1.2 Terms of Reference

1. To examine the role of the VC(G)S in relation to the potential increased demand for cytology services;
2. To address strategies for the development and maintenance of a state-wide data base for cervical cancer;
3. To address strategies for the development and maintenance of an epidemiologic component for cervical cancer, pre-cancer and associated risk factors;

4. To address the criteria for the future location of the VC(G)S;
5. To examine options for cytology services in Victoria including funding;
6. To examine the composition and role of the Board of Management in relation to the major users of the VC(G)S.

1.3 Membership of the Working Party:

Dr Sandra Gifford (Chair)

Women's Health Policy and Programmes Unit, Health Department Victoria
(Department of Social and Preventive Medicine, Monash University; from
November 1987)

Dr Patricia Wilkinson

Chief Medical Officer, Health Department Victoria

Dr Michael Quinn

Oncology Unit, Royal Women's Hospital

Dr Nan Presswell

Broadmeadows Community Health Centre and the Department of Community
Medicine, Melbourne University (to November 1987)

Dr Denise Ruth

Broadmeadows Community Health Centre (joined the Working Party in November,
replacing Nan Presswell)

Dr Gabriele Medley

Director, Victorian Cytology (Gynaecological) Service

Dr Judith Lumley

Department of Paediatrics, Monash University and Consultant Epidemiologist,
Health Department Victoria

Dr Robin Marks
Anti-Cancer Council of Victoria

Ms Alexandra Jones (Secretary)
Women's Health Policy and Programmes Unit, Health Department Victoria

1.4 Recommendations

Cervical Screening

1. That the VC(G)S improve its service to enable it to maintain its role as the major cervical cytology service in Victoria.
2. That the median internal turn-around time for the processing and reporting of smears be reduced to five working days, excluding mailing time.
3. That the funding of the VC(G)S be increased in proportion to the recommended increase in workload and shortened turn around time.
4. That new strategies to increase population screening be instituted only after the implications of such strategies on the demand for colposcopy services are assessed in detail. These strategies should be accompanied by the necessary funding to ensure that colposcopy services are adequate to meet the increased demand.

Monitoring and Evaluation

1. That the Working Party develop a proposal to establish a State-wide Registry for Cervical Smears.
2. The the State-wide Registry be independently managed but housed on the same premises as the VC(G)S.
3. That the Working Party submit the proposal to the Women's Health Policy and Programmes Unit, Health Department Victoria and that the Health Department submit the proposal to the Commonwealth on behalf of the Working Party (Appendix I).

4. That the Women's Health Policy and Programmes Unit, Health Department Victoria, convene a Working Party to be responsible for the development and implementation of the Registry and for ensuring that appropriate functional and management links with the VC(G)S are developed.
5. That the following be included on the Working Party:
 - The Health Department Victoria
 - The VC(G)S
 - The Anti-Cancer Council of Victoria
 - A representative from the private pathology services
 - An epidemiologist
 - A computer expert
 - A gynaecological oncologist
 - A general practitioner
 - A lawyer
 - 2 women's health consumers
 - A family planning nurse

A smaller working executive committee should be established consisting of the Health Department Victoria, Anti-Cancer Council and VC(G)S representatives.

6. That in developing a new budget for the VC(G)S, the continued employment of a full-time epidemiologist be assured.

Relocation

1. That the Board of Management enter into negotiations with interested institutions concerning relocation. Negotiations should take into account the criteria outlined in this report.

Board of Management

1. That the by-laws of the VC(G)S be amended so that there is greater representation of both primary and secondary consumers of the VC(G)S services on the Board of Management.
2. That, in addition to the current composition of the Board, the following bodies/organisations be represented:
 - A woman as a secondary user/client of the VC(G)S
 - A family planning nurse (experienced in conducting pap smears)
 - A general practitioner from the Royal Australian College of General Practitioners with a knowledge of community health and women's health.
 - A gynaecological oncologist from the Royal Australian College of Obstetricians and Gynaecologists.
 - A staff representative from the VC(G)S
3. That the current representation by the Victorian Branch of the Australian Medical Association be replaced by representation from the Australian College of General Practitioners (as defined above).
4. That the Board of Management review the function and effectiveness of the current Medical Advisory Committee and if necessary undertake changes in the membership and advisory procedures.

Funding

1. That the Board of Management of the VC(G)S ensure that specific performance indicators are developed and implemented.
2. That the Board of Management closely monitor the activity of the VC(G)S with specific attention to the monthly workflow in order to ensure the median internal turn-around time for the processing of smears is no more than 5 working days.

3. That once arrangements have been finalized concerning the relocation of the VC(G)S, once off funding be provided to undertake a work flow and time and motion study of the VC(G)S. This study should be carried out by a person with the necessary expertise in pathology and should then advise the host institution on the architectural brief and the operating budget.

4. The operating budget should:
 - be based on the number of smears per year processed by the VC(G)S.
 - be adequate to ensure that the median internal turn-around time is no more than 5 working days.
 - be adequate to support an efficient system for the reporting of smear results.
 - provide for evaluation and monitoring (which is dependent upon the position of a full time epidemiologist)
 - take into account certain areas where cost-efficiency can be improved.

5. The Health Department Victoria should pursue a funding mechanism whereby the Commonwealth provides a block grant to the State for all smears processed in Victoria.

2. PRESENT ROLE AND FUNCTION OF THE VC(G)S:

2.1 Background

The VC(G)S was established in 1964 by an order in Council with the following objectives:

- a) to provide in Victoria facilities for research and investigation with respect to the cytological examination of gynaecological specimens associated with cancer detection and to undertake such research and investigation;
- b) to provide a free laboratory service for examination of specimens submitted;
- c) to provide for collection of material for examination and the notification of results of such examinations through the legally qualified medical practitioner submitting such material;
- d) to make arrangements as are necessary with any public or private hospital or the Cancer Institute or any other body or any other person having a similar or allied purpose.

The role and function of the VC(G)S can be broken down into three major activities: diagnostic, teaching and research.

2.2 Diagnostic Activities

From the 1st July 1986 to 30th June 1987 the VC(G)S received 281,346 cases. This represents a decrease of .07% on the number of smears received the previous financial year.

Since each individual "case" may comprise two or more smears, the VC(G)S has processed over 287,488 smears in the last financial year. At present, the VC(G)S processes approximately 800 to 2000 cases per day.

In addition to diagnostic activities the VC(G)S maintains a rigorous follow up of all abnormal smears. This entails contacting the medical practitioner who submitted the specimens to ensure that he/she has followed up the abnormal smear.

Private general practitioners make up the majority of users of the VC(G)S. The service is also used by government family planning clinics and community health centres. Recently, the government funded health services have begun to send smears to the private sector. A major reason given is the longer turn-around time for the processing and receiving of results by the VC(G)S. Of eleven community health centres who take pap smears, only five send all their smears to the VC(G)S, five using a combination of VC(G)S and private services and one using only private services (appendix B).

Between January and July 1987, the median internal turn-around time calculated from the date a smear was received to the date the report was posted, was 10 calendar days (appendix D). As of January 1988, the mean internal turn-around time was 9 working days. This compares to an internal turn-around time of between 2 to 5 calendar days when processed by the private sector. Part of this difference in turn-around can be accounted for by the fact that private labs provide a courier service to transport smears from the clinic to the lab. However, it is clear that the longer turn-around time is a major reason why public and private screening services are turning to the private sector for the analysis of smears.

2.3 Teaching Activities

Since the inception of the Cytology Service, the VC(G)S has played a major role in training scientists, technologists and pathologists in the specialised aspects of cytology.

The entire cytology component of the Bachelor of Applied Science at the Royal Melbourne Institute of Technology is the responsibility of the VC(G)S and Prince Henry's Hospitals Department of Cytopathology. In addition to formal training, the VC(G)S provides training for personnel from hospitals and laboratories throughout Australia and overseas. The VC(G)S also provides training for Royal College of Pathologist trainees and the majority of funding is provided by the Health Department Victoria.

2.4 Evaluation and Research

In 1985, the VC(G)S appointed a full-time epidemiologist in order to carry out and expand the vital population research role. The VC(G)S has provided a substantial body of the research on cervical cancer in Australia (appendix E).

Major research activities include risk of cervical cancer among women who have cytological evidence of infection with human papilloma virus, transition time from normal cytology to histological carcinoma in situ, age specific pap smears usage rates for women between 1965-1986, and frequency of screening for women by age, area of residence and type of practitioner.

2.5 Financial Aspects

The 1986-87 operating costs of the VC(G)S were \$1,943,009 (appendix F). This represents an increase of \$171,699 or 9.69% over 1985-86 costs.

The cost per specimen was \$7.76 compared to the medicare benefit of \$15.65, (the scheduled fee being \$18.40) in the private sector. At present, the VC(G)S runs a cost-effective service although the turn-around time is still considerably longer than that in the private sector. However, the current level of funding is inadequate to cope adequately with any increased demand for services.

2.6 Staffing and Location

In 1987, the VC(G)S employed 61.48 EFT staff. The staffing establishment consisted of:

	2.75	E.F.T.	pathologists
	1	F.T.	epidemiologist
	19	F.T.	scientists, technologist, technicians
*	27		part time scientists, technologists, technicians
	1	F.T.	business manager
	1	F.T.	secretary/administrator
	20	F.T.	V.D.U. operators, file and mail clerks.
*	5		Part time V.D.U. operators, file and mail clerks

The VC(G)S is located at Prince Henry's Hospital in the same location it has occupied since 1969 when 107,794 smears were processed (compared to 281,346 processed in 1986/87). The area consists of approximately 526 square metres, split into 6 major areas. The work areas are overcrowded with poor access to natural light and no exterior outlook, a critical disadvantage since most staff conduct tedious and repetitive work. The work environment has resulted in a high staff turn-over and an increased rate of work related injury.

- * 16.73 EFT represented by 32 part-time screeners, scientists, VDU operators and mail clerks.

3. FUTURE ROLE AND FUNCTION OF THE VC(G)S:

3.1 Background:

The Working Party is of the opinion that the VC(G)S should aim to maintain its role in processing the majority of smears taken in Victoria. To do this, the VC(G)S should provide a high quality screening service that maintains a follow-up service on abnormal smears and a central registry providing data for evaluation and recall at a cost that is acceptable to the community.

3.2 Issues

There are three key issues which need to be addressed in relation to the future role and function of the VC(G)S.

3.2.1 Turn-Around Time for Smear Results

As discussed in section 2.2, the turn-around time for processing and reporting smears is considerably longer than that of the private sector. Reasons include the fact that the VC(G)S uses the Australian postal service for pick-up and delivery of smears. Other alternatives are significantly more expensive. The Working Party agreed that the postal service is the appropriate mode of transport and that this mode should be continued. Other reasons for a longer internal turn-around time include inefficient work practices, staff turn-over, and a shortage of trained staff. These factors are more fully discussed in appendix G. The Working Party is of the opinion that a more appropriate internal turn-around time is 5 working days excluding mailing time.

3.2.2 Increased Demand for Services in Relation to State-Wide Screening

Given the recent concern to increase the proportion of women receiving regular smears, it is likely that there will be an increased demand for VC(G)S services. While a national policy for screening intervals has yet to be set, the costs of screening campaigns have two likely scenarios. In Victoria, if annual

screening is recommended, 1,256,729 women will be eligible and 1,336,940 smears will be processed at the VC(G)S cost of \$10.375 million. If screening is conducted at 2 yearly intervals, a total of 628,365 women will be eligible and 731,309 smears will be taken at a cost totalling \$5,674,957. If the interval is set at 3 years, a total of 418,910 women will be eligible and 529,430 smears will be taken at a cost of \$4,108,376 (appendix H). These are the maximum figures that can be maintained if all women take part in a screening program at the recommended intervals. At present the uptake rate is far lower than the maximum level and activities of the Anti-Cancer Council of Victoria and the proposed cervical smear registry are aiming to increase the current uptake rate. The VC(G)S must be properly funded to cope with this increase should state and national screening policies be introduced.

