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WEDNESDAY 5 JULY 2000
THE HEARING RESUMED AT 9.37 A.M.

TRACY MELLOR (On former oath)

MR CORKILL ADDRESSES PANEL

MR CORKILL: Before I resume the cross-examination there is a matter I wish to seek leave of the committee to see the committee about in chambers concerning the logistics of the women's evidence and I just raise that formally. I have raised the matter with my learned friend Mr Hodson in particular and am more than happy for him or anyone else who has an interest in that aspect to be present.

CHAIR: What I suggest is when we break at 11, we will break until 11:30 and we can meet between 11 and 11:15. Would that be enough time Mr Corkill?

MR CORKILL: Yes that would be fine thank you?

CHAIR: And any Counsel or party who would like to be present is certainly most welcome to be present as well.

MR HODSON: If I may raise another subject from yesterday, which was the question of the slides. I have taken instructions and there are people interested in this and I can say that the evidence will be that if Dr Bottrill's initials appeared on the report, then he read the slide, if they did not, he did not and I can further indicate that on the inquiries that I have made it is accepted that the figure of something like 3,000 and there is a wide possible variant in that were not read by Dr Bottrill.

CHAIR: Right, thank you very much Mr Hodgson. While we are

dealing with these housekeeping matters, Mr Curtin, in terms of your three witnesses, I've read the briefs of evidence overnight and I would like them to be called. Now if there is any difficulties about that I suggest you liaise with Mr Hindle but certainly the Committee of Inquiry wants to hear from them. When you are ready Mr Corkill.

MR CORKILL XXN OF DR PETERS CONTINUES

MR CORKILL: Dr Peters I asked you late yesterday to deal with one or two matters overnight. I think the first of those was to do with the status of current contracts particularly with laboratory providers.

A: Yes, I have made some inquiries into this overnight. The matter is covered quite fully in Ms Mellor's supplementary evidence however community laboratories agreed in March and April this year to a price increase for the reading of cytology smears and in conjunction with that to comply with the draft quality standards and the variation also includes a requirement that they will comply with variations on the quality standards as these are made from time to time. Now the finalised standards will also be referred to in the National contract which is currently being negotiated with hospital and community laboratories, and as I have indicated, and Ms Mellor will indicate, my team is working with the personal health operating group on the implementation of the standards once they are finalised and a combined cross-operating group team has been formed to ensure that implementation occurs. I can also confirm, because I was directly involved in this, that the development and implementation of quality standards and monitoring requirements for the programme was indicated in one of the schedules of the HHS contracts which have – of the 2000/2001 contract, and that they would be subject of review once they were finalised.

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Q: Now when you refer there to the quality standards having been brought in the way you've just described to both classes of provider, which draft are you talking about. Are you talking about the, if we just go to the relevant tab, draft that we discussed yesterday, the first of the drafts that appears in your evidence?

A: Initially that variation would have referred to draft one, but all the laboratories will be in receipt of draft two now.

Q: And draft one, just to follow this through, is at tab 20, and draft two is at tab 40, is that correct?

A: that's correct.

Q: so your position is that, to all intents and purposes, the laboratory providers are bound by that material at this stage?

A: That is my understanding, yes.

Q: Now the other matter I asked you to consider overnight was the budget for 2000 and 2001.

A: Yes, that is correct. I have confirmed the budgets overnight. The budget I have available for all the developmental work for the cervical screening programme in the next year is a little over \$2M. That would include funding to do any upgrade work that is required on the register and funding for monitoring, ongoing monitoring of the programme. So for a contract with an independent monitoring group. That does not include the operating budget for staff salaries and other overheads.

Q: the \$2M does not?

A: that is exclusive of my operation budget.

Q: Roughly how much for the upgrade, because a year or so ago you were talking about \$1.5M for the upgrade.

A: I discussed that with Ms Matcham overnight, we think there was

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probably an extra zero put on that figure and we have settled on a figure of \$120,000.

Q: for the balance of the upgrade?

A: yes.

Q: and the rest of it is what you call developmental work, which is these various special projects you've been involved in?

A: yes and establishment of service provision, for example for monitoring and audit.

Q: which takes it through to the end of July next year

A: that is correct.

PROFESSOR DUGGAN: I notice that rapid re-screening of 100% of ? is part of the proposed upgrading of laboratory practice.

A: Yes.

Q: Who is responsible for the training of the technologists in this activity?

A: You mean their basic training or their training within the laboratory?

Q: Let me rephrase this. Is this currently routine practice in NZ laboratories?

A: I couldn't give you an exact figure, but I understand it is already very prevalent, for example when I made enquiries about this myself, at about this time last year, I was assured that a majority of laboratories would already be doing this.

Q: so it may already be covered, no additional budget is needed for this?

A: It may well be in a majority of laboratories, yes.

Q: but if it is not?

A: Well laboratories have already had a price increase this year for the reading of cytology smears.

Q: So the assumption is that within the budget they can facility the training

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of the technologists in this new technique?

A: My understanding would be yes, but my understanding would be yes. However, I have to say I myself have not explored the issue of training in detail.

Q: do you have any concerns about this?

A: I have concerns about training, and when I was reflecting last night on some of the issues we covered yesterday about the advantages of the National screening team being in control of the budget, I noted that one of the advantages was that it would enable us to make budget bids directly to cover issues such as the advancement of training within the programme, which at the moment, because we are not directly in control of that budget we have to work through another group to enable that to happen, or we would have to.

Q: as long as you are aware it's an issue.

A: I'm very aware it's an issue.

MR CORKILL: Is the position, as far as training courses Dr Peters, that National Women's runs two three days courses/year for technologists?

A: I'm not aware of the details of the courses, but I do understand – I am aware that National Women's is heavily involved in the training.

Q: and the NZ Society of Cytologists also?

A: Yes.

Q: But that is all?

A: As I said to Professor Duggan, I am aware that training within the programme is an issue.

Q: Now we left off yesterday looking at tab 32 and the issues and options paper, p12 – do you have that?

A: Yes, I do.

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Q: And I think we'd got down to number 3 and number 4 in the list of disadvantages is the risk of the screening programmes becoming disenfranchised if they are not represented at a senior level within the Ministry.

A: Yes.

Q: Now your evidence is that, as manager, you will be level 3 in the new organisation.

A: that's correct.

Q: do you have any view as to the adequacy of that level of seniority?

A: I think it's adequate and I note in the para under the table, the second para, that in this paper which I say was a think piece written by my group, that we saw reporting either being in the second tier or the third tier, but the manager of the National screening team would be adequate.

Q: Has the new Deputy Director General, Public health been appointed yet

A: Yes, he has.

Q: who is that?

A: Dr Don Matheson.

Q: And he is presently an employee of the Health Funding Authority, is that correct?

A: that is correct.

Q: What is his role at the moment?

A: He is the General Manager of Public health within the Health Funding Authority.

Q: So there are some existing professional relationships in place that will be carried over?

A: Yes, that is correct.

Q: Are you, and you may not be because you are in the Health Funding Authority and you're not an employee at the moment of the Ministry, but are

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you aware of any commitment given by the Director General to the programme?

A: I am not personally aware of any commitment. When I say I am not personally aware, I am aware that the recommendations contained in my exhibit 33 were agreed to by the sector steering group and my understanding is that Dr Patasi is a member of that group so I take it from that that she has made some commitment to the screening programme but I have not personally been in contact with her.

CHAIR: Dr Peters what is the status of the sector steering group?

A: My understanding is that it is a combined Ministry and Health Funding Authority a small group overseeing the structural changes. I think there are about five individuals in the group.

CHAIR: And what power does it have to actually implement change?

A: I think you would need to speak to the steering group about that but my understanding is that it is quite powerful because it contains some of the most senior people in the health bureaucracy on it.

CHAIR: So that fact that the steering group has supported your proposals can be taken to mean something significant?

A: I think so yes.

MR CORKILL CONTINUES XXN

MR CORKILL: Is it correct that following that meeting of the steering group, documents were issued by the Director General to all staff outlining the new divisions within the Ministry including the locations of the Cervical Screening Programme and the Breast Screening Programme.

MS MELLOR: Yes this paper went to the sector steering group in March when the actual planning for the merging of the Ministry and the

Health Funding Authority was still I guess being planned but this was seen as important to retain stability in the screening team and subsequent to that more planning of the structure of the new Ministry occurred and the nature of the National Screening Programme was again confirmed in that structure.

Q: But I think it's correct that Dr Patasi communicated with all managers and staff in March of this year indicating what the proposed new organisational structure would be.

A: I can't remember the exact dates I'm sorry I know I say a proposal towards the end of May. There may well have been a new structure, a proposed structure in March but I can't recall it at the moment.

Q: Perhaps if we just look at the document that the Registrar will give you. There are actually two documents being circulated at the moment Dr Peters but the first is communication from the Director General on 22 March 2000 to all managers and staff in both organisations, have you got that.

A: Yes.

Q: And we see that on the very last page of that document step 10, the new Ministry structure, was to be fully operative as from 1 July.

A: Yes that's correct.

Q: And in the second document which is the organisational design for the Ministry of Health we see on the front page the eight new directorates and if we go to page 7 of the document we have the Public Health Directorate, the management structure indicating the Deputy Director General as the leader of that particular directorate and then the managers including manager National Screening Programmes which is yourself.

A: That's correct yes.

Q: And over on page 8 the role is described as co-ordination of designated nationally managed programmes for population health.

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A: Yes.

Q: And you understand that that is the new organisational structure now in place in the Ministry?

A: Yes that's correct. That structure was confirmed at the end of May.

Q: Is there a known date for the dis-establishment of the Health Funding Authority?

A: Not to my knowledge. I gather it's planned for towards the end of the year but I don't have a direct date.

Q: I wonder if these could be assigned exhibit numbers please. [Exhibit JMP/HFA/049 and 50 produced]. Now Dr Peters going back to the options paper, numbers 5 and 6 in the disadvantages are really to do with physical location in Wellington and don't require further discussion because you say the unit will be in Auckland.

A: Yes.

Q: 7, any change has potential to threaten stakeholders, particularly if the change in personnel was required, that has somewhat been mitigated by the staff being carried over and yourself remaining as manager is that correct?

A: Yes that's correct.

Q: 8, lack of leverage for reducing costs as purchasing relatively small volumes. Can you just elaborate on that a bit please as a disadvantage for being in the Ministry.

A: I think perhaps on reflection that's not a disadvantage of being in the Ministry. I think that's probably a reality of being small purchaser if you like as a national screening unit. We are not purchasing large volumes of services and I guess that –

Q: Compared with the total mix.

A: Yes, for example there are probably some economies of scale when

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the Cervical Screening Programme services have purchased as part of a large contract such as an HHS contract and as a smaller unit purchasing smaller volumes we wouldn't have that kind of advantage.

Q: But where the screening programmes are located in an organisation which is trying to deal with the entire health budget, you clearly are a very small drop in the bucket.

A: We are.

Q: And there are those difficulties of competing with everything else.

A: That's correct.

Q: More vulnerable to changes in the health sector that if it was a separate unit. Now that is clearly a disadvantage isn't it given even just looking at the history that we know about in the last ten years, this programme has been blown in all sorts of different directions as various theories have been pursued regarding the delivery of health care and it is vulnerable in that sense isn't it?

A: There has been a lot of restructuring of the health sector over the last 15 years and I think it has to be a reality that when you are part of that level of the health sector, when there are changes in the central bureaucracy you may be affected. A unit such as ours may be affected.

Q: Were the units such as yours to be in a separate agency you would perhaps be more immune from those sort of pressures. Do you agree with that?

A: I'm aware that in this paper I have implied that we may be more immune, but I think on reflection a separate unit isn't necessarily immune because separate agencies such as the public health commission have been formed and dis-established, so I don't think one can say a separate unit is necessarily immune.

CHAIR: but Dr Peters, putting aside the prospect of a separate unit being dis-established, it would seem that a separate unit would be less immune than a programme that was part of the mainstream health service.

A: I think that is possible. I guess there are a number of things I would say about that. I think there are clearly advantages and disadvantages to being a separate unit. As a separate unit you are much more a drop in the bucket, as Mr Corkill put it. There is a risk of isolation from the rest of the health sector and I don't think one should under-estimate the work involved in setting up a stand alone unit, but I'm not denying that there may be some advantages in terms of sustainability.

Q: but if the programme was a stand alone business unit within the Ministry of Health so that there was no need for various functions to overlap within the other groups within the Ministry of Health and the programme as a separate unit had sole responsibility for engaging providers funding those providers and ensuring that those providers were effectively monitored, would that not put it in a better position and make it less immune to more general changes within the health system which might be driven by political concerns or general theories about health delivery.

A: You are referring to a separate stand alone unit within the Ministry?

Q: Yes.

A: I think that's true, and I think that's actually in effect in some ways what we are moving to. Although it's not officially described as such, in some ways we are moving towards a more stand alone unit.

Q: given the new changes envisaged, the 22 new health boards, if the programme wasn't set up as a stand alone unit within the Ministry how could you in fact operator a programme without risk of fragmentation if parts of the programme were going to be the responsibility of the district

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Health Boards and other parts would be the responsibility of units within the Ministry?

A: I think the functions have to be centralised within a separate unit, but district Health Boards will still be involved in provision of the services through funding arrangements with that unit.

Q: but in that sense the district health Board would just be another provider in the way that a laboratory is a provider to the service, would it not?

A: yes, it would be. One of the difficulties is that the whole way that District Health Boards will function – I haven't been closely involved with it and developments are occurring so I'm not exactly sure how they're going to work, but I agree with you they would be another provider.

Q: are you in a position to find out what is likely to happen in respect of the District Health Boards and their impact on the programme?

A: I can certainly make some more enquiries if that would be helpful.

Q: The inquiry's already heard from Dr Boyd and the fact that at the very early stage when the programme was being established it had been suggested that there be an executive body to control the programme, with a chief executive, and that the recommendations from the Ministry had not been accepted by the current Minister of Health and instead, because of the move towards Area Health Boards and decentralisation of health services the programme ultimately started up in a way in which there was a National co-ordinator who just facilitated and monitored and delivery was done through the 14 Area Health Boards and would you not, given your role now and which you know, be concerned if there was the possibility that in this new time of restructuring, given the move to 22 District Health Boards, that there was the possibility that the programme might once again find itself being swamped in these changes and so have to fit in with a new vision of how a

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health service should be delivered rather than function in the best way possible for the programme

A: yes, I would be concerned about that, and I was concerned about that devolution which is why I took steps earlier this year with the briefing paper to our Chief Exec to expedite centralism of funding under the public health operating group and subsequently it's been agreed that under my team for the programme.

Q: And are your concerns being treated seriously and listened to and are you getting the responses you would like to receive?

A: Yes I think I am. But I don't have all the details and if the inquiry would like me to pursue the details some more I can do that.

Q: We would appreciate that. Obviously the new form that the programme takes will be very relevant.

MR CORKILL: Just on that Dr Peters, in your various options that you considered, one of them was what you described as "National co-ordination and devolved funding", and that's perhaps what the chair was alluding to a moment ago, that that sort of possibility of key aspects of the operation being devolved – namely the funding, is it your understanding that in the new regime your unit will be entering into the contracts with the various providers?

A: As I said yesterday, and I clearly need to follow this up, that I have not been clear whether we would be in direct relationships with providers or, although the funding would be our responsibility, that the funding would go through the funding directorate of the Ministry of Health, and I clearly need to clarify that. However, I tried to make it clear yesterday that my own professional view was that my unit needed to have a direct relationship with providers because it enables us to go back to them with the outcomes of

monitoring and relate directly to the providers. It enables us to plan the service delivery, and as I said before, to directly involve ourselves with funding for things like training.

CHAIR: who would have responsibility for determining the terms of the contract between the programme and the provider? The party responsible for funding, or could you have a situation where, as the co-ordinator of the programme, you negotiated the contracts directly with the providers but funding came from another source?

A: I'm not quite sure what you are asking me? If the funding is under the Personal Health operating group then no matter how the funds are disbursed, it's still within the ambit of public health but the question is whether we do the direct funding or not. I think it is ideal if we do the funding directly, however we have been able to work with the Personal Health operating group say over the community laboratory funding and have our requirements incorporated into the community laboratory contracts.

CHAIR: That's what I am trying to get to as the talk of funding I'm finding confusing because I want to know, control is going to be determined by contractual arrangements between providers and someone within the Ministry of Health is it not?

A: I may need to get you more detail on this. I mean my understanding of how things are at the moment is that District Health Boards would be funded on some kind of population-based funding formula and there would be requirements that they had to meet within the services they provided. Now the question for the screening programme is do we have some kind of separate arrangement with that District Health Board or are we part of that global funding and are requirements are incorporated within that global funding. So that is for the publicly owned and funded health services.

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Where there are private providers, I would envisage that there will continue to be contracts with those providers as we now have.

Q: With the public sector, my understanding from reading your evidence was that there had been a move away from the programme services being part of the main stream funding contracts and an attempt to bring more under the control of the Cervical Screening Programme is that correct?

A: If we had continued in the model that we currently have and that might be the easiest thing to explain, the direction we are moving in at the moment is that the funding for laboratory and colposcopy services would have come under my team and I would have had a team where we arranged individual contracts with those providers.

Q: Right.

A: That is certainly how I have envisaged it.

Q: And that would give you hands on control would it not.

A: It would.

Q: And are you concerned that there may be a risk that if funding under the new scheme for the programme services becomes part of the general funding to the various health boards that it will mean that the service delivery could vary according to which board was responsible?

A: Well if they were clear about the quality standards that they needed to meet in delivering the service and also part of the requirements were that they would participate in ongoing programme monitoring and service audit, I think one could still be confident that there would be an adequate quality of service and that we would be able to keep oversight of that and my understanding is that is how the majority of funding will occur, with health and hospital services, but as I say I don't have the details and it may be better if I try get some more detail.

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Q: Well the committee has already heard about what happened in one incident when funding money for the programme was given to Tairawhiti and the evidence was that the Tairawhiti Ethics Committee, someone within Tairawhiti decided that the money should go elsewhere.

