The three A's of colonoscopy referral

To the Editor: The National Bowel Cancer Screening Program will reduce the burden of colorectal cancer, saving lives and money.[1] The benefits of the program, however, rely on both public and private sectors to deliver colonoscopy, surgery and, if necessary, advanced cancer care. Public confidence in the whole program is likely to be affected by the affordability, ability and availability of these frontline services.

Some public hospitals are unable to reliably deliver timely colonoscopy (ie, within 120 days).[2,3] Private practice is an efficient and, for many, affordable option, but there is considerable variation in price. Furthermore, pricing information is often not readily available before referral and can be complicated by multiple separate fees. In contrast, the public hospital system is affordable (free), but there may be issues of availability due to waiting times. The ability of the colonoscopist is relevant to both settings, with adenoma detection rate a well validated quality indicator.[4]

To test the performance of a discounted, anaesthetist-assisted, private colonoscopy service for high-risk public patients, we conducted the following observational study in a metropolitan practice. Through efficiencies and cost sharing, we provided colonoscopy for a discounted out-of-pocket fee of $310 ($300 for the colonoscopy plus $10 for the bowel preparation kit). We performed 100 colonoscopies and diagnosed seven cancers, with an adenoma detection rate of 66% and a median wait of 29 days. These colonoscopies, if performed publicly, would have cost the state budget over $190 000, at approximately $1900 per colonoscopy (Margaret Clark, South Australia Health, personal communication; July 2018). In contrast, the total cost of this program was about $94 895, comprising the total patient payment of $31 000 plus the total combined bulk-billed fee for clinicopathological services of $63 895. This program did not cost-shift, it cost-saved about $95 105.

Private and public services should provide current information to general practitioners, patients and government concerning their affordability (total out-of-pocket fee), ability (http://recert.gesa.org.au/recertified.php) and availability (waiting time from GP referral to colonoscopy). The $310 out-of-pocket fee is unlikely to be the equilibrium price for self-funded colonoscopy in Australia and investment in public colonoscopy remains important. Nevertheless, we suggest that patient autonomy and access would be improved by real time accurate information about their colonoscopy options to allow them to make a rational choice. This would help optimise the benefits of the National Bowel Cancer Screening Program and allow public and private sectors to work together to eradicate bowel cancer death in Australia.

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