3.2.3 Increased Demand for Colposcopy

Any strategies aimed at increasing the number of Victorian women screened will result in an increased demand for colposcopy services, especially in the public sector. Abnormalities for which colposcopy is recommended are currently being detected in about 4% of cases examined at the VC(G)S and it may safely be assumed that this incidence will be at least as high, if not higher, in a previously unscreened population. Compliance with annual screening would predict the need for 53,478 women to receive colposcopy each year.

3.3 Recommendations

- 3.3.1 That the VC(G)S improve its service to enable it to maintain its role as the major cervical cytology service in Victoria.
- 3.3.2 That the median internal turn-around time for the processing and reporting of smears be reduced to five working days, excluding mailing time.

- 3.3.3 That the funding of the VC(G)S be increased in proportion to the recommended increase in workload and shortened turn-around time.
- 3.3.4 That new strategies to increase population screening be instituted only after the implications of such strategies on the demand for colposcopy services are assessed in detail. These strategies should be accompanied by the necessary funding to ensure that colposcopy services are adequate to meet the increased demand.

4. STATE-WIDE REGISTRY FOR CERVICAL SMEARS:

4.1 Background:

Since 1965, the VC(G)S has served as the central Victorian registry for Pap smears. With the recent expansion of private laboratories, the ability of the VC(G)S records to provide comprehensive information for Victoria, has been diminished. It is vital that a comprehensive data base be maintained in Victoria as it provides a population perspective on cervical cancer and there is no other equivalent data source in Australia.

4.2 Issues

The need for central registries has been raised by the Australian Health Minister's Advisory Committee, Cervical Cancer Sub-committee. The Commonwealth Department of Community Services and Health is currently calling for proposals from the States to establish pilot cervical cancer screening programmes and State-wide registries. The State of Victoria, since it already has a well established and well regarded public screening service, is in an ideal position to submit a proposal to the Commonwealth for funding to establish a State-wide registry, to be housed within the VC(G)S.

4.3 Recommendations

- 4.3.1 That the Working Party develop a proposal to establish a State-wide Registry for Cervical Smears;
- 4.3.2 That the State-wide Registry be independently managed but housed on the same premises as the VC(G)S;
- 4.3.3 That the Working Party submit the proposal to the Women's Health Policy and Programmes Unit, Health Department Victoria and that the Health Department submit the proposal to the Commonwealth on behalf of the Working Party (appendix I);

4.3.4 That the Women's Health Policy and Programmes Unit, Health Department Victoria, convene a Working Party to be responsible for the development and implementation of the Registry and for ensuring that appropriate function and management links with the VC(G)S are developed;

4.3.5 That the following bodies/organisations be included on the Steering Committee:

- The Health Department Victoria
- The VC(G)S
- The Anti-Cancer Council of Victoria
- A representative from the private pathology services
- An epidemiologist
- A computer expert
- A gynaecological oncologist
- A general practitioner
- A lawyer
- 2 women's health consumers
- A family planning nurse

A smaller working executive committee should be established consisting of the Health Department Victoria, Anti-Cancer Council and VC(G)S representatives.

- 5.2.2 Data required for defining unmet needs:
- for both services and subgroups;
 - for developing appropriate education and promotion programmes for both providers and women as clients.
 - for identifying high risk groups and risk factors.
- 5.2.3 Data required for evaluating the effectiveness of system changes such as call and recall strategies;
- 5.2.4 Data required to review screening policy;
- 5.2.5 Data required for quality control:
- false negative and false positive rates;
 - reporting of normal and abnormal smears;
 - responses to queries, requests for further information, repeat smears.
- 5.2.6 Data required for feedback to both staff and providers;
- 5.2.7 Liaison with the Cancer Registry:
- reviewing the incidence and mortality of carcinoma in situ and cervical cancer;
- 5.2.8 Analytic studies:
- continuing studies of the natural history of cancer of the cervix;
- 5.2.9 Collaborative studies:
- case-control studies;
 - randomized trials;

5.2.10 Response to requests for information:

- from the Health Department Victoria;
- from providers;
- from users;

5.2.11 Professional education and continuing education for staff and health service providers.

The Working Party is in strong agreement that a properly funded epidemiologic component is essential for the VC(G)S to provide a high quality, efficient and effective service. The epidemiologic component also has an important advisory role to the formulation of health promotion goals and targets and screening policies.

5.3 Recommendations:

- 5.3.1 That in developing a new budget for the VC(G)S, the continued employment of a full-time epidemiologist be assured.

6. FUTURE LOCATION OF THE VC(G)S:

6.1 Background:

Given the increased workload of the VC(G)S, the current lack of space to accommodate staff and the move of Prince Henry's Hospital to one of several venues within the new Monash Medical Centre, relocation of the VC(G)S is both inevitable and necessary. While several options are presently available, the Working Party agreed that it would be more appropriate to identify clearly the key requirements for location. The VC(G)S should then proceed to negotiate with the relevant institutions concerning an appropriate site.

6.2 Issues:

Given the current and future recommended role of the VC(G)S, the Working Party has identified the following criteria as essential for the effective functioning of the VC(G)S:

6.2.1 Requirement for the physical venue area at least 1043 M² is required to house the VC(G)S (see appendix J). This has been checked against possible requirements should expanded services be required.

The following criteria are considered by the Working Party to be either desirable or essential:

- a. VC(G)S services should all be housed on one floor (see appendix K) - **Desirable**
- b. venue should be quiet (see appendix K) **Desirable**
- c. security - **Essential**
- d. exterior outlook - **Essential**
- e. natural lighting - **Essential**

6.2.2 Support from Host Institution

- a. catering (60) meals - **Desirable**
- b. administrative support for
seventy four staff - **Desirable**
- c. utilities - **Essential**
- d. waste disposal - **Essential**
- e. parking - thirty staff - **Essential**
fifty staff - **Desirable**
one/two visitors - **Desirable**

6.2.3 Relationship with Host Institution

- a. independent management - **Essential**
- b. independent professional direction - **Essential**
- c. independent service facilities - **Essential**

6.2.4 Additional Characteristics of Host Institution

- a. teaching hospital
 - Gynaecological - **Essential**
 - Location in association with a
Department of Histopathology - **Desirable**
- B. provides other gynaecological
and women's services - **Essential**
- c. provides other non-gynaecological
cytological services - **Essential**
- d. good image with VC(G)S staff,
other hospitals, women and
general practitioners - **Essential**
- e. Accessibility to
 - public transport) - **Essential**
 - private transport) - **Essential**

Further details and ranking of requirements are given in Appendix K.

6.3 Recommendations:

- 6.3.1 That the Board of Management enter into negotiations with interested institutions concerning relocation. Negotiations should take into account the criteria outlined in this report.

7. COMPOSITION OF THE BOARD OF MANAGEMENT

7.1 Background:

The Board of Management has overall responsibility for policy, management and administration issues. The by-laws of the VC(G)S which came into operation on the 2nd of August, 1965, set the criteria for membership on the Board: (appendix L).

Members are appointed to hold office for a term not exceeding three (3) years and they are eligible for re-appointment. (See appendix M for current members of the Board).

In addition to the Board of Management, the VC(G)S has a Medical Advisory Committee. (appendix N). However, this committee meets infrequently and in fact, has met only once in the last five years.

The membership of the Board of Management is composed primarily of persons with scientific, technical and clinical expertise on issues relating to cytology, pathology and cervical cancer.

7.2 Issues

In reviewing the above composition of the Board of Management, the central issue addressed by the Working Party concerned representation by the major users of the VC(G)S. The underlying principle in considering this issue is that health services, through their Board of Management, should be directly accountable to users as well as to the funding agencies.

The Working Party was concerned that, without sacrificing the essential scientific and technical expertise, the Board of Management have a more balanced membership with greater representation by consumers.

In considering the issue of consumer representation, it is important to identify clearly the consumers of the services provided by the VC(G)S. The

consumers can be grouped into Primary or direct service users:

- private general practitioners;
- Community Health Centre medical/nursing staff;
- government family planning clinic medical/nursing staff;
- Family Planning Association medical/nursing staff;
- gynaecologists;
- epidemiologists

and

Secondary or indirect service users:

- women receiving pap smears (through a health service provider)

The recommended changes to the Board of Management follow from this definition of relevant consumers.

7.3 Recommendations:

7.3.1 That the by-laws of the VC(G)S be amended so that there is greater representation of both primary and secondary consumers of the VC(G)S services on the Board of Management;

7.3.2 That in addition to the current composition of the Board, the following bodies/organisations be represented:

- A women as secondary user/client of the VC(G)S;
- A family planning nurse (experienced in conducting pap smears);
- A general practitioner from the Royal Australian College of General Practitioners with a knowledge of community health and women's health;
- A gynaecological oncologist from the Royal Australian College of Obstetricians and Gynaecologists;
- A staff representative from the VC(G)S.

- 7.3.3 That the current representation by the Victorian Branch of the Australian Medical Association be replaced by representation by the Australian College of General Practitioners; (as defined above)
- 7.3.4 that the Board of Management review the function and effectiveness of the current Medical Advisory Committee and if necessary undertake changes in membership and advisory procedures.

8. FUNDING OPTIONS FOR THE VC(G)S

8.1 Background

Ultimately, the effectiveness and efficiency of screening services depends upon adequate funding. However, the Working Party recognizes that monies available to fund screening services are finite. Therefore, it is essential that there be adequate accountability for funds received and services provided.

8.2 Issues

There are several key issues which need to be addressed in relation to the funding of the VC(G)S.

8.2.1 Productivity

Despite a marginal increase in funding in 1986/87, the overall productivity of the VC(G)S has fallen. Some of the reasons for this decrease have been detailed in Appendix G. However, full and detailed explanations for this decrease remain unclear. It was beyond the scope and expertise of the Working Party to undertake a detailed systems analysis of the work-flow and cost-effectiveness of the VC(G)S.

Therefore, a more comprehensive systems analysis consisting of a time and motion study would assist in developing performance indicators for greater accountability.

8.2.2 Specific Budget of the VC(G)S

The Working Party is of the opinion that it is not appropriate to negotiate a specific budget. Rather, this is the role of the Manager of the Service and of the Board of Management. However, in negotiating the budget, the Working Party believes that the

following factors should be taken into account:

- That the budget should be based on the number of smears per year processed by the VC(G)S.
- That the budget should be adequate to ensure that the median internal turn-around time is no more than 5 working days.
- That the budget is adequate to support an efficient system for the reporting of smear results.
- That financial provision be made for evaluation and monitoring (which is dependent upon the position of a full time epidemiologist)
- That the budget should take into account certain areas where cost-efficiency can be improved.

8.2.3 Funding Mechanisms for the VC(G)S

The VC(G)S has been fully funded by the state of Victoria. The Working Party is of the opinion that full funding should continue to be provided by the government. In broad terms, the Health Department has several optional funding mechanisms for screening services which it may pursue including fee-for-service and medicare rebates. However, the Working Party believes that in the longer term, a block grant from the Commonwealth to the State which would fund all cervical smear screening is the best option to pursue. This funding mechanism has the advantage of not only being more cost-effective but of enabling the State to develop and implement better quality control and accountability mechanisms for both publicly funded and private laboratories.

8.3 Recommendations

- 8.3.1 That the Board of Management of the VC(G)S ensure that specific performance indicators are developed and implemented.
- 8.3.2 That the Board of Management closely monitor the activity of the VC(G)S with specific attention to the monthly workflow in order to ensure the median internal turn-around time for the processing of smears is no more than 5 working days.

8.3.3 That once arrangements have been finalized concerning the relocation of the VC(G)S, once off funding be provided to undertake a work flow and time and motion study of the VC(G)S. This study should be carried out by a person with the necessary expertise in pathology who should then advise the host institution on the architectural brief and the operating budget.