MR CORKILL: I think it was the Tairawhiti Area Health Board ma'am. They expressed a few, I'm not sure that it went as far as deciding that the money should be allocated elsewhere, they expressed an opinion that they thought the money could be better utilised elsewhere. It's in the volume of Ls Lacken's materials dealing with the Tairawhiti Area Health Board.

CHAIR: Would you be concerned about the possibility of that happening once you move into health boards again?

DR PETERS: I think one would need to be vigilant to ensure that that didn't happen and perhaps that is one advantage of a direct contract. The disadvantage of a direct contract is of course the size of that contract for the services we are purchasing in comparison with the global funding, the District Health Board would be receiving, that we are relatively such a small player.

Q: But also because you are such a small player there is a danger that if you are just part of the main stream contracts you might get overlooked by other more pressing matters.

A: That's definitely a risk yes.

MR CORKILL CONTINUES XXN OF WITNESS

MR CORKILL: Certainly the evidence showed at an early point, I think in the first and second establishment years, there were some statistical reports produced by Dr Green I think it was, which did suggest that funding had not been tagged in the early staged and had by in some ways apparently

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been utilised for purposes other than the programme and it think that's the point that Madam Chair is making and which you agree needs to be avoided at any cost.

A: I certainly agree that needs to be avoided.

CHAIR: How do you think it can be avoided?

A: I think whenever funds go into a large organisation there is the risk that they may not be used for exactly what they were intended to because there are other more pressing urgent requirements and I would need to think more about how one can absolutely avoid that. I guess one way of doing that is as we have discussed previously provide an audit where you do ensure that the resources that have been provided for the service are being applied to it.

MR CORKILL: Ten minutes ago we were discussing separate units and separate agencies and Madam Chair referred to the evidence given by Dr Boyd about an earlier option of an executive body and a stand alone unit as it were for the programme and I think one or two other witnesses have referred to that possibility now and other witnesses to come will do the same. There is another related theme in the evidence which is to do with a cancer control strategy and a cancer control unit which of course we do not have at the moment and you may recall the evidence of Professor Skegg about that and again there will be other witnesses coming before the inquiry who will advocate the possibility of the screening programmes being in the context of a stand alone cancer control agency. Now that sort of thing does not happen overnight but can I ask you for your view that where the Government to move within the relatively near future to the concept of a cancer control unit, that it would be logical to include the screening programmes in such a unit?

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A: You are asking me for my personal view?

Q: Yes I am.

A: I think one would have to concede that it is a possible option for the future of the screening programmes.

Q: Yes. And it would be an option that would take care of a number of the disadvantages you have identified for the location in the Ministry in your options paper?

A: As with all the options I gave, it has advantages and disadvantages.

Q: Of course. But it would take care of a number of these matters that we've been talking about, of the vulnerability of the programme within the Ministry, for a variety of reasons wouldn't it?

A: It does have some advantages, I agree. However, I think we have come to a good arrangement in terms of National structures in the current health restructuring, and I realise we do need to sort out some more of the detail, and I'll get more information about that.

Q: but you're talking about the immediate future, and I'm perhaps asking you to consider a little further out a target that is very worthy of aiming for – namely a cancer control strategy and an agency that picks up these programmes.

A: I have already said that I think it could have some advantages, however one need to have a lot more detail about what the scope of that agency would be – what would it do: would it be a policy agency, would it be an advocacy agency, would it have funding role? So there's so much unknown about that proposition, to me, that it's difficult for me to really proffer an opinion.

Q: but you are aware of the recent moves, the setting up of a working party on overall cancer control, following a workshop last August, and current

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initiatives to try and get this particular possibility moving, aren't you?

A: yes, I'm aware of that.

Q: And do you agree that the Ministry should be keeping an open mind, therefore, about the possibility of these programmes being associated with such initiatives?

A: I really feel I can only give my personal view, which is that I can see that there could be some advantages, but I think if you want more information about that, then I am not the person to whom those questions should be addressed.

Q: Thank you.

CHAIR: Dr Peters, you are, though, someone who has specialist qualifications in public health

A: Yes.

Q: And I note that, as part of your role, you have traveled to the UK and examined their screening programme, so on the basis of that expert knowledge perhaps it would be helpful to have your opinion on Mr Corkill's proposition.

A: well, the screening programmes in the UK are an integral part of the NHS and so is the National office, and there has been no move to move the screening programmes into a separate agency. I believe that if the screening programmes can be protected in a central agency it is preferable that they remain part of the overall health sector, because I think there are risks of isolation if you are too much removed, and there is overlap between the screening programmes and other parts of the health system. For example, while we concentrate predominantly on the screening programmes, for example in the breast screening programme, there is an overlap, for example, between screening mammography and diagnostic mammography.

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So having those linkages is an advantage. However, I am not denying that there are also some advantages of a stand alone unit and perhaps in view of the vulnerability of the health agencies to restructuring, perhaps in NZ there is a case for.

Q: I also note from your evidence in para 180 that the UK cervical screening programme is split into 8 regions. Given the difference in population between NZ and the UK, if they can split their programme into 8 regions it seems odd that we might contemplate a split of 14 regions and perhaps even down to 22. It strikes me that, with the smaller population base there could be good economies of scale and efficiencies by having a central agency.

A: I agree with you. In fact, I was concerned about the possibility of further devolution, and as I said before, made moves for the centralisation of functions and I think we are actually moving in that direction with the formation of the National screening team.

PROFESSOR DUGGAN: Dr Peters, where in the Minister of Health are there screening programmes such as metabolic and neonatal?

A: they are in the personal health operating group

Q: and where will they be in there in the new structure?

A: I haven't been advised that there would be any change at the moment.

Q: In the Ministry of Health is the concept – I'm loathe to use the word "policy", but concept – with regard to screening programmes to keep all the screening programmes together rather than split them up into neonatal, medical, cancer and so on?

A: Yes. I don't think there've been any discussions about that, but I can see merit in the concept.

Q: so if I understand you correctly then, if that was the concept with regard

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to the screening programmes there wouldn't be any merit, then, in this cancer control unit being responsible for the –

A: That's a good point.

Q: - for the two screening programmes that happened to relate to cancer

A: It would not make sense to have other screening programmes in a separate cancer control agency, no. So if the two cancer programmes were to be part of a separate agency they wouldn't be able to combine with other screening programmes which are not.

CHAIR: How advanced are the other screening programmes?

A: Neonatal screening has been functioning in NZ for many years.

Q: And is it anything like the cervical screening programme?

A: I really couldn't comment on how it operates nationally because I haven't been intimately involved in it.

Q: I had gained the impression that the cervical screening programme was the first sort of organised screening programme.

A: First organised cancer screening programme.

MR CORKILL: Dr Peters, I'm just trying to locate in exhibit 50, which was the organisational design, the precise location of the other screening programmes. You mentioned the – was it the personal and family services directorate?

A: yes, that would be where they were located.

PROFESSOR DUGGAN: I'm sorry, could you repeat that?

MR CORKILL: Pages 12 and 13, Professor Duggan, of Exhibit 50 is another directorate, the personal and family services directorate, and I'm just seeking Dr Peters assistance to locate the other screening programmes. Are you able to help?

A: I think it would be in the personal and family services. I have to say

that I have been involved, so involved with the two cancer screening programmes that I haven't really considered the other screening programmes which I am aware of.

Q: But, in any event, in the new regime they will be in a different directorate and not intended to be part of yours?

A: certainly not that I'm aware of.

PROFESSOR DUGGAN: Could your position be strengthened by including all the screening programmes?

A: I have to say I really haven't considered these issues and I feel a little uncomfortable about just giving my opinion off the top of my head. I would need to think about it.

Q: There are some quite significant difference are there not for instance with neo-natal screening. You don't need to recruit the patient, you don't have the education function and all the other attributes that you need in such a complex programme as breast or cervical screening is that correct?

A: Certainly there are some aspects of it which are probably more simple but I would suggest that in all screening programmes there are issues of quality, false negatives, false positives and appropriate follow-up.

Q: Now I want to move to a different topic now. Paragraph 198, you are dealing with the topic of legal issues involved in auditing cervical cancers and this is a matter upon which you have been taking advice and I think it is around the issue, as I understand it, of the limitations provided by Section 74A is that correct? And the use of data from the register.

A: Yes the advice related to audit of interval cancers in the breast screening programme and all cases of cervical cancer and not just issues to do with Section 74A but also to do with the Medical Practitioners Act and quality assurance procedures.

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Q: Now these issues I take it are relevant for the work that Dr Cox and his team are carrying out the evaluation work aren't they.

A: Yes they are.

Q: Has that work been able to start yet or are there still legal issues around the obtaining of data which have to be resolved first?

A: My understanding is that there are still legal issues around the accessing of identifiable data. In the absence of a woman's consent.

Q: To what extent, and you may not be the right person to talk about this, but to what extent is this to do with Section 74A itself, to what extent is it to do with other legislation?

A: I am not a lawyer and the opinions are not yet finalised, they will be very soon, but I understand for the audit of cases for cervical cancer that it is predominately to do with Section 74A of the Health Act but there will be other issues as well.

Q: You see one of the terms of reference of this inquiry is to do with any relevant legislation and whether amendments are needed in connection with these screening programmes and if there are problems the inquiry team needs to know precisely what they are, so I wonder if we could be provided with information as to precisely what the problems are at least as far as the Health Funding Authority sees it at the moment.

A: My understanding is that these opinions will be finalised very soon and I am happy to make them available at that time.

CHAIR: Dr Peters who engaged Dr Cox in this study.

A: The Ministry of Health.

CHAIR: I want to be very clear on this. Dr Cox has been engaged by the Ministry of Health to do an audit of the screening programme is that correct?

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A: Dr Cox has been engaged by the Ministry of Health to undertake three components of the evaluation plan which he finalised in I think 1998, he and Dr Richardson, and those are the evaluation of the adequacy of the data collected by the Cervical Screening Register for ongoing monitoring purposes. The follow-up of women who have abnormal smears and an audit of cases of cervical cancer from the cancer register.

CHAIR: Under the current policy, I know it is in part out of date, but my understanding is that under the current policy it is the Ministry of Health that is responsible for the Cervical Screening Programme is that correct?

A: Well under the policy document, but in reality the Health Funding Authority is responsible for national coordination and for the register.

CHAIR: Yes but under the policy document itself which has not yet been changed, the Ministry of Health still retains responsibility for the programme does it not?

A: Well it states in the 1996 policy that it does but in reality there have been deeds of transfer of responsibility and staff.

CHAIR: Right so there are other documents we don't have which have altered that policy document.

A: There is a delegation of the register and deeds of transfer of staff.

CHAIR: And did this happen in 1998 when the ...

A: Yes.

CHAIR: Well why then has the Ministry of Health started this study, why wasn't it started by the Health Funding Authority?

A: There is correspondence relating to that in my exhibits and the Ministry of Health commenced the evaluation and I was not a part of the decision making process which resulted in the Ministry retaining responsibility for completing those aspects of the evaluation.

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CHAIR: So is it correct that at the time the evaluation was commenced, responsibility for the programme was with the Ministry but part way through the valuation it passed over to the Health Funding Authority .

A: Yes but a decision was made that the Ministry would continue to take responsibility for and ensure the completion of the evaluation.

CHAIR: And the study was started in 1998.

A: The evaluation plan, I may have the dates slightly correct, but I think it was completed in the middle of 1998. The plan of what could be done.

CHAIR: But in fact the doing of it is still incomplete because of the difficulties Dr Cox has had in accessing information is that correct?

A: The doing of the audit of cases of cervical cancer, my understanding is that that has not commenced but the other two aspects have commenced, they are not complete but they have commenced.

CHAIR: And the audit of cervical cancer can't be done by Dr Cox because of Section 74A of the Health Act.

A: Yes, I'm not a lawyer as I have said and I am worried that I will get out of my depth but my understanding is that there are provisions in Section 74A under Section 5 or clause 5 for the release of identifiable data and no regulations have been made which would enable identifiable data to be released for this purpose without the consent of women.

Q: Does it strike you as odd as a public health specialist that we have a national screening programme and that the Ministry of Health which has responsibility for the programme under the policy and which is the crown entity ultimately responsible to the Ministry of Health, cannot itself have a study completed which allows an audit of cervical cancer in New Zealand?

A: I agree with Professor Skegg that I think this is one of the most important ways that a programme can be monitoring and evaluated so I think

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it is indeed unfortunate that it cannot proceed at the moment. I wasn't involved when the legislation was written and I can only contemplate that this consequence, people were not aware of it at the time.

CHAIR: How much useful data from the programme is in fact inaccessible and unable to be utilised because of s74A?

A: A considerable amount of data. My understanding is that we will not in any way be constrained from undertaking quantitative monitoring of the programme in which women are not identified. But this kind of audit, and indeed the audit of even the follow up of women's – the other study that Dr Cox is doing, the name escapes me, the audit of follow-up and adequacy of treatment, there are difficulties with those proceeding without individual consents.

Q: How important are those audits?

A: I think they are very important.

Q: In terms of the access of quantitative data as compared to the information you would get from these type of audits, which is the most important?

A: I don't think one can say one is more important than the other, but I think they all contribute to enabling one to ensure that the quality of the programme is there for women and that lapses in quality are identified in a timely way and addressed.

Q: If lapses in quality can't be identified and aren't addressed in a timely fashion, how much value is a screening programme for women?

A: I think a screening programme can still be of value as we have seen with the decline in incidence and mortality from cervical cancer in NZ, but I think it can obviously have some very serious consequences, such as the one we are now confronting.

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Q: Could a programme which doesn't allow for an audit of its quality result in a false sense of security for women because they believe that they are being regularly tested for smears and their smears are being read, that they have no health concerns if the results are normal?

A: I think it can.

PROFESSOR DUGGAN: Dr Peters, do other countries with organised screening do such an audit?

A: I haven't personally investigated that myself, as to whether they do or they don't.

Q: I think in Dr McGoogan's evidence she stated that – no, I won't say she stated, I believe I heard her say that they don't do this on a regular basis in the UK, that each laboratory may elect to do so.

A: and I'm sure review of negative slides occurs in laboratories in NZ. I don't know whether it occurs routinely, but I'm sure it does occur in many laboratories where a high grade is found and there is a review of previous negative slides, but I am thinking more on a programme basis where one looks at audits, the entire case, and where things could have broken down because there are other steps, obviously, along the screening pathway where problems could occur.

Q: Without a doubt there are a number of publications on this issue in the literature. I may have misunderstood you yesterday when you addressed this point as well. There is no restriction on the release of aggregate data under s74A

A: there is no restriction on the release of aggregate data which does not identify ethnicity that I am aware of.

CHAIR: Can you audit a programme with that sort of data that access is unrestricted to?

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A: I might need to think about that a little bit. You can certainly undertake quantitative monitoring because you do not need identifiable data to do that. You can audit providers as well, but auditing individual case histories in the current environment appears to have difficulties.

Q: Well Dr Cox is an expert epidemiologist is he not?

A: Yes, he is.

Q: and he considers that he needs access to data that at the moment is inaccessible to him?

A: that is right.

Q: So we could conclude from that that he hasn't been happy to base his studies on whatever data is accessible at the moment.

A: these are all different components of monitoring and evaluation and yes I am agreeing with you that there are important aspects of that which at the moment cannot proceed in NZ because of the restrictions of the legislation.

Q: and because s74A has been in place since the Screening Register has been opt-off, it's effectively hampered any use of data to audit quality of service delivery to women under the programme

A: aspects of that audit, not all aspects, because you could audit a provider against say the quality standards and not need to know anything about women's identifiable data to do that.

Q: but it is helpful –

A: but the sort of case audit it is not possible.

PROFESSOR DUGGAN: Under the current legislation there is no restriction on you, looking at the information on the database, to determine what proportion of women who develop invasive cancer had a smear? There is no restriction on you to do that? Because this is aggregate data.

A: one would need to link information from the Cancer Register to the

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cervical screening register and that identifiable data from the Cancer Register would need to be made available to my team or a monitoring body to be linked to the Cervical Screening Register. I may be getting a little out of my depth as to what is legally possible and what is not possible and I just don't want to mislead the inquiry.

Q: but to link identifiable data from the Cancer Register to the Screening Register you've got to identify the women on the Screening Register to make sure you're talking about the same women don't you?

A: yes, you do.

Q: and I understand your team, because you are employed by the Health Funding Authority, would have no difficulty in doing that if you wanted to do it, or would you run into problems as well

A: when women enroll in the programme the enrolment form does state that people who operate the register will see your data, so I cannot see that there would be a difficulty for register staff to link identifiable data from the Cancer Register if they were able to obtain it to records on the Cervical Screening Register. But in terms of passing that identifiable data to another body, I think there would be problems then. Unless, as you say, the data was made non-identifiable so you had a linked record with no identifying information.

PROFESSOR DUGGAN: Where is the Cancer Registry currently located?

A: in the NZ Health Information Service, which is part of the Ministry of Health.

Q: and where will it be located?

A: I understand in the same location.

CHAIR: there's no difficulty in getting access to identifiable data from the Cancer Registry is there?

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A: I have recently been informed by Dr Cox that there do seem to be some problems with that, but I am not familiar with what those problems are.

Q: Was one of the reasons to move to an opt off programme to ensure that the population base for the screening register increased so that data would be more meaningful.

A: I'm not sure what the thinking was at that point.

Q: My understanding was that before the register became opt off it was considered that there were insufficient numbers on the register to make the statistical data meaningful.

A: I think that would have been a problem, I think logically one can see it would have been a problem to monitor a programme if a large proportion of those participating in it were not able to be identified or did not seem to be enrolled in a specific way.

CHAIR: I'm sorry I don't understand your answer.

A: There has been some debate in the community when we have been consulting on our policy quality standards that it appears that some women do not see that because they opt off, they are not part of the programme, they still believe they are part of the programme they just haven't chosen to be on the register so I am just merely making the distinction that if the register had stayed opt on, there may have been women who thought they were part of a programme who were not identifiable to those of us who manage it.

CHAIR: Yes, I think we are at cross purposes. I wanted to know whether you agreed that while the register was opt on the numbers on the register were not sufficient to make any evaluation of statistical data meaningful.

A: It would have been difficult because there would have been biases in the women who opted on.

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CHAIR: Right and we are now in a situation where although we have an opt off register which should remove those biases from the data available for analysis, we now have other problems in terms of accessibility to that data.

A: That's correct.

CHAIR: Yes Mr Corkill.

MR CORKILL: Just for the sake of the record, you were asked about the work that Dr Cox & Co are doing, that's all fully set out isn't in on page 10 of tab 23 which is the evaluation and monitoring plan. We look at it yesterday?

A: The work that they are undertaking –

MR CORKILL: The three contracts that were let to the University of Otago.

A: Yes.

MR CORKILL: Just for the sake of the record that's where you find them. Now can you please go to tab 17, volume 2, this document, three pages is a print out of a white board following a meeting of regional coordinators in February 1999 is it not. Where you there?

A: Yes I was.

Q: Now if one goes to the second pages, weaknesses providing opportunities on this page, down towards the bottom there is a section there on laboratories don't send all results, using other codes, variance in reporting patterns and those were all still current problems were they in February 1999 as reported by the regional coordinators?

A: Yes that's correct.

Q: Are you able to comment on whether they are still current problems?

A: We do still seem to have a problem with some laboratories either not

or not being able to send their histology results electronically to us.

Q: Yes. Is that a significant problem?

A: I don't know that it is significant but it is certainly a recurring problem and Sandra Metcham will probably be able to speak more about that. Using other codes I can't really speak about that although I am aware that some laboratories use their own coding systems and then convert into the Bethesda code but again it may be better for Sandra Metcham to speak.

Q: And variance in reporting patterns what does that mean.

A: I can't actually comment what that means I'm not really sure on reflection what they were referring to.

CHAIR: If you had direct control of funding and could contract with laboratories as the co-ordinator of the screening programme would that leave you free to just choose a small group of laboratories who would develop work patterns that were entirely satisfactory to the programme?

A: One could do that and I guess I have contemplated that but I am also aware that the cyto screener work force, I don't feel I know enough about the distribution of cytology screeners and I am aware of concerns about destabilisation of that work force and also in general a shortage of cyto screeners and possibly pathologists so I just think one has to be careful that any plans like that were carefully thought out.

CHAIR: Well wouldn't it be best if there was a shortage of cyto screeners and pathologists just to hone in on a few big laboratories where you knew they had sufficient people working for them?

A: Well it might be but one would have to be confident that the work force would relocate to ensure those laboratories did have adequate staff.

CHAIR: But there would be laboratories in the main centres at the moment that could adequately cope would there not?

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A: My understanding that even laboratories in main centres are having work force difficulties.

CHAIR: Is that because of the shortage of cyto screeners in New Zealand?

A: That is my understanding.

CHAIR: Doesn't that still suggest you are better to go with big laboratories if all laboratories are having problems hiring staff what is the point of spreading the work around, best to go to a few laboratories that have an adequate work force at present and if they know they are getting a large portion of your work, they'll take better steps to ensure they have the staff available?

A: I think that is something for consideration but I would need to do more analysis about it or we would need to be sure that the implications for the work force were not adverse. I mean I think it would be improper of me to contemplate what that might be.

CHAIR: But why are you as the coordinator of the screening programme whose concern should be to ensure that contractually you obtain the best laboratory services concerned about the impact that might have on laboratories work forces?

A: Well if we can just speak hypothetically for a moment that there are cytology screeners dotted throughout New Zealand and many of them not in main centres, if we were to centralise all of the laboratory services and large laboratories required more staff, they would be reliant on people being prepared to relocate, if there were not already adequate staff in the main centres.

CHAIR: But why does that concern you as the coordinator of the screening programme?

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A: Well it concerns me that the screening programme can continue to function and that those people are absolutely vital to the screening programme because they read the slides.

CHAIR: Are you saying that at the moment if the screening programmes work was diverted to say half a dozen large laboratories that those laboratories would not be able to cope with the work?

A: I'm saying that may be a possibility yes. Because I haven't explored that I can't say yes or no, but I think it could occur.

PROFESSOR DUGGAN INTERJECTS AND XXN

PROFESSOR DUGGAN: Dr Peters, has anybody done a manpower or human resource study on cytotechnology requirements in NZ and also for a cytopathologist, given that you have half a million PAP smears/year approximately?

A: That's not something that we have been able to undertake in the time we've been responsible for the programme, and I'm not aware that anybody else has.

Q: do you consider that's important?

A: Yes, I do.

Q: Would it be feasible to do such a study?

A: I think it would be, yes.

CHAIR: My understanding is that the educational courses for the cytoscreeners were closed down because there weren't sufficient persons interested in enrolling in them.

A: I don't feel I'm sufficiently familiar at the moment with all the workforce issues to actually comment on them. I absolutely agree it's a very important area, but it's not something I –

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Q: have the laboratories themselves raised this as an issue with you and as a reason for not centralising a smear reading?

A: they haven't raised it as a reason for not centralising smear-reading but they have raised it as an issue with us.

Q: have you looked at the possibility of sending smears offshore if there isn't sufficient provision of smear-reading services in NZ?

A: no, we haven't.

Q: I note that smears were able to be sent to Australia for the purposes of the re-reading. If there is such a deficit of cytoscreeners in NZ that is another possibility, is it not?

A: I'm not saying there is a deficit of cytoscreeners, I'm merely saying that I think a major reconfiguration of laboratory services in NZ for cytology screening would need to take into account those work force issues.

Q: What I'm still having difficulty in understanding is, given the move at the moment to organise health services on a contractual basis, that the coordinator of the screening programme should be concerned about those sort of issues. They seem more political and social issues of a wider context to be taking into account; they are not commercial issues.

A: I think we thought it was most important in the first instance to move the contracting relationships under our team and then, as the next step, to think more about the structure of the programme.

I am aware that we have gone beyond 11.00, so perhaps if we adjourn now. Because of the meeting I will be having with Mr Corkill, I have said around about 11.30, it might be a little bit longer.

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INQUIRY RESUMES AT 11:43

MR CORKILL CONTINUES XXN OF DR PETERS

MR CORKILL: A few lines above the entry we were looking at before is the entry legislated issues ignored by professionals, laboratories, opt off and forms concept. Now opt off and conforms consent would probably be matters relating to the smear taker to GP but I wonder if you could comment on the relevance of the entry laboratories?

DR PETERS: Yes obviously it is some time ago and I can't remember the details of the discussion we had but I think that the co-ordinators raised with us that there were ongoing difficulties with some laboratories meeting their obligations under Section 74A of the Health Act, yes, I mean it must be to do with that.

Q: Now you subsequently wrote to laboratories and at tab 37 we see a letter of October of last year and you refer there to legislative responsibilities and I think there you have set out fairly clearly what you saw the legislative responsibilities as being.

A: Yes I did.

Q: Firstly under the Cancer Registry Act and Regulations and that was the necessity of making sure cancer cases were actually reported to the Cancer Registry.

A: Yes.

Q: And secondly the fact that 74A actually requires on a mandatory basis, except in an opt off situation, psychological and histological specimen reports to be forwarded.

A: That's correct and if my memory serves me correctly I think there have been ongoing problems with some laboratories not forwarding

histology in a timely way to the Register over the years.

Q: Yes, now that was as at late last year, what is the current state of play, perhaps you might want to take us to I think another letter that you wrote in your supplementary evidence quite recently.

A: Yes, is that tab 48? One of my team has kept detailed documentation of all communication with laboratories subsequent to that letter of 23 October but we did send a subsequent letter to a number of laboratories who were still – my letter of the 23 October referred to the legislative requirements but also the requirements of laboratories as set out in the 1996 policy for the timely forwarding of results to the Register and we were still having some ongoing problems with histology reporting, hence my letter of 17 April.

Q: Now in the final paragraph you have asked for confirmation in writing, have they responded?

A: Yes I said in my supplementary brief that all but one laboratory has responded and I can now confirm that all laboratories have responded to this letter and are examining their systems.

Q: And so are you continuing to monitor that particular issue?

A: We are.

Q: Right. Paragraph 114 of your evidence, you are talking there about the fact that in March 1999 when Mr Grieve's letter came to the attention of the Public Health Change Management Team there did not seem to be an established process in place to enable this type of information to be brought to his attention. My question is, is there now?

A: No there are no formal mechanisms that I am aware of and I have contemplated my comments there and I have not been able to work out for myself what sort of process I would envisage but to my knowledge there are

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no formal processes.

Q: When you were in the UK did you reach any understanding as to the availability of such processes there?

A: No I didn't and I think this is a difficult issue because there will always be failings in screening programmes and the issue is whether the failing one is confronted with indicates a deeper underlying issue or is the inevitable false negatives that will occur in any screening programme no matter how good it is.

Q: Is this a matter for the Independent Monitoring Body?

A: I think it could well be.

Q: Is it worth putting on the list?

A: Now that you raise it yes I think it would be.

Q: Tab 38, you refer to a document dealing with new technologies.

A: Yes.

Q: And p5 of that document, which is a report from the Health Technology Assessment organisation, they were asked to report on new technologies to the Health Funding Authority were they not?

A: yes, they were.

Q: Page 5 deals with the matter of human papilloma virus testing

A: Yes.

Q: And it refers to the very recent developments in the UK at the Imperial Cancer Research Fund

A: Yes.

Q: And the last para there contains a recommendation that the Health Funding Authority consider contracting the UK group, led by Professor Cusack, in order to obtain up-to-date information. Has that gone ahead?

A: No, this was discussed at the recent Advisory Group meeting. We took

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this back to the Advisory Group and I just can't remember the details but I do recall there are some ongoing work going on in the UK with respect to this issue and it was the consensus of the Advisory Group that we do not commission this work at the moment but we await the outcome of the UK work.

Q: You are aware that three local authorities in the UK are trialling this form of testing at the moment?

A: yes, and that was the outcome that we are awaiting.

Q: How long did the Advisory Group think they should wait?

A: I'd have to review the draft minutes from the Advisory Group meeting but my recollection of the discussion was that there was little point in us commissioning an update while there was still outstanding work to be reported on and that we were better to wait for that work to be completed.

Q: I see. The difficulty with that is one might wait a very long time to see how a new technology of this nature has worked out in actual practice.

A: I don't think the Advisory Group would let me do that.

Q: well that takes me to the final question I wanted to ask you, which is what are the plans for the Advisory Group at the moment?

A: My understanding is the Advisory Group will continue in its current form, in the new arrangement. I have discussed that with my manager and we are in agreement that the Advisory Group will definitely continue and when we become part of the new Ministry of Health.

Q: has, in the budget that you described earlier, funding been tagged for that purpose?

A: yes, it has.

Q: You obviously recognise the importance of a multi-disciplinary expert group of that nature?

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A: Yes, I think it's extremely valuable to me and to my team.

Q: Thank you. Madam chair, subject only to any further data which this witness may produce subsequently, I have no further XXN, but I wish to reserve leave just on that eventuality.

CHAIR: Certainly, Mr Corkill.

XXD Mr KIRTON:

Q: Dr Peters, I wish to examination a couple of issues with you, and the first continues on from where Mr Corkill left off, the issue of leadership and advocacy within the Ministry of Health, which if I may comment at this stage is probably the most central issue in terms of systemic issues that the inquiry is facing and deserves consideration in terms of the future management of the programme. Can I refer you to para 168 of your brief. Can you confirm, Dr Peters, that the document that you developed, or your team developed called Strategic Options, which I understand is tab 31, was an internal draft paper, is that correct?

A: yes, it was.

Q: Can you refer to para 170 of your brief and confirm that a further paper, which you have notated tab 32, is also an internal document developed by your team.

A: Yes, as I recall I developed that for my General Manager and then I was requested to synthesise that into a further paper for the Steering Group.

Q: so it was developed into a further and final draft, is that your evidence?

A: yes, I think exhibit 32 is a stand alone paper, but I was asked to redraft it for the Steering Group.

Q: and that document was put before the Health Reform Steering Group, is that correct?

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A: Sector Steering Group I think it's called. That's exhibit 33.

Q: So your internally developed document from the Health Funding Authority was put to a bigger group, a collective group, was it not looking at the entire sector changes?

A: Yes, exhibit 33 was, not 32.

Q: so exhibit 33 is the -

A: paper that finally went to the Steering Group.

Q: And that recommendation from tab 33 agree that the National prevention team should be retained as a discreet unit to administer (fund and manage the programme) and that the unit continue to be based primarily in Auckland. That was the recommendation accepted by the group?

A: yes.

Q: it is your earlier evidence that Dr Karen Poutasi, the Director-General of Health, is the chair of that group?

A: I would actually need to follow that up. I'm not sure whether the group reports to Dr Poutasi or she's part of it, but in any event my understanding is that the ultimate decisions are made by her.

Q: can you tell us whether any other submissions were made to the group re other options for the future of the cervical screening programme ?

A: not that I'm aware of.

Q: so from the Ministry itself, given that your documentation was internal, the Ministry of Health in fact made no recommendations to that group about the future of the programme?

A: they may have but I am not aware that they did.

Q: so you're unaware, in fact, whether the personal health operating group within the Ministry made any submissions or other parties made submissions?

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A: Yes, I'm unaware.

Q: You appear, from your previous evidence, to be quite confident about the robustness of the structure you've had accepted within the new Ministry's orbit. Would it be fair to say that you are confident that you can deliver all the aspects of the programme in that format that you've had now accepted, would that be a reasonable assessment of your current position? The National prevention team will be able to deliver, given its discreet nature and its location in Auckland.

A: I acknowledge there's a lot of work to be done, but I am confident that with adequate resources and presuming we can maintain the momentum and the direction that we have, that we can deliver.

Q: Dr Peters would you agree that there is a good measure of nervousness about the future of the programme in the location of the Ministry of Health given particularly your exhibit 18 which was discussed yesterday that the, and quoting from that exhibit, "since the programme was established as a result of the Cervical Cancer Inquiry at National Women's Hospital in 1998 there have been no national quality standards developed, little monitoring of valuation carried out and no strategic review of the programme configuration". The history is it not of the programme within the Ministry is of concern to say the least?

A: Yes I am aware that there are those concerns. I believe I can only speak for what I believe is required for the screening programmes and want to achieve for them and advise the inquiry on the steps I have taken to protect the future of the screening programmes to protect the future of the screening programmes and I think it is over to others here to decide whether they feel that that is adequate.

Q: Can I refer you to paragraph 51 of your brief and there you have

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stated that the Health Funding Authority in terms of transferring the functions of the Cervical Screening Programme from the Ministry of Health to the Health Funding Authority, the Health Funding Authority never received a final version of this letter, a copy of the draft letter marked up to the Health Funding Authority is produced as your exhibit 6. Can I get you just quickly to turn to exhibit 6. So you are saying in your evidence that a letter of transfer regarding the programme was never responded to. This is the marked up letter for adjustment between Patasi and Phil Prke of the Health Funding Authority was never responded to?

A: We don't seem to have received a final version no.

CHAIR INTERJECTS AND XXN WITNESS

CHAIR: Have you made any inquiries of the Ministry of Health to find out why there was never a response?

A: I haven't made any inquiries recently but in preparing my evidence I did speak to staff in the Health Funding Authority who were involved in the transfer and I think they made some inquiries but I'm not sure what the outcome was, it doesn't appear that we have received a final version.

Q: Well what impact did it have on the Health Funding Authorities ability to manage the programme if it hadn't received this letter in it's final form from the Ministry of Health.

A: It didn't seem to make any difference at all because there were transfer deeds which are in my earlier exhibits which were all signed and finalised and there was a transfer of funding.

Q: I note from looking at this letter, if you go to the second page of it, immediately about paragraph c, you will see there that where it talks about for the Health Funding Authority to consult with the Ministry someone

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from the Health Funding Authority has written in the Health Funding Authority will consult with a designated individual at the Ministry. Do you see that?

A: Yes that is on health education resources. There were a number of components. The Cervical Screening Programme was not the only programme that was transferred, those are health education resources.

Q: It seems through that the additions to this letter by the Health Funding Authority was an attempt to introduce some specificity as to who in the Ministry, the Health Funding Authority would be able to deal with on the issues addressed in the letter, is it not?

A: Yes it does appear that way.

Q: And turning over the page dealing with cervical screening there are a number of alterations there and I see that whereas the Ministry's intention in the letter was to say that it would have continuing discussions with the Health Funding Authority over which agency should undertake the funding for the evaluation having been maintained in the Ministry in the meantime the alteration was to ensure that this evaluation is co-ordinated with the Health Funding Authority's ongoing programme monitoring so again there appears to have been an attempt to introduce some specificity as to what action would be taken is there not?

A: Yes there is.

Q: And I see further down, where it says the Ministry will pay the costs associated with the physical transfer of equipment, someone from the Health Funding Authority has introduced a time limit by saying "which are to be agreed by 30 June".

A: Yes.

Q: And over the page again where it refers to the Health Funding

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Authority continuing to purchase the Why Start Multi-Media Anti-Smoking Campaign, again someone has introduced some specificity by saying for the 1998/1999 financial year, see that?

A: Yes.

Q: Is it reasonable to conclude just from the strength of this letter that the Health Funding Authority in its dealings with the Ministry on health matters was attempting to particularise matters to a greater degree than the more general statements issued by the Ministry?

A: It certainly appears that way, I wasn't involved at the time but I do know that my predecessor Dr Millan was concerned to establish ongoing monitoring and that was her main concern where monitoring was concerned.

Q: Has the Health Funding Authority always had a view that monitoring has been lacking in the past and that there was a need for monitoring or at least improved monitoring?

A: Yes I think right from the time that the national functions were transferred to the Health Funding Authority my predecessor and myself had in our minds that ongoing monitoring was something we needed to establish.