8.3.4 The operating budget should:

- be based on the number of smears per year processed by the VC(G)S.
- be adequate to ensure that the median internal turn-around time is no more than 5 working days.
- be adequate to support an efficient system for the reporting of smear results.
- provide for evaluation and monitoring (which is dependent upon the position of a full time epidemiologist)
- take into account certain areas where cost-efficiency can be improved.

8.3.5 The Health Department Victoria should pursue a funding mechanism whereby the Commonwealth provides a block grant to the State for all smears processed in Victoria.

NUMBER OF CANCER DEATHS FROM INVASIVE CERVIX CANCER (ICD 180) FOR VICTORIA 1986
FOR AUSTRALIA 1986

Age Group	0 - 14	15 - 24	25 - 34	35 - 44	45 - 54	55 - 64	65 - 74	75 ⁺	Total
1986 VICTORIA	0	11		5	21	24	21	82	
1986 AUSTRALIA	0	20		43	84	84	70	350	

APPENDIX B

COST OF PROCESSING OF A SMEAR BY VC(G)S YEAR ENDING 1986/87

STAFF		PERCENTAGE	\$1000'S	COST PER SMEAR
(1)	19.73	*Clerical	468	1.66
	4.00	Follow Up	95	.34
	32.75	Screeners	778	2.76
	2.25	Prep Room	54	.19
	<hr/>	<hr/>	<hr/>	<hr/>
	58.73	100%	1,395	4.95
(2)	2.75	Pathologists	192	.68
	TOTAL SALARIES AND WAGES		1,587	5.63
(3)	Administration Costs		322	1.14
			<hr/>	<hr/>
			1,909	6.77
(4)	Capital Costs (Projects funded by HDV 86/87)		119	.42
(5)	Projected Leasing Costs 7000 sq ft @21 per sq ft P/A		147	.52
(6)	Insurances and HCS Computer Costs paid by HDV		14	.05
			<hr/>	<hr/>
				\$7.76
				<hr/>

* Includes Epidemiologist

APPENDIX C

COMMUNITY HEALTH CENTRE USAGE OF VC(G)S AND PRIVATE LABORATORY SERVICES

C.H.S.	VC(G)S ONLY	VC(G)S & OTHER	OTHER PATH. ONLY	SOURCE INFORMATION	COMMENT
B/Meadows	X			Dr N Presswell	
Brunswick	X			Dr R. Misso	
C/Wood		X		Dr S. Crockett	Female Drs tend to use VC(G) and take own smears. Male Drs tend to use Regional Path. and allow Sister to do smear. Small survey found VC(G)S results more specific. Plan to use VC(G)S only.
Deer Park			Macleod	Dr J. North	Has used Macleod pathology Path. 3-4 year - finds it efficient, reports back next day and more information on infections etc.
E. Preston	X			Dr M.Culvernor	VC(G)S problem with mailing - usually takes 3-4 weeks. Otherwise satisfactory.
Kensington		Mainly VC(G)S Occas. Reg. Path		Dr A. Small	VC(G)S - problems with waiting time estimate 2-4 weeks.
N.R.F.C.	X			Dr D. Isaac	
Richmond		Mainly VC(G)S Neil Trezizes Path.Serv.		Dr Pavasaris	
St. Albans		X		Dr Sheppard	Reg. Path quicker - Sister sometimes takes smears.
W. Heid		Mainly VC(G)S		Dr Fernandes	Problems with waiting time - 2 weeks.
W. Region	X			Dr L. Gordon	VC(G)S - bit slow - estimate waiting time - 2 weeks.

APPENDIX D

TURN-AROUND TIME OF PROCESSING SMEARS

	JANUARY 1987	FEBRUARY 1987	MARCH 1987	APRIL 1987	MAY 1987	JUNE 1987	JULY 1987
MEAN DELAY (calendar days)	9.62	9.05	11.98	12.89	10.55	9.89	9.39
MEDIAN DELAY (calendar days)	8	9	13	14	10	10	10
CUMULATIVE PROPORTION REPORTED WITHIN -							
0 - 7 days	37%	30%	15%	10%	16%	23%	19%
8 - 14 days	96%	97%	86%	70%	96%	93%	97%
15 - 21 days	97%	99%	99%	99%	99%	100%	100%
21 - 28 days	97%	99%	99%	100%	99%	100%	100%

APPENDIX E

VC(G)S PUBLICATIONS

1. Prospective evaluation of risk of cervical cancer after cytological evidence of human papilloma virus infection.
Mitchell H, Drake M, Medley G.
Lancet 1982;1:573-575.
2. Screening costs associated with saving a life from cancer of the cervix.
Mitchell H, Drake M, Medley G.
Medical Journal of Australia 1987;146:52-53.
3. Organised mammographic screening programmes: A benign or malignant neglect?
Mitchell H.
Medical Journal of Australia 1987;146:87-90.
4. Cytologic detection of human papilloma virus.
Drake M, Medley G, Mitchell H.
Obstetrics and Gynaecology Clinics of North America
Philadelphia, W.B. Saunders, 1987:431-450.
5. Human papilloma virus infection of the cervix in Victoria, 1982-1985.
Drake M, Mitchell H, Medley G.
Medical Journal of Australia 1987;147:57-59.
6. Pap smears in Victoria: Are the wrong women being screened?
Mitchell H, Drake M, Medley G.
Medical Journal of Australia 1987;147:559-560.
7. Age trends in Pap smear usage, 1971-1986.
Mitchell H, Medley G.
Community Health Studies 1987;11:183-185.
8. Delay times to definitive diagnosis after an abnormal pap smear.
Mitchell H, Medley G.
Australian New Zealand Journal Obstetrics & Gynaecology 1987;27:283-286.
9. Quality control measures for cervical cytology laboratories.
Mitchell H, Medley G, Drake M.
Acta Cytol. in press.
10. Pap smear results of Victorian teenagers, 1980-1987.
Mitchell H, Medley G.
Australian New Zealand Journal Obstetrics & Gynaecology, accepted for publication.

APPENDIX F

HEALTH DEPARTMENT VICTORIA

INSTITUTION: VICTORIAN CYTOLOGY (GYNAECOLOGICAL) SERVICE
 CASH MANAGEMENT RETURN FOR YEAR ENDING 30 JUNE 1987
 CASH PAYMENTS

	HOSPITAL ACTUAL	HDV FUNDED NURS HOME ACTUAL	COMBINED HDV FUNDED ACTUAL	NON-FUNDED NURS HOME ACTUAL	GRAND TOTAL
	\$	\$	\$	\$	\$
Basic S & W (B6)	1,343,059		1,343,059		1,343,059
Overheads (B6)					
Sub-Total (B6)	1,343,059		1,343,059		1,343,059
Add S & W paid:					
- Pay in Advance					
- Off-line	2,786		2,786		2,786
- to other hospitals	211,741		211,741		211,741
- other payments out- side payroll system	5,260		5,260		5,260
Less S & W recoveries:					
- other hospitals					
- Work.Comp./Workcare	(20,573)		(20,573)		(20,573)
- Other	(42,010)		(42,010)		(42,010)
SUB TOTAL	1,500,263		1,500,263		1,500,263
Long Service Leave	55,259		55,259		55,259
Net S & W	1,555,522		1,555,522		1,555,522
Other Expenses *	315,576		315,576		315,576
Superannuation (Emp Cst)	31,151		31,151		31,151
Workcare Premium	7,189		7,189		7,189
Total Other Expenses	352,917		353,917		353,917
Total Budget Payments	1,909,438		1,909,438		1,909,438
Non-Budgeted pyts Pg 2					
- Minor works					
- Specific Purposes (6D)					
- Other (6D)	119,253		119,253		119,253
Sub-Total Non-Budgeted					
TOTAL PAYMENTS YTD	2,028,691		2,028,691		2,028,691

* excluding Workcare, Super

Appendix F Cont.

CASH RECEIPTS

	HOSPITAL ACTUAL	HDV FUNDED NURS HOME ACTUAL	COMBINED HDV FUNDED ACTUAL	NON-FUNDED NURS HOME ACTUAL	GRAND TOTAL
	\$	\$	\$	\$	\$
Inpatients (as per form 5A/5B/5C Cash Collections)					
Other Inpatients					
Gross Inpatient Receipts					
Less Debtors Catchup					
Cwlth Benefits A/c 54000					
Outpatients (as per form 5B Cash Collections)					
Other Receipts (as per 5B/ 5C,6C)					
SUB-TOTAL					
Ordinary Grant	1,789,500				1,789,500
Workcare Grant	25,600				25,600
TOTAL BUDGET RECEIPTS	1,815,100				1,815,100
NON-BUDGETED RECEIPTS:					
- Minor Works					
- Specific Purpose (as per form 6D)					
- Other (as per form 6D)	121,423				121,423
SUB-TOT NON-BUD RECEIPTS	121,423				121,423
TOTAL RECEIPTS	1,936,523				1,936,523

NOTE: Include Personal Care Subsidy (Hostel), where applicable, in A/c 54000.

CASH POSITION : OPERATING ACCOUNT

	HOSPITAL	HDV FUNDED NURS HOME	NON FUNDED NURS HOME	TOTAL
A. Prior years' Surplus (Deficit C/F (ie opening Cash Book Balance	(23,429)			(23,429)
B. Less Funding of Prior year result in current yr. HDV Funded; Hospital Funded; Debtors Catchup	28,900			28,900
C. Net prior Year's Surplus (Deficit) (A+B=C)	5,471			5,471
D. Current YTD Surplus (Deficit) Budgeted Items	(94,338)			(94,338)
E. Cash Book Sub-total (C+D=E)	(88,867)			(88,867)
F. Current YTD Surplus (Deficit) Non-Budgeted Items	2,170			2,170
G. Balance as per Cash Book: In hand (O/D) (E+F=G)	86,697			88,697
H. Actual closing operating Bank Balance: In hand (o'draft) (See Note 6 reverse Form 6A)	XXXX	XXXX	XXXX	(44,054)

APPENDIX G

REASONS FOR THE TURN-AROUND TIME OF SMEARS PROCESSED BY THE VC(G)S, 1988

The current mean internal turnaround time of smears within the Service is 8-10 working days. At present, abnormal smears take 13-14 working days or more to process. This internal turnaround time is unacceptable and with increasing development of private cytology services there has been a trend away from usage of the Service.

The aim should be a maximum internal turnaround time in the Service of 5 working days. This should result in an anticipated maximum total turnaround time of two weeks between the time a woman has a smear and when the report is back with the health service provider.

While the total picture for the long internal turnaround time is at present unclear, some contributing factors include:

Internal Factors:

- lack of adequate work space for screeners;
- lack of appropriately trained staff;
- variation in the average daily screening rates between screeners;
- increased numbers of double or multiple smears for a single test;
- increases in the number of abnormal smears reported;
- need for updated equipment including automated mechanical filing systems and "Bowie" automated form processor;
- lack of clear routine service loads or productivity guidelines for VC(G)S staff.

External Factors

- staff drain to private cytology services;
- poor quality of data provided by those requesting the service on the request form;
- irregular work flow due to variation in daily rates of smears received and lack of elasticity within the current staffing system.