Q: And was it there before when it came to you or was it absent.

A: It was absent.

MRS BARRETT INTERJECTS AND XXN WITNESS

MRS BARRETT: Mr Kirton could I asked Dr Peters a question? Still with paragraph 51 and the letter that we are looking at now, particularly in d of paragraph 51, the appointment of a maori advisor with responsibility for screening programmes, are you able to define for me whether in fact that replaced a national maori coordinator position.

DR PETERS: It says maori advisor but we appointed a national maori

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coordinator. I think probably the letter means the same thing but not having written the letter I can't be sure.

Q: It's just that I thought well first it went from a national maori coordinator to an authority capacity but if you had appointed a national maori advisor, and that was done – it was transferred over?

A: Yes. No, we agreed that we would appoint a National Maori co-ordinator, and we did that.

Q: What I'm saying is that, and it may be unfair to ask you this question, but on 24 April 1998 that transfer and that function should have transferred according to the letter the 3rd page in – the fourth para.

A: Yes, that is a little unclear. I'm not aware of any Maori advisor associated with the screening programme who was transferred to the Health Funding Authority. I'm wondering if that should actually be a separate para that sentence, the full physical transfer.

Q: Tight. Thank you.

CHAIR: At the time was there a Maori Co-ordinator or a Maori adviser employed the Ministry of Health for the screening programme?

A: not that I'm aware of.

Mr KIRTON: Dr Peters, just to conclude the questioning on this area, your exhibit 4, which are the Deeds of Transfer, are they not simply relating to employment conditions of the transferring staff?

A: Yes, they are. I'm not a lawyer.

Q: so there was simply an administrative undertaking from the Ministry of Health to transfer the staff and to confirm that, to transfer the dollars and no more.

A: It appears that way.

Q: going to para 52 of –

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CHAIR: If I could just interrupt here. Dr Peters, you've been talking about deeds and I hadn't actually located them, I am grateful to Mr Kirton for referring me to Exhibit 4: is this the sort of deed you are talking about when you've referred to deeds earlier on when I was asking you questions about exhibit 6?

A: Yes.

Q: from my reading of this deed it bears no relationship to the sort of issues covered in exhibit 6. Is there likely to be a deed which does cover the issues raised in exhibit 6?

A: the issues pertaining to?

Q: the letter in exhibit 6 sets out a number of issues which were originally dealt with by way of the Ministry writing a letter, the Health Funding Authority marking its alterations on the letter, returning the letter to the Ministry and there any action on the letter seems to have halted, and I'm trying to discover whether or not in fact the letter was overtaken by some other document or whether these matters have just languished.

A: I would need to make further enquiries. I think that probably the staff were transferred, the budgets were transferred, and I would need to make further enquiries – and the Register was transferred – about the fate of the letter.

Q: that would be helpful if you could.

MR KIRTON: Can I refer you Dr Peters to para 52 of your brief, which states, does it not, the Ministry of Health maintained its role of providing policy advice to the Minister of Health on the programme and for monitoring the Health Funding Authority with respect to the programme. Now, you are unable to say if any individual person was made responsible within the Ministry for undertaking monitoring?

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A: Undertaking monitoring of the Health Funding Authority?

Q: Yes, your statement in 52 states that the Ministry's role was to monitor the Health Funding Authority. Was there no-one assigned within the Ministry to do that?

A: the monitoring occurred through the funding agreement and we maintained a relationship with the performance monitoring branch.

Q: so it was the performance monitoring branch's role to monitor the programme and relate specifically to you as the head of the programme, the Health Funding Authority, is that how it worked?

A: Yes, I had some reporting requirements as part of the funding agreement and as with many people in the Health Funding Authority would prepare what was required and provide the reports on a quarterly basis.

Q: So the relationship in fact was through the funding agreement, is that correct?

A: Yes.

Q: Can you tell us whether the funding agreement was adjusted to take account of the transfer that took place on 7 May 1998. Was the funding agreement altered in any way?

A: I can't state that for sure because I'm not familiar with the requirements of the earlier funding agreements, but I guess the National reporting requirements would not have been there previously because National co-ordination would have been within the Ministry.

CHAIR: Dr Peters have you exhibited a sample of one of the reports you would have sent to the performance monitoring unit, the Ministry of Health?

A: No, early in the first financial year I think the reporting was quite limited but in the last financial year I have furnished them with a more detailed report at their request every 3 months and I can provide some of

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those.

Q: Yes, if we could have copies please of the reports that you were furnishing the performance monitoring unit with.

A: Ok.

MR KIRTON: Dr Peters, could I put it to you, given your last comment that very little was done in the 98/99 year by way of reporting to the Ministry, that the Ministry simply waved goodbye to the former ogre it had around its neck, the cervical screening programme, and were wishing to wave it goodbye without any comeback?

A: I really don't think I can speak for the Ministry, I think you'd have to ask them about that.

Q: Can I also put it to you that the response or requests in 1999/2000 by the Ministry were made in response to the events of Gisborne rather than any desire to have any direct ongoing relationship with the programme

A: I'm not sure about that. I know we had an agreement with them that there was a time at which we would agree more detailed reporting on the programme to the Ministry and I don't think that bore any relation to the events that were before us. I think that had been a long standing agreement that at some point we would agree more detailed reporting.

CHAIR: did the impetus for monitoring of the programme once it had passed to the Health Funding Authority come from within the Health Funding Authority itself, from you and your predecessor, or did it come from the Ministry of Health?

A: I think it came from me and my predecessor.

MR KIRTON: Dr Peters I simply, in this line of questioning, wanted to appreciate the vulnerability that the programme currently faces in the new arrangements and I would like to refer to you now, and I will read this out

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rather than doing a paper trail on it – this is the evidence of Judy Glackin at her para 118.3, and it says in relation to an 11 April 1996 inquiry of accountability of arrangements of the programme: “Current accountability arrangements limited the ability of the RHAs to develop flexible purchasing arrangements that were best suited to local needs and that could be more consistent with the government’s principles for purchasing.” Do you think that similar competing issues are and will for the programme residing in the Ministry when other purchasing arrangements or objectives of the health sector are in front of and are competing with the programme?

A: I’m a little unclear as to what you are actually asking me.

CHAIR: Perhaps Mr Kirton if you do take the time to show Dr Peters the passage in Ms Lacken’s evidence she can then read the whole paragraph and see it in that context.

MR KIRTON CONTINUES XXN

MR KIRTON: This is paragraph 118.3 page 39.

A: I think that paragraph is implying that the national team had a very operational focus as opposed to a policy development monitoring function.

MR KIRTON: Dr Peters just if you could go to the heading paragraph 118, the review team which was reviewing the location of the Cervical Screening Programme highlighted three problems and the third one being –

A: Oh the third one sorry.

Q: Yes 118.3. So what it is saying is that the accountability arrangements will limit the ability to advance other purchasing arrangement and if I were to offer you one such as budget holding by GP’s as one of those more flexible purchasing arrangements, would you see the dangers that the Cervical Screening Programme faces in it’s future within the Ministry of

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Health?

A: Well I'm trying to understand exactly what this paragraph means and I think it is meaning that the accountability arrangements of the Regional Health Authority is with the Ministry of Health constrained the development of purchasing arrangements.

Q: Yes. That's a correct interpretation in my view.

A: So I'm not clear –

MR MURRAY: If I could help because at the time that the purchaser provider split and of course the restructuring will mean that there will not be a purchaser provider split in quite the same way as the Health Funding Authority functions were within the Ministry and I think drawing the comparison is actually not – unless the question can be somehow related to the whole Ministry policy organisation and the Regional Health Authority as a purchase organisation. If you can take that framework and relate it to the new framework and then identify an issue, we tend to get a bit lost there I think.

CHAIR: I think Mr Kirton has drawn the witness' attention to this as one of the problems identified with the early structure and he is just using it as an example to say well look these are the problems related to the early structure were all very nervous about the proposed new structure because given that once again we've moving from an Health Funding Authority back to, well not just four Regional Health Authorities but to District Health Boards with the Ministry of Health that may create it's own problems as part of whatever devolution does occur in that structure.

MR MURRAY: Yes but I think the key point that Ms Lacken here was talking about the problem with having the screening programme partly in the Ministry and partly with the Regional Health Authority, so as long as that's

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clear because I can see the witness trying to relate that earlier structure which is quite difficult to follow.

CHAIR: Yes, Dr Peters if you read paragraph 117 and then 118 and I think Mr Kirton's concern is that there was a problem at the time because the programme was split between the Regional Health Authority and the Ministry of Health and I think his concern is that with the new structure there could be a potential for a similar split arising. Have I got it right Mr Kirton?

MR KIRTON CONTINUES XXN OF WITNESS

MR KIRTON: Yes ma'am I have an exhibit to follow.

A: Well in fact it would seem to me that the Ministry and Regional Health Authority functions are actually now, the intention is to combine them.

MR KIRTON: However Dr Peters you have established a discreet unit within the Ministry have you not, currently it is a discreet unit within the Health Funding Authority and that will translate to a discrete unit within the Ministry is that correct – based in Auckland?

A: Yes.

Q: The function of that discreet unit include do they not the holding of a great deal of information on the health of women on the register is that correct?

A: Yes.

Q: Can I now refer you to, and unfortunately I haven't got a copy, I can perhaps read from a document entitled primary health care towards 2010 and this is a strategy document issued by the Ministry of Health and relates specifically to new funding arrangements which are being promoted at the

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current time.

CHAIR: Mr Kirton is this document in evidence.

MR KIRTON: It's currently not ma'am I wish to enter it.

CHAIR: You do wish to enter it right and do you need copies made.

MR KIRTON: Yes I do unfortunately.

CHAIR: Perhaps if you could liaise with Madam Registrar about that.

MR KIRTON: In the meantime ma'am could is simply quote one line from it on page 36 of this document?

CHAIR: Yes.

MR KIRTON: It's to do with primary health care strategies and affiliation. "Individuals will be required to be affiliated with a primary health care provider of their choice before they can access Government funded primary health care services." In the light of that intention or policy thrust, is it not likely that the information contained on the Register will in fact be in competition with the desire for a strategy that holds information i.e. budget holding, IPA type arrangements, would you not agree that there will be some contest between the screening programme and these types of other funding arrangements?

A: I would really need to think about it more. I honestly can't see why it would be because there are legislative requirements on smear-takers to provide information to enable women to enroll on the Cervical Screening Register unless they choose to opt out so there is if you like an obligation of enrollment but I think there are risks with budget holding which are different to the sort of things we are talking about now.

Q: You agree that in budget holding arrangements that information, Register type information would be held on separate databases held by IPA's or GP practitioner groups. Is that the case?

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A: Well I think primary care providers already hold a lot of information about their patents.

Q: Yes they do. Can I refer you then just to add emphasis to this issue to your tab 32 on volume 3. If I could refer you to page 13 in which one of the options I understand that your group put up consideration was for the programme, the Cervical Screening Programme to be held in a national agency with funding, is that correct, was that an option that you put up, Option C page 13?

A: Yes we just explored all the possible options there could be.

Q: So it is possible for significant elements of the Cervical Screening Programme to be devolved down to at least the proposed District Health Board level?

A: It would be possible if that funding were not centralised.

Q: so, together with the funding, is it not possible for significant elements of the programme itself, such as data on the Register, to similarly be devolved?

A: Well, it could be, but I think that would just fly in the face of everything that we're trying to do.

Q: Precisely, I agree with you.

A: just on smear-taking services, I mean our concern would be that smear-taking services are readily accessible by women and that they are linked into the appropriate follow-up services.

Q: do you think it's possible and likely probable that an IPA group, a GP group for example would want to have close links with that registered data given that half of their enrolled patient population are women and this is significant data that is held about them?

A: what sort of information are you thinking of?

Q: is it not likely that GP groups would want to at least try and mirror the register information, would in fact hold information on smear-taking on their own records for their own purposes?

A: well they might do, and they already have an important role in the programme in terms of call and recall so I would expect them to want to have some information. But I think we need to delineate between the needs of a National programme and managing a local population.

Q: precisely. Can I ask you whether you are aware of the statements made, I think by Dr Poutasi, that a significant number of operational issues such as the cervical screening programme and others will be held and run nationally until District Health Boards have developed capacity to deal with such nationally run programmes?

A: No, I wasn't aware of that.

Q: I will try and find that for you at some point. The point I'm making is that can we proceed with certainty that the environment in which the programme is going to find itself in the medium to long term within the Ministry is not a hostile one and that there will not be attempts to again devolve downward as it did in 1996

A: I'm very aware that that is a recurrent theme of concern that is coming through, and I have done – in my professional capacity – everything I believe I can do to protect the future of the National Cervical Screening Programme and if other assurances are required I don't think I'm the right person to be giving them.

Q: May I say you've done a great job of doing that as well.

CHAIR: And Dr Peters, just looking at your document 33, which was your report to the Steering Group, the second page, the structure that you most favour is one where all elements of the screening programme are transferred

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to what is at the time the national prevention team, is that correct?

A: yes, I have a proviso on that and that was with the exception of smear-taking services because I didn't feel we would have the workforce to manage that.

Q: but putting aside smear-taking services.

A: Yes.

Q: So the committee could rely on what is set out in your report in exhibit 3 as evidencing your view of what the best structure should be for the programme.

A: exhibit 33, yes.

PROFESSOR DUGGAN: Dr Peters before we leave this item, maybe you can clarify for me: we've heard the World Health Organization requirements or guidelines re successful screening programme a number of times and nowhere in those requirements do I see the word "National". It always refers to a population.

A: Can I just have a look at them again. I would just like to have them in front of me.

Q: It is the 1996 policy document.

CHAIR: If you go to exhibit 32 you've got them there, second page.

A: Well, it says a central office. And it may not need to be National but I think in a country the size of NZ that central office could well be a National office.

PROFESSOR DUGGAN: As I would read these guidelines, the office relates to the population? And a population can be defined in many ways?

A: yes, that is correct.

Q: In the context of NZ, when we are talking about the population, are we talking about the population of the whole country?

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A: Well, when I talk about the population for the screening programme I'm talking about the population of NZ women aged 20 to 69 years.

Q: You're being more precise than I am but it is within the geographic confines of this country, correct?

A: yes. I agree you can define populations in different ways.

Q: I would just like to establish for this panel, when everybody else speaks about the screening programme do they define the population the same way that you do?

A: I'm not sure that they do because there are a lot of people who talk about the screening programme, and for example the legislation requires results on all women regardless of their age unless they opt-off to be provided to the Cervical Screening Register. So It does rather broaden the population of people who are in fact involved in the screening programme.

Q: true, but it is still the NZ population?

A: Yes. Well, that's how I think about it when I'm thinking about the screening programme.

Q: I just need to be reassured that the population covered by the screening programme is the NZ population and not a reversal I think to what was here in 1990 of 14 stand alone cytology registers covering the population of those areas.

A: those 14 register sites are still in existence but I think we're increasingly moving to a view of a National programme. Certainly that's been the approach that I've taken. But I couldn't say for sure that other people aren't thinking about their regional programme.

Q: do the people that you report to see the population as National?

A: Yes.

Q: All right,

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MR KIRTON: One final question Dr Peters to round that issue off. Are you aware of IPA groups also calling their groups enrolled populations?

A: I am.

Q: Thank you. Can I move on to the issue of education.

CHAIR: Could I just interrupt there. What are IPA groups?

A: Independent practitioner associations; they are groups of primary care providers.

PROFESSOR DUGGAN: Is that like a professional practice group?

A: I don't really know what their business structures are, but when they say independent they are independent practitioners who are affiliated in some way. And they may have different levels of affiliation..

MR HODSON: If I could help ma'am. Generally groups of GP's incorporated under the Incorporated Societies Act binding together largely as purchasing agents and they may be I think in Auckland there are two or three and in Christchurch there is one large one.

CHAIR: And they purchase services or funds. What do they purchase?

MR HODSON: They purchase anything that a doctor needs to carry on his business on whatever terms they can get it.

CHAIR: I see. Yes Mr Kirton?

MR KIRTON CONTINUES XXN OF DR PETERS

MR KIRTON: I'd like to turn to the issue of education Dr Peters and can I refer you to your volume 4 tab 48.

A: Yes.

Q: Is this the draft 2 of the policy and quality standards

A: Sorry you said 48 you mean 40?

Q: My apologies.

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A: Yes it is.

Q: Can you confirm that is the second draft of the policy and quality standards document?

A: Yes it is.

Q: Can I refer you to page 5.5 within that document half way through, chapter 5. On that page you have established have you not at standard 5.01 Transitional Health Authority that pathologists should be fellows of the Royal College of Pathologists of Australasia or hold an equivalent qualification and etc. throughout that standard.

A: Yes.

Q: Did you consider the next part of that document where it talks about additional qualifications, did you consider that pathologists should in fact hold an Royal College of Pathologists of Australasia diploma in cytopathology, is that something that would be?

A: Yes we have certainly had some feedback about that and I can certainly recall a recent letter where a pathologist has indicated that they believe that additional qualification should be mandatory so we may relook at that.

Q: Perhaps within two years.

A: Yes.

Q: Can I turn now to the next page where it referred to qualifications of cyto technologists and cyto technicians. The standard you have established, standard 502, it says that laboratories conducting cytology should employ at least one senior registered cyto technologist with a minimum of 5 years experience. Why was it that you didn't establish a minimum standard for the cyto technicians or technical assistants?

A: For their experience to work unsupervised you mean.

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Q: No you refer to it above that standard both to the qualifications of cyto technologists and cyto technicians, can you just explain why the standard itself does not refer to a minimum standard for cyto technicians?

A: I see what you are saying. You are saying we have indicated what the training should be but haven't noted it as a standard.

Q: That's correct. Is there any reason for that.

A: No but I will check back with my team. It probably should be.

Q: And just under that, under continuing education, did you give thought to making continuing education, putting a standard around continuing education?

A: Well we've said what the minimum should be and we have said that at least the minimum should be offered and we would expect that to be documented so that we can review it.