APPENDIX H

CALCULATIONS FOR ESTIMATED NEED FOR SMEARS

ELIGIBLE WOMEN: 1,256,729

If

(a)	3 yearly screening	418,910	women
(b)	adjusted for current ratio of smears to women	445,648	smears
(c)	+ 10% of those <u>not</u> called up who have annual smears	529,430	smears

If

(a)	2 yearly screening	628,365	women
(b)	adjusted for current ratio of smears to women	668,473	smears
(c)	+ 10% of those <u>not</u> called up who request annual smears	731,309	smears

If

(a)	annual screening	1,256,729	women
(b)	adjusted for current ratio of smears to women	1,336,940	smears

DATA ON WHICH THE CALCULATIONS HAVE BEEN BASED

Age (Years)	1986 Census Women	Proportion with intact uterus+	Eligible Women	Applying WA* Age specific rates to this population
15-19	173,564	1.00	173,564	19,092
20-24	165,175	1.00	165,175	47,900
25-34	327,735	0.97	317,903	104,875
35-44	283,511	0.87	246,655	63,803
45-54	195,611	0.76	148,664	35,209
55-59	94,238	0.77	72,563	8,953
60-64	91,653	0.79	72,406	5,497
65-69	73,826	0.81	59,799	3,322
TOTAL	1,405,373		1,256,729	288,653

* Source Armstrong, Rouse and Butler 1987

+ Holman et al, 1986

APPENDIX J

SPACE REQUIREMENTS FOR THE VC(G)SVC(G)S PROPOSED ACCOMMODATION

AREA	EXIST M ² NET	ADD M ² NET	TOTAL PROP. M ² NET	COMMENT
RECEPTION	10.5	-	10.5	
CLERICAL AREA (Includ Mailslashing + kit prep : 3 Slide Ident : 13 Cyt No Ident : 4.5 Stationery : 1.5)	22	-	22	
FILE CLERK	3	-	3	
VDU WORKSTATIONS	16	6	22	Exist. 6 workstations 2 additional proposed.
WORDPROCESSING & TYPING (noisy area)	6	-	6	
FILES	36	-	36	
BUSINESS MANAGER	10	-	10	
SECRETARY (B.M.)	6	-	6	
COMPUTERS (Includ Comp Room : 9 Printing, etc. : 10)	19	-	19	
STORAGE	96	4	100	Bulk storage to be located in basement.
LABORATORY	65	55	120	Cytology Lab from MMC relocated to VC(G)S
CLINICAL ROOM	9	6	15	
SCREENING	93	72	165	1. 3 No Supervisor cubicles 2. 8 No additional workstations 3. Ergonomic workstations

AREA	EXIST M ² NET	ADD M ² NET	TOTAL PROP. M ² NET	COMMENT
SCREENING SUPERVISION	6	4	10	
D.N.A. MICROSCOPE	7.5	2.5	10	
FOLLOW-UP	15	5	20	
TEACHING:				
MICROSCOPY & TCHG RM	33	6	39	Add Supervisor cubicle
SEMINAR ROOM	32	-	32	
MULTIHEAD MICROSCOPE	10	0	10	
EPIDEMIOLOGIST OFF	13.5	-	13.5	
RESEARCH ASS/STAT	-	13.5	13.5	
PATHOLOGISTS OFFICES	30	10	40	Exist 3 No path offices Add 1 No. path office
TRAINEES (2 No)	-	10	10	
DIRECTOR'S OFFICE	12	3	15	
SECRETARY (DIRECTOR)	10	-	10	
TEA ROOM	10	5	15	
	570.5	202	772.5 + 35%	NET
			1043	GROSS

APPENDIX L

BY-LAWS

VICTORIAN CYTOLOGY (GYNAECOLOGICAL) SERVICE

1. These By-laws shall come into operation on

2. Definitions

"The Act" shall mean the Hospital and Charities Act 1958 or any amendment thereto, and regulations made thereunder by the Governor-in-Council.

"Commission" shall mean the Hospitals and Charities Commission constituted under the Act.

"Board" shall mean the Board of Management of the Victorian Cytology (Gynaecological) Service.

"Service" shall mean the Victorian Cytology (Gynaecological) Service.

"Hospital" shall mean the hospital where the laboratory of the Service is located.

"Manager" shall mean the Manager and Secretary for the time being of the hospital where the laboratory is located who shall also be Manager and Secretary of the Service and Secretary of the Board.

"Minister" means the Minister of Health for the time being.

COMMITTEE

3. There shall be a Board of Management of the Service consisting of nine (9) persons appointed by the Honourable the Minister of Health and comprise:-

1 person nominated as Chairman by the Minister of Health;

2 persons from the Anti-Cancer Council of Victoria;

2 persons from the Board of Management of the hospital where the laboratory is located;

1 person from the Victorian Branch of the Australian Medical Association

the Director of Pathology of the hospital where the laboratory is located;

the Director of the laboratory of the Service, and,

one other person.

4. Members shall be appointed to hold office for a term not exceeding three (3) years and shall be eligible for re-appointment.

5. The Board shall elect its office bearers at the first meeting after its initial appointment.

SUB-COMMITTEE

12. The Board may at any time appoint any Sub-Committee from amongst its members or person co-opted by the Board and may prescribe the functions of any such Sub-Committee.

STAFF (Other than Medical)

13. All employees of the Service shall be appointed by the Board.
14. All employees on duty in the Service shall conform to discipline and directions as to conduct as if they were on duty in the hospital.

FINANCE

15. The financial administration of the Service shall be the responsibility of the Board which shall maintain separate records of receipts and expenditure and carry out other accounting procedures in relation to the Service.
16. The Board shall open and maintain a bank account styled "....." into which all receipts shall be deposited and from which all disbursements shall be made.
17. All pecuniary gifts (inter vivos or testamentary) made to the Service for any specific purpose shall be placed to the credit of a separate fund in the books of the Service and shall be applied by the Board as far as is possible in accordance with the terms of the gifts. In disposing of such funds, the Board may take the advice of any person or group of persons with special knowledge on the subject for which the gift is to be applied.
18. The Manager, or other officer of the Service authorised by the Board, shall receive all moneys on account of the Service and issue official receipts forthwith.
19. The Board shall make all payments on behalf of the Service.
20. The Board shall meet the reasonable cost of Services provided for it by the hospital and shall cause to be kept adequate records showing the costs of the Service.
21. The Board shall in consultation with the Minister establish budgets for the financial management of the Service and shall ensure that all expenditure is kept within the limits thus imposed.
22. The Board shall prepare and submit to the Minister and the Commission separate reports and financial statements which may be required by the Minister or the Commission from time to time.
23. The continuing audit of the books and accounts of the Service shall be carried out by the auditor appointed by the Board in accordance with these by-laws.

TRUSTEES

24. The Minister shall appoint three (3) Trustees who shall enter into a declaration of trust in respect of their trusts under these by-laws.

APPENDIX M

BOARD OF MANAGEMENT OF THE VICTORIAN CYTOLOGY

(GYNAECOLOGICAL) SERVICE

Members

Professor R. Peppere11	Department of Obstetrics and Gynaecology The University of Melbourne (Chair)
Dr. Ironside	Director of Pathology Peter McCallum Clinic (Representative of Minister as "other person")
Mr. A.G. Bond	Head of Gynaecology Unit Prince Henry's Hospital (Representative of A.M.A.)
Mr. L.P. White	Board of Management Monash Medical Centre
Dr. N. Gray	Director Anti-Cancer Council (Representative of Anti-Cancer Council)
Mrs. D. Sergeant	Director Social Biology Resources Centre (Representative of Minister as "other person")
Assoc. Prof. E.P. Guli	Director of Pathology Royal Southern Memorial Hospital (Representative of Anti Cancer Council)
Dr. P. Dennis	Chairman of Pathological Services Prince Henry's Hospital (A rotating position)
Ms. E. Sims	Representative of the Board of Management, Monash Medical Centre

The Business Manager, the Chief Executive Officer and Director of the VC(G)S are non-voting members.

APPENDIX N

VICTORIAN CYTOLOGY (GYNAECOLOGICAL) SERVICE

MEDICAL ADVISORY COMMITTEE

Members:

Medical Members of Board of Management of Service:

Professor R.J. Peppere11 (Chairman), Mr. A.G. Bond, Dr. M. Drake,
Dr. N. Gray, Assoc. Professor E.P. Guli, Dr. P. Ironside.

Other Members:

Professor N.A. Beischer Professor of Obstetrics and Gynaecology,
Melbourne University,
(Mercy Maternity Hospital)

Professor E.C. Wood Professor of Obstetrics and Gynaecology,
Monash University

Representing:

Mr. A. Day Queen Victoria Medical Centre

Mr. W. Chanen Australian Society for Colposcopy and
Cervical Pathology and
The Royal Women's Hospital

Mr. P.P. Glenning Australian Medical Association

Dr. E. Goodman The Royal Australian College of
General Practitioners

Dr. J. Hayman The Royal College of Pathologists of
Australasia

Mr. R. Rome Royal Australian College of
Obstetricians and Gynaecologists

Invitee:

Dr. G. Medley Victorian Cytology (Gynaecological) Service

Cervical

Date: early 88?

DRAFT

REPORT OF THE VICTORIAN
CYTOLOGY (GYNAECOLOGICAL) SERVICE
WORKING PARTY

CONVENED BY: THE WOMEN'S HEALTH
POLICY AND PROGRAMMES UNIT,
HEALTH DEPARTMENT VICTORIA

F. J. ...

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REPORT OF THE VICTORIAN CYTOLOGY (GYNAECOLOGICAL) SERVICE

WORKING PARTY

1. INTRODUCTION

1.1 Background

The Victorian Cytology (Gynaecological) Service (VC(G)S) was established in 1965 to provide a laboratory service to examine cervical smears taken from Victorian women. The overall goal of the VC(G)S is to provide a high quality and cost efficient laboratory and monitoring service for cytological specimens. In this regard, the VC(G)S provides a crucial public health service to women in Victoria in the early detection of cervical cancer:

1. Within a public health framework, the VC(G)S provides rigorous follow-up of all women with abnormal smears;
2. The VC(G)S is cost efficient, with each smear costing approximately \$7.76, compared with a rebate cost of \$17.20 in the private sector (appendix A);
3. The VC(G)S has established a comprehensive data base which has allowed for epidemiological research and monitoring of cervical cancer and its associated risk factors.

The usage of the VC(G)S has grown over the years and it currently collects approximately 75% of all smears taken in Victoria. Several recent developments have made it necessary to examine the current and future role and function of the VC(G)S.

- The Commonwealth and State Governments have given priority to developing public health policies and programmes for cervical screening. Cancer of the cervix is one of the few cancers that can be prevented if abnormalities are detected in their early stages. An effective public health programme has the real potential of reducing the mortality due to the disease.

- The Anti-Cancer Council of Victoria convened a working party to develop a policy for cervical cancer screening. The Working Party identified as a major barrier to developing a State-wide campaign, the difficulties that the VC(G)S will have in responding to the increased demand for their services;
- Due to increased awareness among primary health care providers of the benefits of the Pap smear, there is an increasing demand for the services of the VC(G)S. This is making it difficult for the VC(G)S to continue to provide a high quality and prompt service;
- Policy changes are currently taking place concerning accountability mechanisms of health services to consumers. It is therefore timely to review the composition of the current Board of Management of the VC(G)S with a view to ensuring greater consumer representation.

In August 1987, the Women's Health Policy and Programmes Unit, Health Department Victoria, convened a Working Party to examine the current and future role of the VC(G)S in relation to the above issues.

1.2 Terms of Reference

1. To examine the role of the VC(G)S in relation to the potential increased demand for cytology services;
2. To address strategies for the development and maintenance of a state-wide data base for cervical cancer;
3. To address strategies for the development and maintenance of an epidemiologic component for cervical cancer, pre-cancerous conditions and associated risk factors;

4. To address the criteria for the future location of the VC(G)S;
5. To examine options for cytology services in Victoria including funding;
6. To examine the composition and role of the Board of Management in relation to the major users of the VC(G)S.

1.3 Membership of the Working Party:

Dr Sandra Gifford (Chair)

Women's Health Policy and Programmes Unit, Health Department
Victoria

Dr Pat Wilkinson

Chief Medical Officer, Health Department Victoria

Dr Michael Quinn

Department of Obstetrics and Gynaecology, Royal Women's Hospital

Dr Nan Presswell

Broadmeadows Community Health Centre and the Department of
Community Medicine, Melbourne University

Dr Gabriele Medley

Director, Victorian Cytology (Gynaecological) Service

Dr Judith Lumley

Department of Paediatrics, Monash University

Dr Robin Marks

Anti-Cancer Council of Victoria

Dr Denise Ruth

Broadmeadows Community Health Centre (joined the Working Party in November, replacing Nan Presswell)

Ms Alexandra Jones (Secretary)

Women's Health Policy and Programmes Unit, Health Department
Victoria

2. PRESENT ROLE AND FUNCTION OF THE VC(G)S:

The VC(G)S was established in 1964 by an order in Council with the following objectives:

- a) to provide in Victoria facilities for research and investigation with respect to the cytological examination of gynaecological specimens associated with cancer detection and to undertake such research and investigation;
- b) to provide a free laboratory service for examination of specimens submitted;
- c) to provide for collection of material for examination and the notification of results of such examinations of results of such examinations through the legally qualified medical practitioner submitting such material;
- d) to make arrangements as are necessary with any public or private hospital or the Cancer Institute or any other body or any other person having a similar or allied purpose.

The role and function of the VC(G)S can be broken down into three major activities; Diagnostic, teaching and research.

2.1 Diagnostic Activities

From the 1st July 1986 to 30th June 1987 the VC(G)S received XXXX specimens. This represents an increase of XXXX per cent on the number of smears received the previous financial year.

While each individual "specimen" may comprise two or more smears, the VC(G)S has processed over XXXX smears in the last financial year. Of all the smears received, approximately 3-4% need further investigation. At present, the VC(G)S processes approximately 1,000 to 1,500 smears per day.

In addition to diagnostic activities the VC(G)S maintains a rigorous follow up of all abnormal smears. This entails contacting the medical practitioner who submitted the specimens to ensure that he/she has followed up the abnormal smear.

Private General practitioners make up the majority of users of the VC(G)S. The service is also used by government family planning clinics and community health centres. Recently, the government funded health services have begun to send smears to the private sector. A major reason given is the longer turn around time for the processing and receiving of results by the VC(G)S. (Appendices A). Of eleven community health centres who take pap smears, only five send all their smears to the VC(G)S, five using a combination of VC(G)S and private services and one using only private services (Appendices B).

2.2 Teaching Activities

Since the inception of the Cytology Service, the VC(G)S has played a major role in training scientists, technologists and pathologists in the specialised aspects of cytology.

The entire cytology component of the Bachelor of Applied Science at the Royal Melbourne Institute of Technology is the responsibility of the VC(G)S and Prince Henry's Hospitals' Department of Cytopathology. In addition to formal training, the VC(G)S provides training for hospitals and laboratories throughout Australia and overseas.

2.3 Research Activities

The VC(G)S appointed a full-time epidemiologist in 19XX and the VC(G)S has provided the bulk of research concerning cervical cancer in Australia. (See Appendices F).

Major research activities include risk of cervical cancer among women who have cytological evidence of infection with human papilloma virus, transition time from normal cytology to histological carcinoma in situ, age specific pap smears usage rates for women between 1965-1986, frequency of screening for women by age, area of residence and type of practitioner.

2.4 Financial Aspects

The 1986-87 operating costs of the VC(G)S was \$___XXX. (Appendix C). This represents an increase of \$XXXX or XXX per cent over 1985-86 costs.

The cost per specimen is \$7.76 compared to a cost of \$16.00XXX in the private sector (Appendix D). At present, the VC(G)S runs a cost-effective service. However, the current level of funding is inadequate to adequately cope with any increased demand for services.

2.5 Staffing and Location

In 1987, the VC(G)S employed XXXX E.F.T. staff. The staffing establishment consisted of:

2.75 E.F.T. pathologists

- 1 E.F.T. epidemiologist
- 19 E.F.T. scientists, technologist, technicians
- 27 part time scientists, technologists, technicians
- 1 E.F.T. business manager
- 1 E.F.T. secretary/administrator
- 20 E.F.T. V.D.U. operators, file and mail clerks.
- 5 Part time V.D.U. operators, file and mail clerks

The VC(G)S is located at Prince Henry's Hospital in the same location it has occupied since 1969 when 107,794 smears were processed (compared to XXX processed in 1986/87). The area consists of approximately 526 square metres, split into xxxxx_ major areas. The work areas are overcrowded with poor access to natural light, a critical disadvantage since most staff conduct tedious and repetitive work. The work environment has resulted in a high staff turn-over and an increased rate of "work related injury".

3. FUTURE ROLE AND FUNCTION OF THE VC(G)S:

3.1 Background and Issues:

TO BE EXPANDED

3.2 Recommendations:

4. STATE-WIDE REGISTRY FOR CERVICAL SMEARS:

DRAFT

4.1 Background and Issues:

Since 1965, the VC(G)S has served as the central Victorian registry for Pap smears. With the recent expansion of private laboratories, the ability of the VC(G)S records to provide comprehensive information for Victoria, has been diminished. It is vital that a comprehensive data base be maintained in Victoria as it provides the only population perspective on cervical cancer not only for Victoria but for Australia as a whole.

The need for central registries has been raised by the AHMAC Cervical Cancer Sub-committee. The Commonwealth Department of Community Services and Health is currently calling for proposals from the States to establish pilot cervical cancer screening programmes and State-wide registries. The State of Victoria is in an ideal position to submit a proposal to the Commonwealth for funding to establish a State-wide registry and the VC(G)S is ideally suited to housing such a registry.

4.2 Recommendations

- 4.2.1 That the Working Party develop a proposal to establish a State-wide Registry for Cervical Smears;
- 4.2.2 That the State-wide Registry be independently managed but housed on the same premises as the VC(G)S;
- 4.2.3 That the Working Party submit the proposal to the Women's Health Policy and Programmes Unit, Health Department Victoria and that the Health Department submit the proposal to the Commonwealth on behalf of the Working Party (appendix ___);

4.4.4 That the Women's Health Policy and Programmes Unit, Health Department Victoria, convene a Working Party to be responsible for the development and implementation of the Registry;

4.2.5 That the following bodies/organisations be represented on the Working Party:

- The Health Department Victoria
- The VC(G)S.
- The Anti-Cancer Council of Victoria
- A representative from the Private Pathology Services
- An epidemiologist
- A Computer expert
- A gynaecologist
- A general practitioner
- A lawyer
- 2 women's health consumers
- a family planning nurse

5. EPIDEMIOLOGIC COMPONENT:

5.1 Background and Issues

Until recently, the VC(G)S has operated without an epidemiologic component. In 19__, an epidemiology position was funded out of operating costs. The need for a permanent staffing position for an epidemiologist is seen to be crucial to the effective functioning of the VC(G)S. Two considerations justify the need for the epidemiological component:

1. The collection of information without accompanying analysis, interpretation and dissemination is not an efficient nor effective use of money;

2. Analysis, interpretation and dissemination require a person who is primarily responsible for this task and who has the requisite epidemiological skills;

The current epidemiologic needs of the VC(G)S include;

1. Monitoring and surveillance;
 - The use (uptake) of cervical screening
 - The differential uptake:
 - secular trends
 - age-specific rates
 - variability within age groups
 - geographical/regional differences
 - socio-economic differences
 - by country of birth
 - by provider category
2. Data required for defining unmet needs:
 - For both services and subgroups;
 - For developing appropriate education and promotion programmes for both providers and women as clients;
3. Data required for evaluating the effectiveness of system changes such as call and recall strategies;
4. Data required to reviewing screening policy;
5. Data required for quality control:
 - false negative and false positive rates;
 - reporting of normal and abnormal smears;
 - responses to queries, requests for further information, repeat smears.

6. Data required for feedback to both staff and providers;
7. Liaison with the Cancer Registry:
 - reviewing the incidence and mortality of carcinoma in situ and cervical cancer;
8. Analytic studies:
 - continuing studies of the natural history of cancer of the cervix;
9. Collaborative studies:
 - Case-control studies
 - randomized trials
10. Response to requests for information:
 - from the Health Department Victoria
 - from providers
 - from users
11. Professional education and continuing education for staff and health service providers.

The Working Party is in strong agreement that a properly funded epidemiological component is essential for the VC(G)S to provide a high quality, efficient and effective service.

5.3 Recommendations:

1. That the Health Department Victoria increase the staffing establishment of the VC(G)S to provide for a full-time epidemiology position.

6. Data required for feedback to both staff and providers;
7. Liaison with the Cancer Registry:
 - reviewing the incidence and mortality of carcinoma in situ and cervical cancer;
8. Analytic studies:
 - continuing studies of the natural history of cancer of the cervix;
9. Collaborative studies:
 - Case-control studies
 - randomized trials
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 - from the Health Department Victoria
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11. Professional education and continuing education for staff and health service providers.

The Working Party is in strong agreement that a properly funded epidemiological component is essential for the VC(G)S to provide a high quality, efficient and effective service.

5.3 Recommendations:

1. That the Health Department Victoria increase the staffing establishment of the VC(G)S to provide for a full-time epidemiology position.

6. FUTURE LOCATION OF THE VC(G)S:

It has been made clear from the preceding discussion that the re-location is inevitable and necessary. While several options are presently available, the Working Party agreed that it would be more appropriate to clearly identify the key requirements for location. The VC(G)S should then proceed to negotiate with the relevant institutions concerning an appropriate venue.

Given the current and future recommended role of the VC(G)S, the Working Party has identified the following criterion as essential for the effective functioning of the VC(G)S.

6.1 Area - At least 1043 Square Metres (see Appendix G).

- a. VC(G)S services should all be housed on one floor
- b. venue should be quiet
- c. security - Essential
- d. exterior outlook - Essential
- e. natural lighting - Essential

6.2 Support from Host Institution

- a. catering (60) meals - Desirable
- b. administrative support for
seventy four staff - Desirable
- c. utilities - Essential
- d. waste disposal - Essential
- e. parking - thirty staff - Essential
fifty staff - Desirable
one/two visitors

6.3 Relationship with Host

- a. independent management - Essential
- b. independent professional direction - Essential
- c. independent service facilities - Essential

6.4 Characteristics of Host

- a. teaching hospital
 - Gynaecological - Essential
 - Pathology - Desirable
- b. provides other gynaecological and women's services - Essential
- c. provides other cytological services - Desirable
- d. good image with VC(G)S staff.
Other hospital, women and general practitioners - Essential
- e. Accessibility to
 - public transport)
 - private transport) - Essential

Further details and ranking of requirements are given in Appendix H.

6.5 Recommendations

That the Board of Management enter into negotiations with interest institutions concerning re-location. Negotiations should take into account the above criteria.

7. COMPOSITION OF THE BOARD OF MANAGEMENT

7.1 Background and Issues:

The Board of Management has overall responsibility for policy management and administration issues. The by-laws of the VC(G)S which came into operation on the 2nd of August, 1965, set the following criteria for membership on the Board: (Appendix I)

Members are appointed to hold office for a term not exceeding three (3) years and they are eligible for re-appointment. (See Appendix J for current members of the Board).

In addition to the Board of Management, the VC(G)S has a Medical Advisory Committee. (Appendix K). However, this committee meets infrequently and in fact, has met only XXX__ in the last two years.

The membership of the Board of Management is composed primarily of persons with scientific, technical and clinical expertise on issues relating to cytology, pathology and cervical cancer.

In reviewing the above composition of the Board of Management, the central issue addressed by the Working Party concerned representation by the major users of the VC(G)S. The underlying principle in considering this issue is that health services, through their Board of Management, should be directly accountable to users as well as to the funding agencies.

The Working Party was concerned that, without sacrificing the essential scientific and technical expertise, that the Board of Management have a more balanced membership with greater representation by consumers.

In considering the issue of consumer representation, it is important to clearly identify the consumers of the services provided by the VC(G)S. The consumers can be categorized into two groups:

Primary or direct service users:

- Private general practitioners;
- Community Health Centre medical/nursing staff; ✓
- Government family planning clinic
medical/nursing staff; ✓
- Family Planning Association medical/nursing staff; ✓
- Gynaecologists;
- Epidemiologist.