Q: Can you tell us what the understanding is of the training opportunities for cyto technology and cyto technicians is at the present time including continuing education?

A: I don't think I've got good detailed knowledge, I know there are people in my team who do and I think it would be better if I got that information for you. As I indicated earlier I am aware that adequacy of training or opportunities for training is an issue.

Q: Are you aware or have you given consideration to the budget for the programme, the Cervical Screening Programme to incorporate a measure of centrally sponsored funding programme, educational training opportunities?

A: Yes I have considered that. It is one of the advantages of having funding centralised. We have been able to provide some of those opportunities in the Breast Screening Programme for that very reason and I think it is an important issue for the Cervical Screening Programme.

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Q: But there is no component of the budget yet set aside for training or education?

A: Well I don't as you are aware have the service budget for the programme under my control at the moment so when I did or when I do that will be an issue I want to address.

CHAIR: Have you had the budget under your control at any time?

A: No that the programme is currently almost entirely purchased by the Personal Health operating group so that's the change that we are looking to.

CHAIR: This document we are looking at now, exhibit 40, is it being implemented or is it still being worked upon?

A: It is still being worked upon but there are active implementation plans being devised at the moment. The implementation is being planned for while the document is being finalised.

CHAIR: Right. And how are you able to plan implementation about knowing about the restructuring or knowing what the document will ultimately be based on?

A: Well we can only go a certain way when we don't know what the final document will be and clearly there will be some changes but I don't know whether they will be major. We know that we need to move quickly to work with providers on implementation over the next 6 months and once I am surer about the new arrangements we will need to then, I mean if the arrangement was such that all the funding was under my team, then it would be simply a matter of incorporating this in either funding arrangements or contracts and agreeing, I mean when I say simple, it would be a direct relationship.

CHAIR: Well let's just work with that one for now. If you have full control of funding, how achievable is implementing all the standards set out

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in this document?

A: Well provided that we can agree with providers on the standards and the funding, not particularly problematic only in that there are usually disagreements about standards.

CHAIR: How long would it take before you had finalised what the arrangements would be and what the final form of the document was and implemented it, that's if you have full control of the funding.

A: Well I would have thought that if we had full control of the funding and an adequate contracting team, that 6-9 months would probably be a suitable time to negotiate and ensure implementation had occurred.

CHAIR: And if you didn't have control of the funding but had to rely on influencing another body who itself had direct control of the funding, how achievable do you think the standards would be in this document and how long do you think it would take to implement.

A: I think it's achievable but it makes the relationships a lot more complicated because you are working through another team or directorate and it may well take longer.

CHAIR: When you say longer can you put any estimate on it.

A: Well it's difficult when you are working with other people who have competing priorities, you are trying to get your issue to the top of the pile and that is where difficulties can arise.

Q: So looked at hypothetically it may be that you can persuade those people that your plans should have priority, the other possibility at the other end of the scale is that your plans become submerged in their own priorities and then there's the middle possibility that you come somewhere in the middle?

A: You eventually get there but it takes longer than you hoped.

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Q: Thank you.

MR KIRTON: I have no further questions, ma'am.

XXD MR HODSON:

Q: I have only one topic, Dr Peters. My friend Mr Corkill asked you a question referring to your comment that the letter from Mr Grieve QC had caused concern because there wasn't an established process to deal with such matters.

A: Yes.

Q: Could I refer you please to para 18 of your supplementary brief, in which you are discussing the intended monitoring group.

A: Yes.

Q: I see that you say that, for example, "it will be possible to correlate individual laboratory reporting patterns against demographics and coverage of the populations they serve.

A: Yes.

Q: When that is in place, is it not the case that consistent under-reporting will become apparent to that group in a timely fashion?

A: It should do, yes.

Q: And that's an infinitely more reliable and preferable system than relying on the vagaries of litigation, is it not?

A: It certainly is.

Thank you.

CHAIR: Dr Peters, just continuing from there. Are you able to say why what is set out here couldn't have been done from the time the Register was configured as an opt-off register?

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A: A lot of that would have been able to be done. The only component – and these are just examples that I've mentioned – that wouldn't be able to be done would have been using the histology information to enable some information to be generated regarding the timeliness of colposcopy because histology wasn't being entered on the Register at that point. Actually, until the Register was configured into one central register, it would actually have been difficult to do a lot of this. I need to actually reconsider that. It would not have been impossible but it would have required 14 separate downloads of information and, as we know, there were duplicate entries.

Q: so what you've set out in para 18 then provides a good indication of the drawbacks of not having a central register because you couldn't do what you've now set out here.

A: Well it would have been difficult. I mean, not only duplicate entries but for women who had moved one register site would have had a part of their smear history and another would have had another part. And unless I'm much mistaken, they wouldn't have been linked in one record.

Q: would this have been apparent to the persons responsible for organising the programme in a way in which it had 14 separate registers?

A: I don't know. I mean, it seems obvious, but I really don't know.

Q: well take yourself, for example, you are a public health specialist, if you had been involved at the time in setting up the cervical screening programme when it was suggested that there be 14 separate registers, would it have been apparent to you what the drawbacks of doing that would have been?

A: I think it would have been apparent unless there had been an agreed National minimum data set which was being regularly provided to a central agency.

Q: and did that happen?

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A: not that I'm aware of.

Q: In terms of the monitoring reports which you referred to in para 18, which you say will be generated as a result of the process, when will this happen?

A: I referred to this yesterday. I would imagine it will be happening by the final quarter of this year.

Q: do you know – it's just slipped my mind for the moment, when the register was configured as a central register, I think it was 96 or 97 but I'm not sure.

A: I can't recall when it was completed but I think it was 97.

Q: well if the Register became a single register in 97, is there any reason that you can see why this type of use of the Register in monitoring that you've set out here in para 18 couldn't have been done from that time

A: there's really no reason except that it is also helpful to have the backup of quality standards which you can use as a basis to follow-up on monitoring reports, but really no reason.

Q: and it's not essential to have the quality standards in place?

A: I think it's quite a vital component because when you need to go back from the monitoring report – outcomes of a monitoring report will only give you indications that there may be a problem, and I think you need a standard by which you can go back to a provider to assess where there may be difficulties and if you don't have an agreed manner in which the service is going to be conducted you are not really sure what you're assessing against.

Q: do you think, then, that an absence of quality standards is a good enough justification for not carrying out monitoring when it could otherwise be done

A: Not really. I think there could still have been monitoring.

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CHAIR: Does anyone else have any further questions?

PROFESSOR DUGGAN: If I could just ask one question to follow up from that. The first three statistical reports plus the report on the Maori women, all of those reports were tendered out, is that correct?

A: I'm not sure. The first one was. I thought the final two were. The second and third were written by the Ministry of Health but I'm not sure.

Q: In your design for the programme, this will cease and these reports will be generated by the National screening team, or whatever your name will be?

A: We're certainly generating the one that's currently being worked on and we're planning to generate the 1999 one. And I think we would work with the monitoring group to work out how that should be managed in the future.

CHAIR: When you talk about a monitoring group, do you mean the independent monitoring group which you have in mind to contract with?

A: Yes.

Thank you. Perhaps we will adjourn now for lunch and does anyone have any questions after lunch?

[Ms Janes to question Dr Peters after the luncheon adjournment.

LUNCHEON ADJOURNMENT 12.58 P.M.

TO RESUME AT 2.15 P.M.

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2:20 P.M. INQUIRY RESUMES
FOLLOWING LUNCH ADJOURNMENT

MR MURRAY ADDRESSES THE PANEL

MR MURRAY: Before my friend starts, Dr Peters was going to produce the quarterly monitoring report that she gives to the Ministry of Health and I wonder if I could just confirm what is actually required because we are covering the period 1998 up until now and we could either pick an example of one of those reports at a certain time or we could compile a set of all the quarterly reports and package them.

CHAIR: The latter please. With page numbers. Mrs Barrett asks for that.

MR MURRAY: Will do.

MS JANES XXN THE WITNESS

MS JANES: Dr Peters can I just take you back very briefly to the point at which the Health Funding Authority took over the Cervical Screening Programme. As I understand it both the national coordination and the Register moved into the Health Funding Authority at the same time.

DR PETERS: Correct.

Q: And at that point there was a national coordinator Di Best who came through and Sandra Metcham who was in charge of the Register.

A: That's correct.

Q: Dr Peters if I can just take you to your tab 8 in your exhibit volume 1 which is the job description for the national coordinator at that time, looking through that, did it change at all from the 22nd of July 1996 while Di Best was national coordinator?

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A: I'm not aware that it did but I wasn't involved in it obviously. However this is the job description I understand that Di Best transferred with so I'm presuming it was current.

Q: And it does indicate that she is in the prevention policy section of the Personal Health group.

A: Yes it does.

Q: Looking through that job description, I understand that you were available during the evidence mostly of Dr Boyd and Ms Clachan, and we heard very much about the lack of teeth that the national coordinator role had in that there was a lot of accountability but no ability to enforce or ensure compliance. Is it your understanding, looking at this job description, that that state of affairs actually continued initially under the Health Funding Authority structure?

A: I would need to study the job description in detail. Initially Di Best reported to the general manager of public health and I think quite honestly the focus of the prevention team as it was called at that time was on implementation of the Breast Screening Programme that was its main focus and I think with cervical screening I don't think any detailed analysis of the requirements of the professional apart from Robin Whitaker's work really commenced in earnest until we had implemented the Breast Screening Programme or launched it so it's difficult for me to say whether Di Best would have lacked teeth in our organisation as well.

Q: Was she dedicated to the Cervical Screening Programme as national coordinator.

A: Yes she was.

Q: So it wasn't a job share with the Breast Screening Programme at all.

A: No.

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CHAIR: Dr Peters is your job description included in the exhibits.

A: No it's not.

CHAIR: It would be helpful if we could have your job description if there is one so we could then compare it with the job description for Di Best. Is that possible?

A: Yes it is possible. I would have to say though that my job description when I took the position was a generic senior project manager job description and was not particularly tailored to the role. With a new organisation being established, a large number of the job descriptions were generic but I can provide it for you.

Q: But we're not likely to find a detailed job description for you relating to your role in the screening programme?

A: No it's something I'm working on at the moment.

Q: That's fine, if we could see the generic description please.

A: OK.

MS JANES XXN CONTINUES

MS JANES: The issue Dr Peters that I am concerned to pursue is really the authority and the ability to implement the programme or at least move it up the hierarchy to ensure that action is taken. I think we understand that the Cervical Screening Programme is a small component of the Health Funding Authority's work and therefore it needs sufficient hierarchy to be able to ensure that its needs are being met and we certainly saw through the evidence of the Ministry of Health while it was lodged that that was one of the difficulties that national coordinators had huge responsibilities and very little ability to manage the areas that they were required to look after. As I understand from your evidence and this is at

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paragraph 70 of your brief, in 1998 it moved from one coordinator to two coordinators for the programme is that correct?

DR PETERS: Yes that's correct although that was in the context of a larger team. In the sense that my general manager at that time was committed to providing more resource for the screening programmes as opposed to just having one national coordinator in whom all responsibility was lodged.

Q: So at this point it moved to two coordinators but were they split between both the Breast and the Cervical Screening Programme?

A: Yes they are.

Q: Has that had any impact on the Cervical Screening Programme which is what this committee is focused on?

A: I don't think so because I think overall we have committed a great deal of resource to the Cervical Screening Programme, more than perhaps ever has been before at a national level.

Q: And the fact that the Breast Screening Programme in its implementation phase did not detract from the work done on the Cervical Screening Programme?

A: No, it gave us a lot of work to do but I don't think it's detracted I think we have really worked very hard to resource both programmes adequately.

Q: When you took over both the Breast Screening Programme and the Cervical Screening Programme what were the changes in staffing resources? It says here that you were concerned to enhance the skill mix and ensure the critical mass of staff and therefore the move to the two screening coordinators? How else were you enhanced by way of staff and skill?

A: Well we had two – just trying to remember back to that time – we had

two dedicated analysts for the programme and we were able to appoint a public health coordinator for health promotion aspects of both programmes. There was myself as manager, dedicated to both programmes and we had a dedicated public health medicine registrar and over time we have built up the size of the team, although admittedly the team does cover both programmes.

Q: And is it your understanding that these were significantly greater resources than the Cervical Screening Programme by itself had ever had even if you halved the amount of resources?

A: I don't think I can say that it had ever had because I am not familiar with the early days but certainly my understanding was that when Di Best and Sandy Matcham and Philip Saysall were transferred to the Health Funding Authority that that was the main resource that was available to the national programme at that stage at a national level

Q: And you indicated just previously that there were two analysts employed by the screening programme.

A: Yes.

Q: What were they hired to actually analyse? What were the areas that they were specifically looking at analysing?

A: Well, initially there's been a lot of writing work to do for both programmes. I'm just trying to think of what they have done. As time has gone on we have been able to delineate more carefully what people need to be doing, and one of those analysts is really now dedicated to monitoring of both programmes, so when I say monitoring I mean ensuring that monitoring occurs, following up on monitoring reports with the breast screening programme, working on establishing monitoring for cervical screening. The other analyst does policy work – for example, she's written

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the data release policy, has managed the production of the policy and quality standards, ensured that has all happened. There's a range of work that she undertakes.

Q: so just going to the analyst who looks after the monitoring, who within the Health Funding Authority or the breast screening programme has set the parameters for what is to be monitored. Was that something that was inherited with the programme or something that has been a Greenfield's monitoring programme?

A: For breast screening there was an agreed minimum data set which was agreed prior to the establishment of the programme and I wasn't involved in it but I understand that various key stakeholders in the sector signed off that minimum data set. The independent monitoring group developed a quantitative monitoring plan and we agreed that with them and then they provide the monitoring reports on the basis of that monitoring plan. However, we also receive qualitative reports, not actually related to the quality standards but a 6 mthly qualitative report from all the providers of the breast screening programme.

Q: and it's their responsibility to analyse the qualitative data?

A: my analyst's role is to, one maintain relationships with the monitoring group; two, ensure that they're getting the data they need in a timely way and there are no hitches there, and to ensure that the actual process of production of the report goes according to plan, and then following up on any issues, analysing the reports, the qualitative and the quantitative reports and ensuring that all issues are followed up with providers.

CHAIR: Dr Peters what information is contained in the quantitative reports?

A: It will be issues like coverage. This is for breast screening. Recall to

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assessment.

Q: what about for cervical screening

A: No, the reports aren't rolling yet, they will be later this year.

Q: Just so that I can get a clear idea of what's quantitative and what's qualitative so I know I am not making assumptions?

A: Quantitative duties is rates or proportions - so coverage, enrolment, reporting rates of various abnormalities/1000 women, measures such as cytohisto correlation, whereas qualitative would be more subjective. For example, for a health promotion provider it might be how many groups they have held with providers or women's groups where they've explained things, the makeup of those groups and how the group went – all those kind of things.

Q: and when it comes to comparing information on the Cancer Register with incidence of cancer with the screening registry, and I know it doesn't happen now, but if it did would that be qualitative

A: No, that would be quantitative.

Q: Even though It required identifying the women concerned?

A: yes. Well, it wouldn't necessarily need to do that to produce a rate for a particular region. You wouldn't need to necessarily identify women just to get the rates that we've seen, and that could be used –

Q: but wouldn't you have to identify women initially – in other words, if you're looking at the Tairāwhiti region and you wanted to see how the two compared you'd have to get names off the Cancer Registry and then names off the Screening Registry to link the two together.

A: Well, if you wanted to do an audit of that woman's screening history and individual record to see did that person have regular smears who now has cervical cancer you would need to do that. But if you wanted to take the

incidence of cancer in a region and compare that to the reporting patterns of cervical abnormalities/1000 women in that region you wouldn't need to identify anybody.

Q: And in terms of the latter, how meaningful is that information in comparison with being able to do an audit by linking individuals names on the Cancer Registry and then going to the Screening Registry?

A: I think they're completely different.

Q: So you would use them for different purposes?

A: Yes, I think one would be part of your routine monitoring and the other would be perhaps a more periodic evaluation that you were doing to examine more closely where there might be a breakdown in the screening pathway for a particular person and what lessons the whole programme could learn from that.

Q: but you could, as part of your evaluation, randomly select, say, 50 women from the Cancer Registry and then go back over and look at what their smear test history was, could you not?

A: You could do, yes.

Q: Would that be worthwhile doing?

A: Identifying women and examining their smear history?

Q: Yes, as a random selection. I've just picked the figure 50 out of the air, but I was thinking of a random selection in that way of a means of auditing a programme – would that be worthwhile?

A: Well, Dr Cox might be a better person to ask that about that. And I certainly wouldn't want to put the team wrong about these things, but I think that you could do that but, without examining the case history in detail – for example, if a woman had regular smears yet still developed cancer and you linked her record and you discovered oh, this woman has had a regular

screening history, without looking at the slides and the adequacy of the specimens – correct me if I'm wrong Professor Duggan – I don't think you would really know where, if any, brkdwn had occurred, and there may be none. But there may be at some point a breakdown in quality.

Q: Well, given that we've heard that Professor Skegg has had difficulty in getting approval from the Ethics Committee to carry out his study, do you think it would be best if It were built into the screening programme that there was the ability to carry out such an audit to the degree where you could not only marry up the data on the Cancer Registry with the Screening Register but go back and have a second look at a woman's slides and her medical history as well in order to audit the quality of care she has received?

A: I think for the protection of women at a population level it's very important to be able to do that. But I'm not sure how the women of NZ would respond to that, but I certainly think professionally that it's very important to be able to do that.

Q: Well if someone goes back and has a second look at a slide that's already been read once, lets say 5 years later, and looks at a medical history 5 years after it was taken down, how harmful is that to a patient?

A: that's not harmful but there may be a need to look at people's medical records and talk to medical practitioners about their medical history as part of that. I think if it's done in a very carefully controlled way it should be acceptable to people.

Q: Would you think that if it were being done by medical professionals with a genuine reason for doing so, that it makes sense to allow medical professionals to take those steps.