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Secondary or indirect service users:

- women receiving pap smears (through a health service provider)

7.2 Recommendations:

7.2.1 that the by-laws of the VC(G)S be amended so that there is greater representation of both primary and secondary consumers of the VC(G)S services on the Board of Management;

7.2.2 that in addition to the current composition of the Board, the following bodies/organisations be represented;

- A women as secondary user/client of the VC(G)S;
- A family planning nurse (suitably qualified in conducting pap smears);

- A general practitioner from the Royal Australian College of General Practitioners with a knowledge of community health and women's health;
- A gynaecologic/oncologist from the Royal Australian College of Obstetricians and Gynaecologists.
- A staff representative from the VC(G)S.

7.2.3 that the current representation by the Victorian Branch of the Australian Medical Association be replaced by representation by the Australian College of General Practitioners.

7.2.4 that the Board of Management review the function and effectiveness of the current Medical Advisory Committee and if necessary undertake changes in membership and Advisory procedures.

8. FUNDING OPTIONS FOR THE VC(G)S

To be expanded

8.2 Funding Options

- ~~X~~ - fee-for-service
 - block grant from Commonwealth to the State to VC(G)S
 - Medi-care rebates.
1. that the Annual operating budget be increased by \$____ in 1988/89 to cover the position of the epidemiologist ...
 2. that the VC(G)S receive a grant from the state health department to cover operating costs;
 3. that the VC(G)S not pursue fee-for-service or Medi-care funding;

4. that the Health Department Victoria approach the Commonwealth Government for a block grant for cervical smear services.

9. SUMMARY OF RECOMMENDATIONS

9.4 State Wide Registry for Cervical Smears:

4.2.1 that the Working Party develop a proposal to establish a State-wide Registry for Cervical Smears;

4.2.2 that the State-wide Registry be independently managed but housed on the same premises as the VC(G)S:

4.2.3 that the Working Party submit the proposal to the Women's Health Policy and Programmes Unit, Health Department Victoria and that the Health Department submit the proposal to the Commonwealth on behalf of the Working Party (appendix ___);

4.4.4 that the Women's Health Policy and Programmes Unit, Health Department Victorian, convene a Working Party to be responsible for the development and implementation of the Registry;

4.2.5 that the following bodies/organisations be represented on the Working Party:

- the Health Department Victoria
- the VC(G)S
- the Anti Cancer Council of Victoria
- a representative from the Private Pathology Services
- a computer expert
- a gynaecologist

- a general practitioner
- a lawyer
- 2 women's health consumers
- a family planning nurse

5. Epidemiologic Component

that the Health Department Victoria increase the staffing establishment of the VC(G)S to provide for a full-time epidemiology position;

6. Future Location of VC(G)S

that the Board of Management enter into negotiations with interested institutions concerning re-location. Negotiations should take into account the above criteria.

7. Composition of the Board of Management

7.2.1 that the by-laws of the VC(G)S be amended so that there is greater representation of both primary and secondary consumers of the VC(G)S services on the Board of Management;

7.2.2 that in addition to the current composition of the Board, the following bodies/organisations be represented;

- a woman as secondary user/client of the VC(G)S;
- a family planning nurse (suitably qualified in conducting pap smears);
- a general practitioner from the Royal Australian College of General Practitioners with a knowledge of community health and women's health;

- a gynaecologic/oncologist from the Royal Australian College of Obstetricians and Gynaecologists.
- A staff representative from the VC(G)S

7.2.3 that the current representation by the Victorian Branch of the Australian Medical Association be replaced by representation by the Australian College of General Practitioners

7.2.4 that the Board of Management review the function and effectiveness of the current Medical Advisory Committee and if necessary undertake changes in membership and Advisory procedures.

APPENDICES

- A. Turn around times for processing smears
- B. Community Health Centre Usage of VC(G)S and Private Laboratory Services
- C. VC(G)S operating budget for 1986-87
- D. Cost of processing a smear at the VC(G)S
- E. Estimated need for cervical smears
- F. Proposal for a Victorian State-Wide Registry for cervical smears
- G. Space requirements for VC(G)S
- H. Other requirements for location of VC(G)S
- I. By laws of the VC(G)S
- J. Membership of the Board of Management
- K. Membership of the Medical Advisory Committee

DELAY STATISTICS FOR V.C.(G.)S. SMEARS

	JANUARY 1987	FEBRUARY 1987	MARCH 1987	APRIL 1987	MAY 1987	JUNE 1987	JULY 1987
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MEAN DELAY (calendar days)	9.62	9.05	11.98	12.89	10.55	9.89	9.39
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MEDIAN DELAY (calendar days)	8	9	13	14	10	10	10
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CUMULATIVE PROPORTION
REPORTED WITHIN -

0 - 7 days	37%	30%	15%	10%	16%	23%	19%
8 - 14 days	96%	97%	86%	70%	96%	93%	97%
15 - 21 days	97%	99%	99%	99%	99%	100%	100%
21 - 28 days	97%	99%	99%	100%	99%	100%	100%

APPENDIX B

C.H.S.	VC(G)S ONLY	VC(G)S & OTHER	OTHER PATH. ONLY	SOURCE INFORMATION	COMMENT
B/Meadows				Dr N. Presswell	
Brunswick				Dr R. Misso	
C/Wood		VCGS & Reg. Path.		Dr S. Crockett	Female Drs tend to use VC(G) and take own smears. Male Drs tend to use Regional Path. and allow Sister to do smear. Small survey found VC(G)S results more specific. Plan to use VC(G)S only
Deer Park	-	-	Macleod	Dr J. North	Has used Mcleod pathology Path. 3-4 years - finds it efficient, reports back next day and more information on infections etc.
E. Preston		-	-	Dr M. Culvernor	VC(G)S problem with mailing - usually takes 3-4 weeks. Otherwise satisfactory
Kensington	-	Mainly VC(G)S occas. Reg. Path	-	Dr A. Small	VC(G)S - problems with waiting time estimate 2-4 weeks
N.R.F.C.		-	-	Dr D. Isaac	

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C.H.C.	VC(G)S ONLY	VC(G)S & OTHER	OTHER PATH. ONLY	SOURCE INFORMATION	COMMENT
Richmond	-	Mainly VC(G)S Neil Trezizes Path.Serv.	-	Dr Pavasaris	
St. Albans	-	VC(G)S &	-	Dr Sheppard	Reg. Path quicker-Sister sometimes takes smears
W. Heid.	-	Mainly	-	Dr Fernandes	Problems with waiting time - 2 weeks
W. Region	-	-	-	Dr L. Gordon	VC(G)S - bit slow-estimate waiting time - 2 weeks

APPENDIX C

VC(G)S OPERATING BUDGET FOR 1986-87

G. Medley to insert

APPENDIX D

COST OF PROCESSING OF A SMEAR BY VC(G)S YEAR ENDING 1986/87

STAFF			PERCENTAGE	\$1000's	COST PER SMEAR
(1)	19.73	*Clerical	33.59%	468	1.66
	4.00	Follow Up	6.81%	95	.34
	32.75	Screeners	55.76%	778	2.76
	2.25	Prep Room	3.84%	54	.19
	<hr/>		<hr/>	<hr/>	<hr/>
	58.73		100%	1,395	4.95
(2)	2.75	Pathologists	100%	192	.68
	TOTAL SALARIES AND WAGES			1,587	5.63
(3)	Administration Costs			322	1.14
				<hr/>	<hr/>
				1,909	6.77
(4)	Capital Costs (Projects funded by HDV 86/87)			119	.42
(5)	Projected Leasing Costs 7000 sq ft @\$21 per sq ft. P/A			147	.52
(6)	Insurances and HCS Computer Costs paid by HDV			14	.05
				<hr/>	<hr/>
					\$7.76
					<hr/>

* Includes Epidemiologist

APPENDIX E

CALCULATIONS FOR ESTIMATED NEED FOR SMEARS

<u>ELIGIBLE WOMEN</u>	1,256,729	
If		
(a) 3 yearly screening	418,910	women
(b) adjusted for current ratio of smears to women	445,648	smears
(c) + 5%, in special follow up needing 6 monthly smears	529,430	smears
(d) + 10% of those <u>not</u> called up who have annual smears	613,212	smears

If		
(a) 2 yearly screening	628,365	women
(b) adjusted for current ratio of smears to women	668,473	smears
(c) + 5% of those in special follow up, needing 6 monthly smears	731,310	smears
(d) + 10% of those <u>not</u> called up who request annual smears	794,146	smears

AGE(Years)	1986 Census Women	Proportion with intact uterus+	Eligible Women	Applying WA* Age specific ratio to this population
15-19	173,564	1.00	173,564	19,092
20-24	165,175	1.00	165,175	47,900
25-34	327,735	0.97	317,903	104,875
35-44	283,511	0.87	246,655	63,803
45-54	195,611	0.76	148,664	35,209
55-59	94,238	0.77	72,563	8,953
60-64	91,653	0.79	72,406	5,497
65-69	73,826	0.81	59,799	3,322
TOTAL	1,405,373		1,256,729	288,653

* Source Armstrong, Rouse and Butler 1987

+ Holman et al, 1986

PROPOSAL FOR A VICTORIAN STATE-WIDE REGISTRY FOR
CERVICAL SMEARS

This proposal seeks Commonwealth funding to expand the existing registry at the Victorian Cytology (Gynaecological) Service (VC(G)S) in order to establish a state-wide registry for cervical smears. The VC(G)S currently collects 75% of smears taken in Victoria. Additional funds will allow for expansion of the current registry to include data on all smears taken in Victoria. While funding sought is to expand the existing registry, a comparative costing of funds required to establish a new registry is attached. The proposal has been developed by a Working Party convened by the Women's Health Policy and Programmes Unit, HDV. Members represent the following organisations and areas of expertise: The Anti Cancer Council of Victoria, The VC(G)S, Health Department Victoria (HDV) epidemiology, general practice in community health and oncological gynaecology.

INTRODUCTION

Despite pap smears being available in Australia since the mid 1960's, 350 women still die each year from cervical cancer.

Reasons that have been put forward to account for these deaths include failure of many 'at risk' women to have regular Pap smears, deficiencies in the management of women with precursor lesions, and the concept that the disease has become more malignant in recent years.

Determining the relative importance of these reasons has been hindered by the fragmentary system whereby Pap smears are taken and reported in Australia. Instituting relevant strategies to address the problem has been extremely difficult in the absence of epidemiologic data.

Some valuable information regarding these problems has emerged in Victoria from an analysis of the 4 million records accumulated by the public sector laboratory, VC(G)S.

Unlike other Australian States, one single laboratory, the VC(G)S, has reported the majority of Pap smears taken in Victoria and has thus been able to function as a surrogate statewide register. With the recent move of service provision to private laboratories, the ability of the VC(G)S records to provide such information is being eroded. It is vital that a comprehensive database be maintained in Victoria as it provides the only population perspective on cervical cancer and its screening programme for Australia for the last 20 years.

The value of such a register to women, gynaecologists, cytopathologists, health promotion workers and public health personnel can be readily appreciated.

OVERALL AIM

The overall aim of the Victorian Registry for Cervical Cytology is to facilitate the development, implementation and evaluation of screening strategies to reduce the morbidity and mortality due to cervical cancer among women in Victoria.

SPECIFIC OBJECTIVES

1. To improve the quality of data available to State and Commonwealth Government health bodies concerning cervical cancer and screening rates;
2. To monitor the incidence and prevalence of precursor lesions and trends in risk factors associated with cervical cancer (eg. Human Papoloma Virus);
3. To provide the necessary data for evaluating the effectiveness of screening policies, programmes and strategies that target under screened and high risk groups;
4. To increase the quality of reporting of Pap Smear results in both the public and private sectors by linking together previous smear results with later outcomes.

BACKGROUND

The registry will be independently managed but located within the Victorian Cytology Service (VC(G)S). The VC(G)S is ideally suited to housing the registry as it currently reports on approximately 75% of all Pap smears taken in Victoria.

The VC(G)S, a state-funded public health service, was established in 1965. Since that time, it has served as a central register for Victoria and has provided much of the Australian data concerning cervical cancer trends and the associated risk factors. (1-8).

The computer system at the VC(G)S currently contains all VC(G)S data back to 1965. It therefore has the capacity to:

1. link new and current smear findings with previous ones;
2. to implement a call and recall system in accordance with a national screening policy for women with normal and abnormal screening histories;
3. carry out the required epidemiologic work, as it has a proven monitoring and research capacity.

The remaining 25% of smears which are not reported by the VC(G)S are evaluated in public hospitals and in the private sector.

The Anti-Cancer Council has convened a Working Party of these groups who have agreed to co-operate in the development of a central registry. In the first instance, all laboratories have agreed that a set of minimal data will be collected.

The participation costs of the private sector and public hospitals will be minimal as all major laboratories have computer facilities. Data will be transferred to the central registry via a modem. Access by these sectors to registry data will be via modem and print-out or by telephone. As a confidential safeguard, the laboratories will not have direct access through the use of VDU's. Rather, the laboratory will send via the modem basic identifying data for the women whose smears they receive. The Registry will return to the laboratory the known smear history of the women. The laboratory will complete the transaction by providing a coded cytology report. If the report was significantly abnormal, the registry will request follow up information at a later time. A minimal cost of approximately \$500.00 per participating pathology laboratory will be required for software development.

SPECIFIC REQUIREMENTS FOR THE REGISTRY

Physical Location:

The registry will be housed on the same premises as the VC(G)S. The VC(G)S is currently located at the Prince Henry's Hospital in Melbourne. However, due to the anticipated re-location of Prince Henry's, the VC(G)S is currently reviewing its future location. The Health Department Victoria has undertaken to ensure that additional space is allocated to the Registry both in its present and future location.

Staffing:

The registry will require the following permanent staffing positions:

- * 1 full-time epidemiologist
- * 2 full time VDU operators
- * 1 secretary/receptionist/VDU operator
- * 1 full time medical record administrator

- * sessional consulting statistician
- * sessional software modification consultant.

The epidemiology position will be shared with the VC(G)S and the VC(G)S will provide full funding for that position.

Data Entry and Retrieval Procedures

Initially data to be entered into the Registry data base includes:

Data from participating labs

- Name/previous surname
- Birth date
- Address
- Date of smear receipt

VC(G)S

Name/previous surname
Birth date
Address
Referring doctor
Country of Birth
Parity
Hormonal status
Contraception
Symptoms
Appearance of cervix
Relevant past history
(pelvic irradiation etc.)

Further developmental work to expand the data set will be carried out with participating laboratories.

VC(G)S data will be keyed directly into the data base from VC(G)S cytology request/report forms. Other pathology services have agreed to extract the above data and transfer it via modem to the registry. Mechanisms for promoting the transfer of data from public hospitals are being developed.

Direct access to data retrieval will be limited to the Registry. Private pathology services, general practitioners, public hospitals and other health care agencies will have access to information about the smears submitted by them only by request either through modem and printouts or by telephone.

Legal Issues and Confidentiality

Full confidentiality will be maintained through restricted access to the data. Modem transfer of reports and referring doctors will be by code. The Health Department Victoria, in co-operation with the Anti-Cancer Council of Victoria, is currently undertaking action to ensure that confidentiality is protected.

Follow Up and Recall Procedures:

Initially, the registry will seek follow-up information on all abnormal smears (colposcopy findings, histology reports etc) by:

Phase 1:

- contacting medical practitioners who referred their smears directly to the VC(G)S (this procedure is currently routine within the VC(G)S);
- contacting the participating pathology labs for abnormal smears reported to the registry.

Where the recommendation after an abnormal report was for further cytology, a reminder letter will be sent to the referring doctor three months after the date when the cytology report was due.

Phase 2:

The registry will seek to recall women who have already had a normal smear:

- Reminder letters will be sent to the referring medical practitioners at a defined time interval after the last normal smear;
- The VC(G)S currently recommends biennial (every two years) smears if the past history has been normal. This time interval may need to be adjusted if a different screening interval gains wide acceptance by the learned organisations (NH&MRC, Anti-Cancer Societies, Royal Australian College of Obstetricians and Gynaecologists etc.)

Phase 3:

The registry will seek to develop a call system for all eligible, unscreened women in Victoria if there is community and professional support for such an initiative.

BOARD OF MANAGEMENT:

The Registry will be overseen by an independent council or Board of Management. This body will be formally accountable for the management of the Registry to the HDV. An interim committee is being appointed by the Health Department Victoria to be responsible for the developmental stages of the Registry. Membership on the interim committee will include representation from:

- The Health Department Victoria
- The VC(G)S
- The Anti-Cancer Council of Victoria
- Private pathology services
- An epidemiologist
- A computer expert
- A gynaecologist/oncologist
- A general practitioner
- A lawyer
- 2 women's health consumers
- A family planning nurse
- A public hospital cyto-pathologist

Funding Arrangements:

The costs of the establishment and the maintenance of the data base will be shared between the State of Victoria and the Commonwealth Government.

ESTABLISHMENT COSTS

STAGE 1

To expand the existing VC(G)S name and address file, create "foreigner" slide files and with mutual access between files to allow record updates, histology and cytology case update and to permit statistical analysis of expanded file.

Note: Cost of direct external user access and merge with other major database files such as Medicare, CER etc., has not been included.

Hardware:	300 Megabyte Drive and Controller	
	320 K Memory	
	T. Coupler to allow more partitions	
	Streaming Tape Drive for Back-Up	
	5 V.D.U.'s	\$65,000
Software modifications for modern access for 15 labs at \$500.00		\$ 7,500
Software Modifications:		\$35,000
Purifications of existing file of 4.5 million smears to clean duplications, mis-spelling; this work is partly manual and partly VDU activity. Estimated time required is 6 persons for 6 months. Cost is approximately		\$50,000

Desks (\$650.00 each) x 4	\$ 2,600
Chairs (\$350.00 each) x 4	\$ 1,400
Capital Costs for renovation of floor space	\$15,000
	<hr/>
TOTAL COSTS	\$176,500

STAGE II and III

Costs for stage II and III have not been estimated as further development is dependent upon national policies and strategies for screening.

ANNUAL OPERATING COSTS

Staffing:	full-time Epidemiologist	\$52,000
	2 VDU operators	\$40,000 (\$20,000 each)
	medical/record Admin.	\$23,000
	software consultancy	\$10,000
	statistical consultancy	\$15,000
	Secretary/Receptionist	\$20,000
TOTAL STAFF COST		\$160,000

Plus 12% oncosts \$

Stationery, printing, photocopying	\$ 3,000
*postage - (call and recall)	\$
computer transfer/telephone 30 minutes per day at \$3.00 per minute	\$25,000
Rental space (800 sq feet x \$19,000)	\$15,200

*Total postage costs have not been included as it is not possible to estimate the costs of call and recall notices for Stage 11 and 111 at the present time.

TOTAL **\$203,200**

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- 3) Organised mammographic screening programmes: A benign or malignant neglect?
Mitchell H.
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- 4) Cytologic Detection of Human Papilloma virus
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- 6) Pap Smears in Victoria: Are the wrong women being screened?
Mitchell H, Drake M, Medley G.
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- 7) Age trends in Pap smear usage, 1971-1986
Mitchell H, Medley G.
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- 8) Problems with the Australian Pap Smear Programme
Mitchell H,
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MONASH MEDICAL CENTRE - STAGE II

26/10/87

V.C.(G.)S.: PROPOSED ACCOMMODATION

AREA	EXIST. M ² NET	ADD. M ² NET	TOTAL PROP. M ² NET	COMMENT
RECEPTION	10.5	-	10.5	
CLERICAL AREA (Incl. Mailslashing + kit prep. : 3 Slide Ident. : 13 Cyt No. Ident. : 4.5 Stationery : 1.5)	22	-	22	
FILE CLERK	3	-	3	
V.D.U. WORKSTATIONS	16	6	22	Exist. 6 workstations 2 additional proposed.
WORDPROCESSING & TYPING (noisy area)	6	-	6	
FILES	36	-	36	
BUSINESS MANAGER	10	-	10	
SECRETARY (B.M.)	6	-	6	
COMPUTERS (Incl. Comp. Room : 9 Printing, etc. : 10)	19	-	19	
STORAGE	96	4	100	Bulk storage to be located in basement.
LABORATORY	65	55	120	Cytology Lab. from M.M.C. relocated to V.C.(G.)S.
CLINICAL ROOM	9	6	15	
SCREENING	93	72	165	1. 3 No. Supervisor cubicles 2. 8 No. additional workstations 3. Ergonomic

AREA	EXIST. M ² NET	ADD. M ² NET	TOTAL PROP. M ² NET	COMMENT
SCREENING SUPERVISOR	6	4	10	
D.N.A. MICROSCOPE	7.5	2.5	10	
FOLLOW-UP	15	5	20	
TEACHING; MICROSCOPY & TEACHING ROOM	33	6	39	Add: Supervisor cubicle.
SEMINAR ROOM	32	-	32	
MULTIHEAD MICROSCOPE	10	-	10	
EPIDEMIOLOGIST OFF.	13.5	-	13.5	
RESEARCH ASS./STAT.	-	13.5	13.5	
PATHOLOGISTS OFFICES	30	10	40	Exist: 3 No. path. offices. Add 1 No. path. office.
TRAINEES (2 No.)	-	10	10	
DIRECTOR'S OFFICE	12	3	15	
SECRETARY (DIRECTOR)	10	-	10	
TEA ROOM	10	5	15	
	570.5	202	772.5	NET
			+ 35%	
			1043	GROSS

REQUIREMENTS FOR RELOCATION OF VCGS

Existing Berica:

Independent spatial requirements and relationships

Screening	Laboratory	Data	Clerical	Teaching	Research	Amenities
-----------	------------	------	----------	----------	----------	-----------

1. Area (m²) (see attached)
2. on one floor (E/D/U)*
3. on ground floor (E/D/U)*
4. on same floor as (specify) Desirable to have all on one floor for comfortable traffic flow.

5. quiet (E/D/U)	E	D	D	E	E	U
6. secure (E/D/U)	E	E	E	E	E	D
7. exterior outlook (E/D/U)	E	E	E	D	D	D
8. natural lighting (E/D/U)	E	E	E	D	D	D

E - essential
 D - desirable
 U - unimportant

Chief Rep. Mr. Act.

REQUIREMENTS FOR RELOCATION OF VCGS

11. Support from host institution

	Essential	Desirable	Unimportant
1. catering			
2. administrative support *			
3. utilities:-			
power - routine			
power - emergency			
light - routine			
light - emergency			
telephone - <i>virage</i>			
other?			

1. catering
(No. of meals = appr. 60)

D

2. administrative support *
(No. of staff = less than 1)
↳ 74 staff

D

3. utilities:-
power - routine
- emergency
light - routine
- emergency
telephone - *virage*
other?

E
E
E
E
E
E

4. cleaning Gross 1043M²
(area = Nett 773M²)
(special requirements)

E



D (could be contracted)

* hosp has to take responsibility
* cheaper to contract

5. waste disposal

E - sharp & polluted article to dispose

6. parking

E

(No. of vehicles = ESSENTIAL 30
staff = 30
visitors = 2
patients = 1-2- if non-gynaecological
Cytology also
DESIRABLE 50 (Part-time staff coming and going; would be more difficult in some locations than others.)