A: I think if it's done very carefully and women's confidentiality is protected as much as possible then it is an important thing to be done, yes.

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Q: Do you think that it's essential to get the woman's consent or can you envisage circumstances where a problem might come to mind and you want to take a second look at the treatment a woman has received in circumstances where it might be difficult to contact her but say for example her slides are available in a laboratory and you know where her medical records relating to the problem can be located?

A: I think we are trying to balance, your raising the issue, is the balance of individual rights if you like versus the needs for the protection of a community or a population and I think it's always to my mind there is always tensions there, but I think if we really want this programme to work optimally in New Zealand we need to be able to do that kind of audit.

Q: And in circumstances where the ability to do so is actually built into the programme rather your being dependent on the permission of other bodies such as ethics committees?

A: I think it is very important for the programme to be able to do that. I think it is also important that people feel reassured that it is being done in an ethical way and whether that would be done by recourse to an ethics committee or not I don't know. I feel I am getting slightly out of my depth.

Q: As a coordinator of the programme do you think that it would be better perhaps to develop a process if you had the freedom to have a process which you ran passed an ethics committee in terms of approval of your process and then you just simply applied it in every case which arose rather than have to go off to an ethics committee in every individual case.

A: Yes definitely.

MS JANES CONTINUES XXN OF WITNESS

MS JANES: If I may actually pursue the point, I was going to come

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to it late but while we are discussed this we will do it now. If I understand your evidence from earlier today you indicated that if the expertise were within the Health Funding Authority there would be the ability to audit from the Cervical Screening Register. It's only when a third party outside such as a Dr Cox as Professor Skegg becomes involved, that Section 74A precludes access to that information. Is that correct?

A: I don't think that's quite right. I don't think we have any more access as the Health Funding Authority to the cancer Register information than Dr Cox does.

Q: No, to the Cervical Screening Register.

A: The Register coordinator has access to the Register I don't necessarily have access to the Register.

CHAIR: Could I just interrupt there. Do you see yourself as being hindered by Section 74A from having access or is it just a matter of practical organisation that you don't have access.

A: I just think it's important that nobody is looking at individual records who doesn't need to and I don't need to.

CHAIR: No but if you wanted to you feel that you could.

A: Yes I could.

MS JANES XXN CONTINUES

MS JANES: Are you aware from sitting and listening to the evidence particularly through the Ministry of Health phase that all of the experts were united and there will be evidence also from future witnesses that an annual audit of women who have ended up with invasive cancer as a result should be audited on an annual basis, do you recall?

DR PETERS: Yes I recall that and I agree with it.

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Q: Now taking that the logical step further and obviously that has not been done to date am I correct in that?

A: Yes.

Q: And as I understand it also that in tab 23 of your exhibit on page 10 if we look at the first objective of the Cox Richardson evaluation plan, the first component is an audit of screening history and management of women and I understand your evidence that that has not begun because of the Section 74A issues is that correct?

A: No we have come to an arrangement with the University of Otago to facilitate that component.

Q: So when is that actually going to be able to be underway?

A: That should be underway now.

Q: So it's a year behind schedule. As I understand it was supposed to start in July 1999.

A: Yes that's correct but we have been working with the University of Otago since then to work out a way that it can now happen and we have now come to an arrangement.

CHAIR INTERJECTS

CHAIR: Dr Peters is this a way of getting around Section 74A?

A: Well what we have agreed with Dr Cox for this particular component is that the consent of individual women will be sought. We will work with him, my staff will work with his staff to ensure that there is a random sample of women selected and they are written to by us on their behalf to obtain consent because there was no other way that it could be done.

Q: How long would it take given that you have to track down the women concerned?

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A: Well it is going to add time to it but we've just simply tried to do what we can to enable it to proceed.

Q: And how much of your resources is it going to take up as you have to do this step?

A: It's going to time of Ms Metcham yes.

Q: And if you didn't have to do it it's likely that the study on this topic on page 10 of exhibit 23 could already have been completed, is that a fair assessment?

A: Well it would certainly be well underway. Sorry, I have put you wrong that's the invasive cancer one, I'm confused with the middle one, it's the middle one that's just commenced, sorry the audit hasn't commenced.

MS JAMES CONTINUES XXN

MS JANES: That was about to be my question. My understanding from Professor Skegg's evidence was they are still waiting on ethics committee approval and we are already a year into when it was supposed to be completed in a years time from a two year project and it still has not commenced. Is that correct?

A: That's correct.

Q: And does this underscore the difficulties that any team involved in the Cervical Screening Programme with expert recommendations that this is an annual event and yet here we are 11 years into the programme we still haven't been able to achieve that or even commence it.

A: That's correct, that's why I sought a legal opinion to determine what would need to be done to enable it to happen. That was independent of this evaluation plan.

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CHAIR INTERJECTS

CHAIR: Dr Peters when you went out to seek that legal opinion did you check to see whether in the past while the Ministry of Health had been responsible for the screening programme it had sought any legal advice on the impact of Section 74A on auditing of this type?

A: No I didn't.

Q: Do you know if the Ministry of Health has ever sought any legal advice on the impact of Section 74A on carrying out audits of this nature and how it could accommodate such audits?

A: No I don't.

Q: Just so that I can be clear, the matter that you are going to seek the consent of the women on, that's the one appropriateness of follow up and treatment for women with abnormal smears?

A: Yes that's correct.

Q: And in terms of the first one, audited screening histories and management of women with invasive cervical cancer, which ethics committee would there need to be an application or approval to to carry out this study?

A: Not being a researcher, I'm not sure whether there would need to be an application to all the Ethics Committees, or whether one could just do one, just to one Ethics Committee I'm not sure.

Q: Are they based with each CHE?

A: I think when the Ethics Committees were established they were set up under the Area Health Board structure, so I think there are still 14.

Q: so if you wanted to do a nationwide audit and you wanted to get access to medical files and slides of the women you would have to approach 14 different Ethics Committees? Would that be a fair assumption?

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A: Yes, we are getting here into the area between monitoring, audit and research and whether such an audit comes under the ambit of research, but I know that Dr Cox and Professor Skegg would probably take this to an Ethics Committee but it may be better to ask them about that. Because for routine monitoring one doesn't go to an Ethics Committee all the time.

Q: What about a specialist audit such as the Cox study.

A: I really don't know.

Q: Do you know what the composition of Ethics Committees are made up of?

A: Normally a range of professionals and consumers, but I can't tell you exactly how they're made up.

Q: who would be the best person to advise the committee on the composition of Ethics Committees and their role and the impact they might have on the screening programme?

A: well Dr Cox will have had experience with Ethics Committees. There is a National co-ordinator of the Ethics Committees within the Health Funding Authority.

MS JANES: Professor Skegg will also be returning and he may also be able to assist the panel on that. Dr Peters I'm assuming that when you took over the screening programme for the cervical screening that you would have inherited a lot of paperwork from the previous National co-ordinators and programme, is that correct?

A: I don't recall receiving a lot of paperwork but I did send a member of my team to the Ministry, we arranged with the Ministry to go down and go through the files and collect things which seemed to be relevant.

Q: and do you recall if, in that information that was collected at that point, that you became aware of the requirement for an annual audit against

women who'd developed invasive cancer

A: No, but I don't think I could say that I have scoured the files.

Q: Would it have surprised you to have learnt at that stage that this had been something that had been recommended from the inception but had never actually been taken to a stage where anyone became aware of the restrictions of 74A: It seems a long time into the programme for this legal wrinkle to have surfaced. Would that be fair?

A: it would have surprised me if there'd been a protocol developed and that awareness hadn't arisen, yes.

Q: so we could assume that no protocol had ever got to the stage of going far enough that this particular legal hurdle had ever surfaced prior to the Cox/Richardson study?

A: you are asking me to speculate, but I haven't seen a proposal and I'm not aware that the legal issues had come to the attention of anyone prior to my raising them. Well, I'm aware that Professor Skegg and Dr Cox were aware of them but no-one had made me aware of them.

Q: and any concerns you may have had would have been well and truly hammered home with finding out that even 2 years after the plan we still can't do it because of those same legal hurdles?

A: when I received correspondence from Dr Cox about these – although as I've said twice already I'm not a lawyer – I couldn't see how they could proceed given the way the legislation was written.

Q: You probably read it better than some lawyers!

CHAIR: Dr Peters, do you think one of the reasons why the difficulty about accessing information has never really been recognised before the Cox/Richardson study is because no other attempt at auditing and evaluating the programme had ever gone as far as the Cox/Richardson study in the

past?

A: that may well be the case, that it had never been put to the test.

Q: I see under s74A(7) there is a power to make regulations regulating access to the Register by persons studying cancer and regulating the use, disclosure and publication of information from the Register. Has the Health Funding Authority approached the Ministry of Health with a request to the Ministry to make such regulations so that something can be done to get over the stumbling block that 74A now presents

A: I haven't written to them formally, but we have been in dialogue with them over the last couple of months about this issue, because they are wanting to address it and I of course have just about a legal opinion finalised on the issue, and once that opinion is finalised – which should be within the next week I think – we were intending to meet with them about this issue.

Q: Well the Cox/Richardson project commenced in 98.

A: Yes.

Q: Was there any suggestion in 1998 that the difficulty s74A placed on gaining access to information from the Screening Register could be overcome by making regulations under subsection 7 of the section?

A: not that I'm aware of. But I understand that requirement, as the way to resolve this issue, will be the substance of the legal opinion.

MS JANES: Would it be a possibility Dr Peters, as manager and you've indicated how important you think an annual audit against development of cervical cancer is, is it possible that some protocol could be developed which would enable the Health Funding Authority now, soon to be the Ministry, to institute that annual audit with regulations which would allow it to be carried out by the Health Funding Authority/Ministry on an annual basis to get

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around those issues, because obviously that seems like the sensible way to sort that problem out.

A: in the short term you mean?

Q: In the short term.

A: I haven't thought about that in detail, but I had a meeting with Dr Cox a few weeks ago and we did talk about ways that we might be able to facilitate the audit. We briefly touched on it. I mean, I wouldn't say it was a lengthy discussion how we may be able to do some of the linking in house and work with him in his team.

CHAIR: Dr Peters, given that the Health Funding Authority is now part of the Ministry of Health, and it's the Ministry of Health that is really the Crown body that would be the catalyst for promoting regulations under subsection 7, if you in your role had full powers do you not think it would be appropriate for you to be in a position to promote regulations being made under ss7?

A: well I'm not technically part of the Ministry yet. The new Ministry structure did commence but that is for people within the Ministry. Those of us who will be in the new Ministry but are still part of the Health Funding Authority will remain there until legislation is passed.

Q: But once the legislation is passed and you are part of the Ministry do you not think it would make sense for your role to have some ability to promote regulations relating to the Screening Register

A: Yes, I do.

Q: Have you asked for that to be part of your role?

A: Perhaps naively I assumed it would be part of my role once I was in the Ministry of Health but I guess I would need to work with the legal section of the Ministry on that.

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Q: And what would your understanding be of the length of time such a process would take?

A: I don't know a great deal about these things but I understand it can take several months.

Q: Would that be a priority that the team would look at to institute these annual audits regardless of the Cox Richardson study?

A: Well it seems to me there are a number of monitoring and audit priorities for the programme. There is quantitative monitoring I think that after that audit of screening histories of women, development and implementation of monitoring of colposcopy and there was one other which escapes me, would probably all be competing for top priority and I would discuss with people like Dr Cox what the priorities should be.

Q: Am I right in understanding through Dr Peters that it's not just Section 74A that is a hurdle, is it also access to the patient's actual medical records. My understanding is to do an audit it's not sufficient to access the Register information.

A: Well one would have to, depending on how detailed you wanted the audit to be and I have to say I am not an expert in this area, one would have to access clinical records and possibility slides so yes, gathering all the information would take some time and then you would need to have a panel that was available to do it and one may also want to seek to explore the Medical Practitioners Act to see if there was some need to establish this as a quality assurance process under I think it's Section 6, but I really don't want to stray into legal territory but there are some other issues that the legal opinion will cover.

CHAIR: So ideally you would need perhaps a change in legislation relating to the screening programme which allowed access not only to the

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Registry which could be achieved through regulations being made under sub-section 8 but also a legislative provision which enabled you to have access to a patient's slides, medical records etc?

A: Yes, to do this type of audit.

MS JANES: I realise you are not a lawyer but would you agree it seems to be a sensible, both cost effective, time efficient and resource effective way of ensuring audits can be undertaken whether it's yearly or two yearly or whatever so that this issue doesn't have to be addressed every time that there is a major evaluation planned.

A: Yes I agree.

Q: And just following on from that I understand from your evidence that the second component which is that follow up and treatment you have managed to find a way, albeit more resource intensive, to ensure that that is now underway.

A: Yes that's correct.

Q: And is that still a year projected time to complete?

A: I don't know what Dr Cox although it says one year there so I presume that's what it will take.

Q: And I assume the third component, there is no difficulty with the assessment of the data would that be correct?

A: I don't think so. I think there has been some hold up of the ethnicity flag but as far as the data with no ethnicity identified, that was provided to Dr Cox some time ago.

Q: Again we're heading into an area that I'd planned to do later but we may as well do it while we are here. The ethnicity, you've indicated that there is a delay with anything with the ethnicity flat on it. Is that because of the kaitiaka regulations?

A: Dr Cox needed to apply to the kaitiaka group and I'm not absolutely sure at what point his application is at the moment. Actually I think it's all OK, I think it has gone ahead, I might be getting a bit confused. I would be able to check for you.

Q: Would you be able to check because certainly if this plan came out in 1998 and there are still issues relating to approval from the kaitiaka group would you agree that that would be cause for concern of the delay?

A: Yes.

Q: We'll come back to that when we look at the Whitaker study but essentially what expertise, what skill matrix do you have available to your team. I know you mention at paragraph 65 Dr Bernadette Millen who has a PhD in epidemiology, is she one of your analysts or is she –

A: She was my predecessor and she does do a small amount of work for us but it's not really available. What paragraph at you on sorry.

Q: Paragraph 65 it just mentions her.

A: She was the previous manager of the team.

Q: So currently what skill set and what qualifications and expertise do you have available, particularly looking at areas like evaluation and monitoring and analysis?

A: In reality there is only one other public health medicine doctor on my team and there are other people who do have public health qualifications such as a masters of public health.

Q: Do you have a statistician or an epidemiologist?

A: No I don't and that's the sort of skill mix I would be wanting and the way in which I would want to enhance the team over time.

CHAIR INJERCTS AND XXNS

CHAIR: What is stopping you at the moment from employing a statistician for your team?

A: Well I actually haven't had the facility to recruit more staff.

Q: When you say that, what do you mean, you don't have the money, you don't have room for them?

A: When the Health Funding Authority was formed there was a staff ceiling, one could not recruit more staff than one had allocated except in exceptional circumstances so I was able, because there were some exceptional circumstances, to recruit some additional people, a data manager for the Breast Screening Programme, a health promotion person for both screening programmes, it is not possible just to determine that you want to recruit someone and then go and recruit people, there are processes that one has to go through and I am in the process of identifying what the recruitment priorities are at the moment and I have some approvals but a statistician for various reasons is not at the top of my list.

CHAIR: Do you have the freedom to engage a statistician on a contractual basis on a short term to do any work that you might require?

A: Yes I could do but the public health medicine registrar I have is actually developing her skills quite well in data analysis.

CHAIR: When you say you have had a ceiling placed upon you for the staff that you employ, given the impact of what has happened in Gisborne on resources in terms of making inquiries into having Dr Bottrill's slides re-read etc has that been a drain on your resources?

A: Not on my resources no. It has impacted on our team but the actual investigation hasn't.

Q: Have you had to employ extra personnel because of this incident and the need to inquire into it?

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A: I haven't no.

Q: Has it taken any of your personnel away from work they would otherwise generally be doing?

A: Apart from attending meetings, not really.

Q: I suppose your attendance at the inquiry, you could be doing other things.

Q: Possibly.

MS JANES CONTINUES XXN

MS JANES: Just going down that skill set and expertise available is there, I understand in the Ministry of Health there's a Health Information group that is available for statistical analysis. Is there a similar group available to you to use within the Health Funding Authority or can you access the Ministry of Health's?

A: there's an epidemiologist in the Health Funding Authority who has provided assistance to us – for example, determining the actual extractions for the statistical report, but I think ideally we would have more of that expertise within the team.

Q: It's a very long winded way of getting there but I finally got there. Really, the point I'm getting is what we found when we looked at the evidence from the Ministry of Health is that there was a tremendous amount of very valuable data that was available as a result of the programme but there that didn't seem to be anybody who was tasked with actually sitting down on any sort of regular basis and analysing that data. I guess what I'm trying to ensure the panel understands is whether that is a similar situation while the programme's been under the Health Funding Authority, that again there has been a lot of very valuable data that disappears into a black whole

because of lack of expertise or ability to analyse it and come forward and say “these are the areas of concern that have been thrown up from that analysis”.

A: I think to some extent that’s a fair comment, however I think we have used our registrars, who do have some ability in data analysis – Robin Whittaker – to do data analysis. As soon as we took over the programme we had Robin working on analysis of register data, and we are also using our current public health medicine registrar to work on the statistical report. I think perhaps one of the difficulties we've confronted is that we were to be a generic change management team and in fact that is not what we are, and we've needed to re-focus into what really our role is and we now need to look more carefully at building up the required expertise. I don't think it's fair to say we haven't used any of the data on the register, but I think you are right, we could have more expertise in that area in the team.

Q: and is that something that could be looked at once you are folded back into the Ministry; is there ability to have additional expertise or is there still a ceiling on the resources?

A: Well, I'm working at the moment with my manager on what exactly the workforce it is that I will have, but then even when you've got the approvals you have to be able to recruit the right people. And epidemiologists, I suggest, are not always readily available.

Q: They are not on every street corner, are they?

A: No.

PROFESSOR DUGGAN: Dr Peters, could I ask you a question. When you used the term “or registrar”, do I understand you correctly that this is somebody in training?