* eg. personnel
pay-roll
workcare
(NOT FINANCE)

FACTORS INFLUENCING RELOCATION OF VCGS

Mandatory | Desirable | Unimportant | Weighting
0-5

I. Relationship with host

- 1. independent management (v. integration with host) 5 5
- 2. independent professional direction (v. integration with host.) 5 5
- 3. independent service facilities (laboratory; data collection; clerical) 5 5
but some cross-reactivity with Histopathology Department desirable

II. Characteristics of host

- 1. teaching hospital; 5 5
1a. Hospital Pathology Service ~~Pathology~~ GYN 4
- 2. provides gynaecological & other women's services; 4
- 3. provides other major cytological service(s); 5
(It would be extremely important for the Service to be responsible for non-gynaecological cytology also in order to attract high quality cytotechnical staff and pathologists.) 5
- 4. good image with -

- a - VCGS staff hospitals 5 5
- b - public professionals 5 5
- c - private cytology services 4
- d - general practitioners 5 5
- e - women 5 5

5. accessibility -

- a - public transport 5 5
- b - private transport 5 5
- c -

FACTORS INFLUENCING RELOCATION OF VCGS

	Mandatory	Desirable	Unimportant	Weighting 0 - 5
1. <u>Ability of host to provide independent space/relationships</u>		5		
a. - laboratories **			1	
b. - data base			0	
c. - clerical/office			0	
d. - teaching) ***		3	3	
e. - research)		3		
2. Support services -				
a. - catering			3	
b. - administration			2 *	
c. - utilities			5	
d. - cleaning			5	
e. - parking			5	

* For interchange of experience but not for provision of services in routine activity.

*** Histopathology Department and perhaps Immunology Laboratory are desirable for support for teaching, research and follow-up activity.

* personnel)
payroll)
workcare)

APPENDIX I
BY-LAWS OF THE VC(G)S

TO BE INSERTED

APPENDIX J

BOARD OF MANAGEMENT OF THE VICTORIAN CYTOLOGY
(GYNAECOLOGICAL) SERVICE

Members

Professor R. Pepperell	Department of Obstetrics and Gynaecology The University of Melbourne
Dr Ironside	Director of Pathology Peter McCallum Clinic
Mr A.G. Bond	Head of Gynaecology Prince Henry's Hospital (representative of A.M.A.)
Mr L.P. White	Board of Management Monash Medical Centre
Dr N. Gray	Director Anti-Cancer Council
Mrs D. Sergeant	Director Social Biology Resources Centre
Assoc. Prof. E.P. Guli	Director of Pathology Royal Southern Memorial Hospital (Anti Cancer Council representative)
Dr P. Dennis	Chairman of Pathological Services Prince Henry's Hospital (a rotating position)
Ms E. Sims	Social Worker Springvale Community Aid and Advice Bureau

The Business Manager, the Chief Executive Officer and Director of the VC(G)S are non-voting members.

VICTORIAN CYTOLOGY (GYNAECOLOGICAL) SERVICE

MEDICAL ADVISORY COMMITTEE

MEMBERS:

Medical Members of Board of Management of Service:

Professor R.J. Pepperell (Chairman), Mr. A.G. Bond,
Dr. M. Drake, Dr. N. Gray, Assoc. Professor E.P. Guli,
Dr. P. Ironside.

Other Members:

Professor N.A. Beischer

Professor of Obstetrics and
Gynaecology, Melbourne University
(Mercy Maternity Hospital).

Professor E.C. Wood

Professor of Obstetrics and
Gynaecology, Monash University.

Representing:

Mr. A. Day

Queen Victoria Medical Centre

Mr. W. Chanen

Australian Society for Colposcopy
and Cervical Pathology
and

The Royal Women's Hospital

Mr. P.P. Glenning

Australian Medical Association

Dr. E. Goodman

The Royal Australian College of
General Practitioners

Dr. J. Hayman

The Royal College of Pathologists
of Australasia

Mr. R. Rome

Royal Australian College of
Obstetricians and Gynaecologists

Invitee:

Dr. G. Medley

Victorian Cytology (Gynaecological)
Service.

Cigarette levy will help cervical cancer fight

from R. Galbally, chief executive officer, the Victorian Health Promotion Foundation

In response to your editorial (7/2), I write to draw your attention to the role of the Victorian Health Promotion Foundation in the area of early detection and prevention of cervical cancer.

The foundation has joined the fight against this cancer by funding a community-based pilot cervical cancer screening program for the sum of \$364,478 over two years.

The Victorian Health Promotion Foundation is convinced that the program will play a vital role in increasing the screening rates of eligible women.

It is estimated that up to 250,000 Victorian women of an eligible population of 1.4 million remain unscreened.

According to the Anti-Cancer Council of Victoria, these women are over 40 years of age, of lower socio-economic and educational status and often of ethnic background.

By providing pap smears at local community health care centres, and information in languages and terms women of various ages and cultural backgrounds can understand and accept, we feel we are taking a positive step towards detection and education.

The pilot program was developed by a committee comprising

representatives from key areas of the health field, selected on the basis of their individual expertise and experience.

The cervical screening pilot program will involve community health centres encompassing rural and metropolitan Victoria.

The Victorian Health Promotion Foundation was established as an independent statutory authority under provisions of the Tobacco Act, 1987.

Its major role is to distribute funds gathered by the health promotion levy on wholesale tobacco sales. This levy is expected to raise \$23 million per year.

Rhonda Galbally,
Carlton.

ACCU.

Twenty-five years on, experts fail to agree on test frequency

It is 25 years since Pap smear tests were introduced in Australia, yet there are still no national guidelines for how often the tests should be done.

Dr Robert Planner, gynaecological oncologist at the Mercy Maternity and St Andrew's hospitals in Melbourne, and Dr Michael Quinn, the director of oncology at Royal Women's Hospital, two of the leading gynaecological oncologists in Melbourne, say the tests should be done yearly to ensure the greatest protection for women.

However, the medical epidemiologist at the Victorian Cytology (Gynaecological) Service, Dr Heather Mitchell, argues that it is more cost-efficient to screen women every three years. "If every woman had a three-yearly Pap smear test it would cost the taxpayer \$60 million a year. If programs cost a lot of money we must get the best value," Dr Mitchell said. "The additional number of women prevented from cervical cancer by one yearly tests is very small and the cost three times as great."

Last year, at a meeting organised by the Australian Cancer Society, discussions to establish a national consensus on how often women should be screened broke down. The consensus recommendation was that women should have two tests a year apart, and, if

The medical profession seems unable to reach agreement over how often women should be screened for signs of cervical cancer, a disease that has a lifetime risk of death of approximately one in 250 Australian women. **LOUISE BELLAMY reports.**

the results were normal, subsequent screenings every three years. The policy of the Royal College of Obstetricians and Gynaecologists is that yearly Pap tests from the start of sexual activity up to the age of 35 and every subsequent two years is appropriate if there is no abnormality.

But the screening-interval debate aside, Drs Planner, Quinn and Mitchell agree that the accuracy of Pap smear tests is paramount.

At present, any laboratory in Australia that has general approval can conduct a Pap smear test. At the cytology service the false negative rate among women with squamous cell carcinoma (the most common cancer which occurs between the squamous cells of the vagina and the columnar cells of the uterus) is five to seven per cent in the 12-month period preceding the diagnosis of cancer.

The false negative rate among

Dr Mitchell says: "We don't know how good the private laboratories are. If a small number of tests are reported in a laboratory, it is possible the staff has insufficient experience to be most accurate."

"Women and their doctors are in no position to judge how good or accurate a laboratory is. No centralised registers of data exist within each state, which leads to a situation where a laboratory reporting on an abnormal smear may not have available to it the preceding smear reports of the woman, which hinders the ability to give the most accurate report."

Dr Planner is concerned that the system is generating a group of doctors who have little practical knowledge of cervical cancer because, he says, some interns get inadequate gynaecological experience during their training. Student doctors, he says, do not begin to study obstetrics and gynaecology until they are in fifth year and they may not use a speculum again for two or three years.

But it is not just the young doctors who may be inexperienced. Dr Mitchell said: "Doctors who have been in practice for many years may not have had the opportunity of the best instruction in how to take Pap smears because the emphasis on preventive medicine is rather recent."

Carry

Women need information

The Anti-Cancer Council conducted its first Pap smear education program last year, directing information at women aged over 40 who lived in country areas.

Gynaecologists worked with local doctors around Geelong and north-west Victoria to alert women to the advantages of Pap smear testing.

This year, two additional programs will be conducted in north and central Victoria. According to Dr Heather Mitchell and Dr Robert Planner, the target group of country women and non-English-speaking women are most in need of information.

Dr Mitchell is the medical epidemiologist at the Victorian Cytology (Gynaecological) Service. Dr Planner is the gynaecological oncologist at Mercy Maternity and St Andrew's hospitals in Melbourne.

Dr Mitchell said many country women would consider it inappropriate to have their family doctor, who may also be a family friend, administer a Pap smear test. While she endorsed the edu-

cation programs, Dr Mitchell said Australia should be ashamed of the inadequate way in which women have been informed about Pap smear testing.

"In Britain and in many Scandinavian countries, women are invited to have smear tests," Dr Mitchell said. "In Australia, women — particularly older women — are too reticent and/or embarrassed to be screened."

Dr Planner said the problem with the 40-plus age group was that the women usually just did not want to know. He said education programs should begin at school, but Dr Mitchell said the over-40s should be addressed first.

The other group in need of special information about smears is the ethnic community.

Referring to a recent survey of 200 cervical cancer patients, which found that 56 per cent had never been screened and 25 per cent had been screened irregularly, Dr Planner said that 30 per cent of those who had never been screened were non-English speaking.

STUDY REVEALS POSSIBLE LINKS

Results of a Sydney study published in the 'Medical Journal of Australia' today has revealed a link between sexual, reproductive and contraceptive factors and cervical cancer.

Women who had had seven or more sexual partners in a lifetime had a six-fold increase risk compared to those with one or no partner.

Early-age sexual intercourse was also a risk factor, but this effect was reduced substantially after adjustment for the number of partners.

The long-term use of oral contraceptive agents was also associated with higher risk. The risk increased with the number of induced abortions, but this effect was not statistically significant.

A protective effect was found for women who had had a tubal ligation, women who practised the rhythm method of birth control and women who breastfed.

Cancer test is unreliable, says physician

By PHILIP McINTOSH

A Melbourne physician has criticised a new screening test for cancer of the cervix. The test is being promoted by clinics in Melbourne and Sydney.

Dr Heather Mitchell said the test, known as cervicography, produced a high rate of false positive results, was expensive, and had not been adequately evaluated.

She also expressed concern about favorable comments about the test by some gynaecologists in the Australian media. "I suspect that many of them haven't taken the time to fully look at the literature. They've just accepted, possibly, the glossy brochures of the management company that is trying to market it," she said.

"As a health professional, I have a responsibility not to believe everything that's told to me, but to evaluate the evidence scientifically. I don't think many people have done that."

Dr Mitchell is the epidemiologist with the Victorian Cytology (Gynaecological) Service, the state's cervical screening service, at Prince Henry's Hospital. She was speaking at a conference on prospects for prevention in medicine. The conference was organised by the College of Physicians, the Monash University department of social and preventive medicine, and the Baker Medical Research Institute.

A cervigram is a magnified photograph of the cervix, projected on to a screen where it is examined for signs of cancer or pre-cancerous changes. Dr Mitchell said the test had been used on

4271 women in three US hospital clinics.

This was an inadequate number for a diagnostic test that could be marketed in Australia to 4.5 million women — the number who were at risk of cervical cancer. "You'd never get away with that in a drug trial," Dr Mitchell said.

She said that none of the studies had evaluated whether the results of cervigrams taken today would influence death rates, or even cancer rates, several years ahead. By contrast, Pap smears had been shown to influence an outcome many years after they were done.

Dr Mitchell said the high false positive rate of cervicography made it seem a "grossly insensitive" test. "In other words it categorises a far-too-high proportion of women as being sick. One in seven women has a suspicious finding (with the test), but one in seven women does not have cancer of the cervix," she said.

"It takes a lot of sorting out of those women with other tests, all of which have a cost, emotional and financial. I don't underplay the potential damage to a woman's psyche of having to have a cervical biopsy, only to be told it was benign and there's nothing wrong.

"I suspect some women will always have that heightened anxiety that maybe there was something there."

Dr Mitchell said the price of the test was \$40. "Medical people should not be seen to be marketing tests that are of dubious value and where the possibility of financial reward is not inconsiderable," she said.