A: In public health medicine, yes. They will probably have a Masters of

Public health.

Q: These are MD's or PHD's?

A: MD's

Q: So your programme is dependent on trainees?

A: for a lot of the statistical analysis that we have done I have not had an epidemiologist on my team, so that's true, I have depended on public health medicine registrars who have a Masters of Public health in addition to their basic qualification.

Q: So the projects that they have undertaken, this is part of their course work towards their ?

A: Towards their Part II, yes.

Q: And do you function as their supervisor in this?

A: I am for the current person, yes.

Q: Do you have a guarantee that you will have registrars every year?

A: I have a facility for a registrar but I don't have a guarantee that I will.

Q: So if the all decided to become pathologists and nobody went into public health you wouldn't have any registrars?

A: No, all these people are wanting to become public health medicine specialists. All the registrars that I'm interested in.

MS JANES: I think what Professor Duggan is getting at is there a steady supply of people who want to become public health –

PROFESSOR DUGGAN: Is there a steady supply?

A: Yes, yes. Of people training in public health medicine, yes.

Q: However, is it appropriate for your programme to be dependent on such individuals to evaluate the data?

A: No, and I guess it's not and that's why I want to increase the skill mix of the team and why it's also so important for us to work closely with the

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University of Otago.

CHAIR: Is the skill mix of your team and the members of your team documented anywhere in the exhibits or in your evidence?

A: No, it's not.

Q: Could you say please first of all how many people are in your team?

A: at the moment there are 10.5 full time equivalents.

Q: and of those persons could you list what their qualifications are?

A: No, I couldn't just like that, I would have to get that information for you.

Q: Could you get the inquiry a list of the members of your team and what their qualifications and their years of experience are, including those that are contracted in.

A: Yes.

Q: Are you the only public health specialist in the team

A: Yes.

Q: And you have a public health registrar?

A: Yes.

Q: And are there any other medical practitioners in the team?

A: Not at the moment.

Q: Would you like

A: Yes, there is sorry – oh, the register, sorry.

Q: there is the registrar and you?

A: Yes.

Q: Would you like that number of medical practitioners in your team to be increased?

A: Yes, I think that would be appropriate.

Q: You are the first person in charge of the cervical screening programme who has been a medical practitioner and a specialist in public health are you

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not?

A: I understand that I am, yes.

Q: Do you think that the knowledge and experience you have as a result of your qualifications and background has better enabled you to carry out your job?

A: than the previous incumbents.

Q: than the previous incumbents. I'm going back to the Ministry of Health days as well.

A: well, to some extent I think it has, but I think also I have been at a higher tier in the organisation that has given me more authority, more ability to make things happen.

Q: So that's made a difference too?

A: Yes. I mean, I wasn't experienced in screening when I took this role, but I think having a background in public health medicine has enabled me to relatively quickly understand what the issues are.

Q: who made the decision to employ someone such as yourself in the role of the – what is your official description in terms of the – are you still described as a co-ordinator of the programme?

A: No, manager. I was appointed ultimately by the previous General Manager of public health, Bette Kill.

Q: and is she the person responsible for upgrading the role of the person leading the cervical screening programme

A: Yes.

Thank you.

MS JANES: Are you aware of the basis for that decision?

A: No, but I think my predecessor, Dr Bernie Mullen was fairly clear that a public health medicine specialist needed to lead both the programmes.

Q: and you indicated earlier that you would like to enhance the skill mix. Given an ideal world, where you can indulge your requirements, what ideally would that skill mix include that you haven't got at the moment?

A: Well if I just go through the various functions that I think we need to be able to carry out, I think we would have people who were able to – I mean we do have some of these people already, but people able to take policy development work and analytical work and people who were medically qualified and had skills in epidemiology and had a clinical background. So I think those people would be an integral part of the team.

A: They would be involved in policy but probably also in monitoring and evaluation. Then we would also need people with experience in contracting, funding and contracting. We need people who are experienced in IM systems and data management and data quality issues. I think we need to enhance the maori coordination aspect of our team and I think we need to increase, well we don't have at the moment, we need a pacific coordinator for both programmes.

Q: So out of that wish list, what percentage would you say that you had accessible to the Cervical Screening Programme at this point?

A: I just really can't put a percentage on it but I think we're working towards it but I think we are quite a long way away from it. I mean we were a completely new team, I don't think there is anyone in my team who had been in the Health Funding Authority or the Regional Health Authorities before the team was formed and so we have had to all come to grips with the tasks ahead of us.

Q: And in your view has that been done successfully in the short period of time that you have been involved?

A: I think we have been as successful as we could be under the

circumstances we have had to work under which is as I say a completely new team, most of us not experienced in working in screening and with a lot of work to do.

Q: And being facetious so don't take this seriously but one could be tempted to say instead of a generic change team it has been a continuous change team so that has problems of its own. Just briefly going to the maori coordinator I understand that in 1998 there were two national coordinators, one being a maori and one being a non-maori.

A: In 1998?

Q: Yes in paragraph 70 of your brief. There were two national coordinators, one being a maori and one being a non-maori.

A: Yes that's correct they are both still there.

Q: So when it became a national team and the national coordinator roles were disestablished, those individuals stayed with the team.

A: The maori coordinator was a new appointment under the Health Funding Authority and the non-maori coordinator was appointed, there was an appointment process.

Q: And where do they fit in the hierarchy?

A: They report to me.

Q: Given that you have only had a couple of years in it, is it your sense that the policy in relation to delivery of cervical smear services to maori is adequately resourced at this stage?

A: I think ideally we would have more than one maori screening coordinator. That would certainly be my desire.

Q: What do you think that would delivery that's not being delivered at the moment?

A: I think we need to be able to get a much better understanding of the

difficulties we have with coverage among Maori women that it is so low and to understand that more and to try and address it and I think with one person we are struggling to do that because so much time is spent with provider coordination and networking and ensuring that the providers know exactly what is happening that I think often important analytical work might not get addressed.

Q: And is it the case that the maori coordinator under the Health Funding Authority structure is purely devoted to the screening programmes there is no other issue of maori women's health as I understand that was the case under the Ministry that there was a slightly split responsibility but they are absolutely dedicated.

A: Absolutely dedicated.

Q: And the advisory group, when you took over under the Health Funding Authority did you inherit the same advisory group that had been set up under the Ministry of Health cervical screening terms of reference?

A: I don't know that those advisory groups were any longer in existence. We established a new one.

Q: And some of the membership, the same names appear, how was your advisory group constituted. Who was responsible for that?

A: How was it constituted or how was it?

Q: How was it.

A: My understanding is that we undertook a consultation process to determine whether there would be one advisory group for both programmes or two, one for each programme or one with two kind of sub-groups and we ultimately decided on having one with the ability to second special expert advice if required and we took nominations for the make up of the advisory group, we also reserved the right to appoint people where no nomination was

received because we identified the skill mix that we thought would be required.

Q: And you were able to achieve that skill mix in the constitution of the group?

A: Yes I think so.

Q: Is it my recollection that after the advisory group started meeting you actually determined it was more effective to deal with say half a day for cervical smear and half a day for breast screening rather than combining the two?

A: I think the advisory group itself would say that it sort of swung between each screening programme, initially we dealt a lot with the Breast Screening Programme and then we dealt a lot with the Cervical Screening Programme or they have, and then I think at the last meeting they agreed that finally it was sort of half and half.

Q: And what sort of weight is given to the advisory group, the reason I raise that is because again you will have heard evidence that there were a tremendous amount of recommendations from previous advisory groups that disappeared into the ether and weren't particularly given the weight one would have expected, what's your experience of the recommendations and the weight given to those of the advisory group?

A: In general, although it's sometimes stressful to have all those demands made on you, I find the advisory group valuable because it's a lot of people who are external to what we are doing, who are seeing things perhaps more clearly and can identify priorities so I certainly take their advice seriously.

Q: Am I correct in assuming that you liaise with the advisory group and then any recommendations are routed through you to your general manager.

A: Yes.

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Q: And then the next layer up is the Director-General of Health from there.

A: Well it will be at the moment it is our Chief Executive.

Q: Dr Matheson.

A: No, Dr Matheson is the general manager of public health, Peter Hughes is the chief executive.

Q: So a recommendation, just so I'm absolutely clear, goes from the advisory group to you to, whose the next person?

A: To Don Matheson. I mean in reality there are often things they raise with me and if I know it needs to be done then we just get on and do it, if it's something that is more strategic and they want to correspondence directly with Don Matheson, they do so.

Q: So can I take from that that you actually do have executive making decision as the chair pointed you to one of Dr Boyd's exhibits this morning which is actually at tab 14 where it indicates that there should be an executive group with decision making power and power also to allocate funding, now I know the funding is being taken care of and isn't quite there but would you describe yourself and your management team as having sufficient executive power to make the necessary decisions to ensure a quality programme is delivered?

A: Yes I would but obviously any big decision I would take to my manager and we would discuss it but we seldom disagree.

Q: And are you confident that in the reform that is ahead of you that you will retain sufficient executive decision making power so that the programme is not vulnerable to similar circumstances as it was under the previous.

A: Yes I am if what I understand is going to happen does happen.

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Q: When is that going to be finalised, you've explained this morning in your evidence what you believe the structure is going to be, when is a final decision to be made on that?

A: Well the final structure of the Ministry has been established, the actual -

Q: So is it one of your options.

A: Yes.

Q: And that's not likely to change.

A: No.

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INQUIRY RESUMES

MS JANES: If I may just turn you to para 95 of your brief, because we were talking about Maori co-ordinators and this is an opportune time to move into the Kaitiaki Group and the analysis done by Dr Whittaker.

A: yes.

Q: How is the working group formulated, and before we go there was there a reason given by the Kaitiaki Group as to refusing to release the information until this working group had been established. Was that ever made clear to you

A: No, it was one of the conditions of the data release.

Q: and is there any requirement on the Kaitiaki Group to give reasons for imposing conditions on release of information, or do they have carte blanche to put conditions on?

A: Not that I am aware of, but I think the regulations do give them considerable powers.

Q: So they can impose these conditions such as this working group and then you were required to go away and set this group up?

A: Yes, that's my understanding.

Q: were there any conditions set on what the group should comprise or was that left open to the Health Funding Authority?

A: If I recall correctly that was left to us.

Q: At para 96 you indicate that having established the group then the project was completed in March 1999 but that there were objections from the Kaitiaki Group to release of some of the data in the format that it was

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presented. As you able to outline for the committee what those objections were?

A: Yes. But first I think it was useful having the oversight group. It was the power of the Kaitiaki Group to require us to do that, but I also think it was useful to have that oversight.

Q: in what way – can you explain?

A: in the input to understanding the data, what it meant for Maori women and what recommendations were pertinent from that. I don't think it was without merit. I'm not saying –

Q: so it added a dimension to understanding of the data?

A: Yes. If my memory serves me correctly, the oversight group suggested that we compare the Maori women's analyses with the Pacific women's analyses and the Kaitiaki Group was unhappy for that comparison to occur and we therefore needed to rework the way the report was presented.

Q: Were you given any understanding of why there was an issue, in terms of a comparison with Pacific Island data?

A: I think they felt it was inappropriate for the indigenous people's data to be compared with other groups.

CHAIR: why did you want to compare the Maori women's data with the Pacific Island women's data?

A: I think that was a suggestion of the oversight group.

Q: Do you know why they were suggesting it?

A: No, I don't, but it may be because there are some similarities in some of the issues around enrolment and coverage.

Q: As a public health expert are you able to say whether or not any meaningful knowledge could be gained from comparing Maori women's data with Pacific Island women's data?

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A: I think it does enable one to look at where, if there are similarities in under-enrolment or coverage to see if there are similar patterns in that, but I think one can also obtain that information by not directly comparing the two groups as well.

Q: Would it be preferable that you were able to compare the two groups as well from the epidemiological sense?

A: I don't really think I can give an opinion on that. I mean, I'm just not sure. It may be, but I think it's possible to also gain a good understanding of the issues for both groups by not comparing them.

MS JANES: was there any objection to comparison of the Maori data with non-Maori data rather than Pacific Island

A: not that I'm aware of.

Q: Because I note in your supplementary brief the statistics 2.5% Maori incidence over non-Maori

A: yes.

Q: so it was purely just Pacific Island comparisons that were objected to?

A: Yes.

CHAIR: I see from para 96 that the first full draft of the report was completed in March 1999 but because of the objections from the Kaitiaki Group it seemed that it's only recently the report has been finalised, is that correct?

A: that's correct.

Q: What impact has this had on the usefulness of the report?

A: well, internally not a great deal because we were still able to use the report, but externally of course we were not able to distribute it.

Q: what impact has that had?

A: well I can't actually quantify the impact but I know that people working

in the programme want information about what is happening and therefore we want to be able to provide them with that and so it's delayed that.

Q: So when you say you internally had access, you mean your team has had access but other persons who are components within the cervical screening programme that are not part of the Health Funding Authority have not had access to this material?

A: No, not until recently.

Q: and how important do you think it is that they should have had ready access to it?

A: I think the Kaimahi group, which are Maori women who work in the programme, have been very pleased to receive the report and obviously want information. So I think – sorry, I can't remember your question.

Q: My question was how important was it that other components of the screening programme had ready access to this report.

A: I think that given that we hadn't been able to produce a statistical report for some time that this information was being sought and therefore delays were obviously regrettable.

Q: given that you would like to report annual statistic reports, what impact do you envisage the Kaitiaki Group will have in the future on the annual publication of reports?

A: We don't seem to have had any problems gaining consent to have data released to prepare the statistical report. We received our data on the first application for the statistical report for 1996 to 1998 if my memory serves me correctly and I think we've recently had consent to extract data for the 1999 report so if the applications are well prepared, I don't think there is usually a problem. Well we haven't had a lot of problems.

Q: But one factor you will have to take into account in terms of your

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goal and producing annual statistical reports is the likelihood at some stage that the kaitiaka group might delay information being release?

A: Yes they might, but as I say with the two applications we have submitted it hasn't been a problem.

MS JANES CONTINUES XXN

MS JANES: Dr Peters under the cervical screening delivery requirements there is a specific maori policy both related to the Treaty of Waitangi and also to the policy documents is that correct?

A: Which policy documents?

Q: The 1996 cervical screening policy document.

A: Yes.

Q: And there are certain objectives in terms of an annual statistical report as being a goal obviously not achieved by anybody yet, but it is a goal.

A: Yes.

Q: At the point that you took over the third statistical report had been prepared but was delayed until, was it 1999 that that was actually released?

A: I'm not sure I think it was 1998.

Q: Right, but it was some considerable time from 1995 to 1998 when it was released.

A: Yes.

Q: And as I understand it, and not inputting any improper motives or ill-will, as I understand the evidence a part of that was because it went backwards and forwards to the kaitiaka group for approval, is that your understanding?

A: I'm not aware that the third statistical report has separate maori data in it.

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Q: Sorry I'm talking about the maori statistical report.

A: I have no knowledge of the process of that report being prepared and that was released last year that's correct.

Q: So I guess when you actually look at the Whitaker report and perhaps if I can take you to just a couple of examples, it's tab 15 and if we go to page 62, there are some findings which I assume would be of concern to people involved in the Cervical Screening Programme for instance under 5.1.4 it's indicated that the number of Maori women having a smear each year has decreased in the youngest age groups and I don't know if you were here when evidence was given, there was an article from Dianne Van de Mark who is a gynecologist in Tairāwhiti region indicating that this appeared to be an epidemic amongst younger women with relation to development of cervical cancer so reading something like this comment in the Whitaker report is obviously of concern in terms of strategy for delivering cervical screening services to young women would that be fair? That the sooner you knew that that was an issue, the more quickly one could formulate a strategy for determining how to best deal with it?

A: Yes I'd need to think a little more about that because if the actual absolute numbers of Maori women in that age group had declined one would expect if the age structure of the population was changing one would expect a decrease in the number of smears but presuming that the age structure hasn't changed, yes that would be of concern.

Q: And if we turn to page 64 under the first graph, it indicates that fewer maori women have enrolled each year across all registered sites so one assumes the interpretation of that is that maori are opting off more or not screening.

A: No one wouldn't necessarily assume that, one would assume that as a

programme becomes established and increasing proportions of the population are enrolled, that the absolute numbers of new people enrolling each year would decline because you have already got a majority of people enrolled.

Q: There is actually a comment in here to that effect but it indicates that that, on page 80, exactly as you said, under 5.5.2, again talking about decreased enrollment of maori women, it has been said that a decrease in the total number enrolling is to be expected as the programme achieves a higher overall enrolling rate, however this is not necessarily the case for Maori women as the enrollment rate is much lower so that obviously has been taken into account but there is still an issue there.

A: Yes that's true.

Q: And then under the second graph on page 64 again, it indicates that the number of Maori women enrolling has decreased in each age group every year. Now without really unraveling what that means, I guess my point is that if there is a mechanism which has been interposed in the ability to use statistics, in this case the kaitiaka group, where you have a report completed in March 1999 which is not able to be distributed and used by people who would be in a position to do something about this until recently, would you agree that that has impeded the ability of the Cervical Screening Programme firstly to develop timely strategies to deal with priority groups that have been identified both by Government policy and under the partnership of the Treaty of Waitangi. I know that's a very long question.

A: I agree that it does have the potential to do that particularly if it becomes a persistent theme because particularly smear-takers and health promoters need this information so they know whether what they are doing is effective I mean it's one of the inputs to knowing whether they are actually

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having a positive impact in their region.

Q: And I assume educators also need to know so that they can revisit their strategies as to should they now be approaching younger women.

A: And we need to know so that we can be sure our national strategies are appropriately targeted.

Q: Given that there have probably been two major maori statistical analysis, one being the first maori statistical report in this one, so persistent may not be the term to use, but if one is delayed four years before it is released and this is delayed a year, would that be cause for concern as to the timeliness of being able to look at delivery of an effective quality programme?

A: Well if it was persistent it certainly wouldn't help, what it think is important is that we do establish a process where there are regular statistical reports and we are not having the big delays that we have seen.

Q: And if you feel able to start implementing annual statistical reports, for which you would deserve a medal, do you see that the kaitiaka group would or would not be an impediment in terms of timely release of that data?

A: Well I'm not aware that the group imposed any constraints on the statistical report 1996-1998 so we are currently preparing so I see no problems with the release of that report, I mean any delays will be at our end in terms of finishing it, and we don't see to have any problems in obtaining data for the 1999 report, so while we have had some issues with this report, I'm not convinced that it is going to be a persistent issue.

Q: So you don't envisage in future trouble collecting the data but once it has been analysed and published, it has to be referred back to the Kaitiaki Group before it can be formally released.

A: I'm not aware that there's any requirement for us to do that for the statistical reports. Naturally, I mean, once we start the regular monitoring reports I think the monitoring group will need to make application and we'll need to see how we get on.

Q: My understanding was that you have to report within 6 months of an approval.

A: That's true, you do have to report back, yes, and we have provided those reports.

Q: So even without again imputing any motive, it just is a natural delay that if it has to be referred to somebody who then approves it and they only meet 4 times a year, that is an inherent delay built into – it may well be fine once you start annual reports, but initially it is going to cause a pushing out of the date isn't it?

A: It creates additional steps along the way that one has to comply with, if you like.

CHAIR: the Kaitiaki Group oversees the release of aggregate data for Maori women, does it not? That was my understanding from Ms Mellor's evidence yesterday.

A: that is certainly the way the regulations are used, although they are pursuant to a section about identifiable data but they have been applied to non-identifiable data – aggregate data.

Q: I see. And are you seeking a legal opinion on the application of the regulations?

A: I am trying to clarify that.

Q: Just to clarify for me, I think I can work it out but at para 97 you refer to Dr Whittaker's report was exhibit 15. Para 96 you talk about a draft report completed in March 99. Is that, I take it, the draft of Dr Whittaker's report?

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A: yes.

MS JANES: there are obviously ongoing difficulties with ethnicity classifications as well, is that correct? I just note that on p106 of the Whittaker report that one of the recommendations that the programme improves the definition and recording of ethnicity information on the register.

A: yes, we are fairly confident there's mis-classification of ethnicity. We in the policy and quality standards have a section on collection of ethnicity data indicating how it should be done and one of the appendices will provide more detail about that. So yes, we would like to improve that, but obviously with 6000 smear-takers around the country it's something that just requires constant working at.

Q: Would it be fair to say it's a variable that is somewhat out of your control?

A: A little, yes.

Q: but that is something that is being addressed to the best of the ability of the programme?

A: Yes.

Q: And another recommendation for Maori was there be further evaluation of groups with low enrolment and coverage rates, and again obviously there are Maori groups and Pacific Island groups that may well fall into that category. Are those recommendations that have been taken under advisement by the programme and plans formulated to –

A: Yes, we have commissioned reports which analyse what health education and health promotions strategies are being employed in the programme to see exactly what is happening. And they and other reports have been used as a basis for a revised National public health plan. But I

think we actually have quite a lot of work to do, to be honest, in the issue of enrolment and screening of Maori and pacific women and other under screened groups.

Q: In the new formed system that you're going into with the district health boards, how are you able to even put an imprint on that unless there is direct funding? When we actually looked back in the Ministry of Health evidence when there were first Area Health Boards and then the Regional Health Boards, it seemed that, as my learned friend Mr Corkill has pointed out, that there was a discretion to use cervical screening funding for other purposes. Is that likely to be an issue in the future that there may be diversion of funding that means targeting of those low enrolment groups as a continuing difficulty?

A: I think one of our first aims is to get greater clarity about what health promotion and health education work is occurring and how funding at regional sites is being employed in that area between managing the register and the health education/health promotion responsibilities. I think we need to get greater clarity about that before we can strategise for the future.

Q: is it your understanding that you will be directly responsible for that health promotion and education role or the District Health Boards?

A: well for all I actually did speak to my manager and he spoke to Dr Poutasi at lunch time and my understanding is that all funding for all aspects of the programme, with the exception of smear-taking, will be under my team and all the accountability will be to my team. There may be some mechanism by which funding does go through the directorate, the funding directorate, but the ultimate accountability for those services will be with me.

Q: so you will be able to direct those resources without having to liaise

with the District Health Board management for delivery of health promotion and education?

A: Yes, I mean we will need to work with district Health Boards but putting aside the issue that you're discussing, which is public health funding which gets diverted to other issues, the intention would be that the funding would come from my team and would be employed in the way that is required in the health promotion and health education activities.

Q: the circumstance I am hoping to be able to have the panel have information on is we saw that Sharon Read who is the Tairawhiti coordinator was spending 80 to 85% of her time just inputting data and she also lost her .5 educator, and obviously that has repercussions on a territorial or regional basis that we would want to be assured was not going to occur again in the future. Are you able to give that assurance?

A: I think there are a lot of issues in that area that need to be addressed. I can't give you an assurance that – I'm not quite sure what assurance you're looking for, but I am aware that that is an issue and it is certainly one, in terms of the resources devoted to effective health promotion and health education, that I'm aware is something that needs to be addressed and that perhaps the amount of energy that has gone into that work has declined as perhaps resources have been diverted and the register naturally becomes then the most important thing that needs to be dealt with because it's so immediate at a site where you've got the combined functions.

Q: And are you comfortable as things stand at the moment, and I know you can't crystal ball gaze, but as you understand things to be at the moment are you comfortable that the structure that is going to be put in place once you re-merge with the Ministry, that those are issues you would be able to control and have influence over?

A: Yes, I am, but I think that we need to be realistic that over the years of the health structures that we've had there's probably a lot of inconsistency in the way the funding was distributed between those regional sites and that will need to be analysed.

Q: Just in terms of contracts, I don't want to dwell on the contractual issues because Mr Corkill did go through that in quite some detail this morning, but I just want to turn to para 26 of your brief where you indicate that, with the regional co-ordination sites such as laboratories you do not have any contractual responsibility for these other providers in the programme?

A: The regional coordination sites.

Q: Yes. Once we move into district health boards, is that going to be a similar set up, that there will be no direct contractual links between the District Health Boards and the other providers to the Cervical Screening Programme?

A: Well it couldn't be if the contractual relationship was with my team. If we are contracting with all the providers then the regional coordinators will not have a contractual relationship.

Q: So they will have no responsibilities say for instance Tairāwhiti Health Care will have no responsibility for the laboratories, there is no other indirect links.

A: Well unless District Health Boards became purchasers of private laboratory services then I think that's unlikely but I can't say it wouldn't occur but it's certainly not the model that I am working to.

Q: So you are comfortable that as things will stand contractually, that the Health Funding Authority will have the sufficient lines of accountability to the providers for the Cervical Screening Programme to be able to monitoring, evaluate –

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A: As it has been described to me by my manager and Dr Patasi at lunchtime, yes I am, but of course it is a funding relationship and there are requirements within the funding relationship but the line management still remains within the HHS or wherever the site is situated.

CHAIR INTERJECTS

CHAIR: Dr Peters if things go as you would like them to go, will your team be able to contract directly, say for example, laboratories to read smear tests?

A: My understanding, which was conveyed to me at lunchtime, was that if we are not actually ... yes we would be, I mean we may not be the final contracting mechanism, but we would to all intents, have the funding and the accountability and the power to do the quality monitoring.

Q: And to that extent then would you have the freedom to choose between private laboratories and the laboratories that are part of hospitals?

A: Yes we would but for hospital laboratories to undertake the reading of smears which are taken in a primary care session would need to have a collection mechanism.

Q: Right, do hospitals at the moment participate much in smear-reading?

A: We touched on that this morning and my understanding is that hospitals undertake approximately 3% of smear-reading at the moment and in fact although I have given you quite a long list of laboratories many of them are only reading histology the hospital laboratories and in fact I think we are currently down to about 13 laboratories doing a majority of the smear-reading in the country.

Q: Right. Now are any hospital laboratories doing cytology readings?

A: Yes they do a small amount. There are five I think.

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Q: And in terms of those five hospitals, given that you want to introduce minimum standards of reading a minimum of so many smears per annum for each smear-reader how is that going to fit with the five hospital laboratories given that they are doing such a small percentage of the cytology readings?

A: My understanding is that as things are currently only one hospital laboratory National Women's Hospital would be able to meet that target.

Q: And does that have any flow on concerns in terms of education etc that other hospital laboratories won't be able to make your targets?

A: That is the issue that the hospital laboratories have raised with us and we are going to meet with them about those issues.

Q: And from the perspective of women's health and ensuring that their smears are read by the most competent people, would you say that the priority lay in ensuring that there were minimum standards adhered to universally?

A: I really think we have to deal with that issue, I just don't think that a laboratory that is reading say 1,000 or 2,000 smears a year can really .. I mean when I have done the figures that comes down to in some cases 2 a day or something like that, it's just really not enough.

Q: Thank you.

PROFESSOR DUGGAN XXN WITNESS

PROFESSOR DUGGAN: Dr Peters I am not clear about the hospital laboratories can the programme contract directly with the hospital laboratories to provide screening services?

A: At the moment, the hospital laboratories are funded through a generic contract which is part of their big hospital contract so there isn't, in my understanding, a separate laboratory contract but I understand we are

moving towards a national contract which covers both hospital and private laboratories so they could contract to do more work for the screening programme. One of the issues they would confront is being able to collect specimens because private laboratories have a network of collection sites around the country where specimens are collected and delivered to the laboratories.

Q: A solution could be a public private partnership.

A: Yes it could be.

Q: Now the histology, is this mostly done in the hospital laboratories.

A: Yes I think I've given a figure in my exhibit 41 of the proportion of histology I think it's around 50% which is done in hospital laboratories. On page 8, 63% of histology.

Q: So the hospitals do the majority –

A: Those five gynecological oncology centres process around 63% of histology and approximately 49% in total of histology results are process in 14 hospital laboratories.

Q: So the hospital laboratories do proportionately more of the histology than they do of the cytology.

A: Yes, naturally because that's where women are going to have colposcopy once they have been found to have an abnormal smear.

Q: Have you established any standards around the histology?

A: We have suggested that it is preferable that the histology is read where the cytology was undertaken because we haven't made it mandatory because we are aware of this situation.

Q: Have you established any minimum or maximum numbers in order to establish competence and maintain competence.

A: No I don't think we have at this stage.

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Q: Have you considered this.

A: Yes we have but I think to be honest we haven't considered it in detail but we are aware of the issue. We have looked at minimum numbers of colposcopies for individual colposcopists but not for histology at a particular laboratory.

Q: It is conceivable that one could have the same problem.

A: It is.

CHAIR INTERJECTS

CHAIR: I see in exhibit 41 page 8, you have recorded there part way down the page that whereas when the programme first began most smears within a region would have gone to laboratories within the region, there is now significant change in laboratories and they are being moved around the country.

A: That's correct.

Q: And you now, my understanding is there are only 13 community laboratories carrying out cytology work now.

A: Yes.

MS JANES: That's exactly where we were going, so let's just stay where we are.

PROFESSOR DUGGAN: It's a bit concerning that the unsatisfactory rate of the histology is almost 2% from your statistical report, exhibit 47, p29.

A: right, just let me have a look. Yes. I mean, the issue you raise of minimum volumes is an important one. I guess I've been considering how much we sort of change in one go.

Q: Some of this perhaps may be definitional, i.e. I don't know if there are uniform definitions of unsatisfactory histopathology specimens in the NZ

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laboratory practice. So one laboratory may call something satisfactory and another laboratory may call it unsatisfactory.

A: Yes.

Q: Or it may be the colposcopist didn't sample anything. So there are a variety of reasons for this?

A: Hmm.

Q: But I would be concerned about histopathology reporting.

A: Ok. Thank you.

MS JANES: Just on the laboratories, if we can stay there briefly. Can we just correlate in your brief at para 30 you've indicated that there are 27 laboratories providing services cytology and histology to the programme, but then at tab 41, p8, you indicate that there are 13 community laboratories

A: what para of my evidence?

Q: 30.

A: Yes, well 13, I was merely talking about cytology when I said 13 community laboratories undertaking cytology. That doesn't mean they don't do any histology, I was just referring to cytology.

Q: So your evidence this morning that 27 may have gone down a couple, it hasn't gone down as dramatically as 13 plus 4?

A: no, the 27 includes the hospital laboratories, some of which only read histology.

Q: Just on p8 of tab 41, if you are able to get consensus agreement on the 12000 minimum smear-reading it seems to indicate at the second para on p8 that there would be 4 laboratories that would no longer be able to provide service to the cervical screening programme, would that be correct?

A: well it would be unless they can come to some partnership agreement with another laboratory whereby there are sufficient slides transferred.

Q: is there any ideological reason that the cervical screening programme and you as its manager should be concerned about the number of laboratories providing the services as long as they met the standards – this goes back to a question asked by Madam Chair I believe much earlier as to would it be possible to centralise the reading of smears with laboratories who you were absolutely convinced were complying with all of the standards?

A: there's no ideological reason why one wouldn't move to a much smaller number of laboratories.

Q: And is there any economic reason why you would be concerned, say that a pathologist from Gisborne moved to a bigger centre in order to provide the services to that laboratory?

A: No, there's no concern about that. I think where my concern has come from is the understanding I have, and I accept that I haven't done a detailed analysis, but I've heard reasonably frequent reports of the difficulties with the cytoscreener workforce in terms of recruiting and retaining people. And that even in large centres there are shortages, so there is absolutely no ideological reason why one wouldn't move to a smaller number of laboratories but there are some other issues to consider.

CHAIR: the general trend, though, in terms of difficulties in accessing the workforce tends to be in smaller centres. I would have thought that cytoscreeners would be likely to be wanting to be living in the major centres.

A: well that's true, but I understand that there is a shortage in Auckland. Maybe it's not useful to go into it in depth since I don't have a map or anything of where all these people are, I'm just alerting you.

MS JANES: I'm trying to ascertain the relevance of that being a concern for the cervical screening programme rather than just saying we need this

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standard of service delivered. Correct me if I'm wrong, but the Ministry of Health certainly had an obligation with regard to training and workforce planning which, in 1993, disappeared essentially. Is it my understanding and is it correct that the Health Funding Authority cervical screening programme has no such constraints on it in terms of obligations to ensure sufficient and adequately trained personnel for the providers of the service?

A: When you say constraints, I'm not quite sure what you mean?

Q: Is it something that you are tasked with ensuring that there are adequate and sufficient numbers of cytoscreeners?

A: No-one has raised it with me as to being my responsibility, but that doesn't mean it isn't my responsibility, it just hasn't been brought to my attention. But I'm aware the fundamentally one cannot have a screening programme unless you have a sufficient number of cytology screeners to screen the slides, it's just not possible. So in that sense it is of concern to me.

CHAIR: is it also not of concern to you that in the Cartwright Report it was documented there, one of the concerns about having a cervical screening programme was the lack of cytoscreeners in NZ and here we are in the year 2000 and it still seems there is a lack of cytoscreeners.

A: yes, it is a concern and I have requested a person who is contracted to me to start looking into these issues and make enquiries as to what training is available and who is responsible for what so I can get a clear picture of it.

Q: and in your role, if you're given sufficient powers, would you be able to do something to ensure that there was adequate training for cytoscreeners in NZ?

A: well, if I had sufficient powers. I would need to look in to see what the situation is and where the responsibility currently lies.

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Q: well who else could do it?

A: Well I think it is the role of a National office to keep abreast of those issues. But it's just not something we've got to yet. And I'm not actually clear in the sector at the moment who is responsible for what in this regard. So I need more information.

MR HODSON: Ma'am it occurs to me that the Association of Community laboratories might be well placed to assist us in this topic if your counsel were to so enquire.

CHAIR: Yes, well is anyone representing them at the moment because I know Mr Collins is but he's not here at the moment. Is anyone keeping a watching brief for Mr Collins? Counsel assisting can perhaps do something. You could liaise with Mr Collins Mr Hindle.

PROFESSOR DUGGAN: Dr Peters, do you have the authority to make the decision to alternate screening in the event that the manpower situation cannot be rectified so that you can meet your standards?

A: I don't know that I have that power, but if I am in control of the budget for cervical screening then within our health sector if you require additional funding for a service which there is a prioritisation process one has to enter basically a budget bidding process. There is a prioritisation process for increasing funding for various services. I have to say I haven't been intimately involved in contracting so my understanding is broad.

Q: But you could bring this initiative forward?

A: Yes I could move it forward.

Q: OK.

MS JANES CONTINUES XXN

MS JANES: Just staying with that, in the National Cervical

Screening quality policy standards am I correct in assuming under chapter 7, I have actually got it on the first draft not the second draft which is tab 20 but I don't think it changed, I'm really just looking at the senior cyto technologist – page 4 of 24, tab 20, chapter 7 – it looks to me that the intention is that there, and I know there somewhere else in that document that I can't just find at the moment, where basically there has to be a pathologist who reads minimum number of 20 abnormal smears per month.

A: That actually did change.

Q: That changed?

A: Yes.

Q: Right. And then they must employ at least one senior cyto technologists which is standard 703, so under that standard of training and staff, it would be an impossibility to have a sole pathologist laboratory such as the Gisborne laboratory situation where you had Dr Bottrill as primary screener and secondary and tertiary screener.

A: Yes it would be.

Q: And has that standard been developed as a result of concerns about sole pathologist or just as best practice?

A: I think just as best practice but I think the minimum volume that we established took into account the information we had that from the research we could find about the better accuracy of reading in a collaborative environment where there were a number of staff.

CHAIR INTERJECTS

CHAIR: This research is it relatively new or is this view that a collaborative environment and where more persons are employed is likely to lead to more accuracy in smear-reading been around for some time?

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A: I think the paper was published in the 1990's – 1993.

Q: What exhibit is that.

A: We have referred to it in exhibit 41.

Q: Did it surprise you when the programme came into the Health Funding Authority and you took on the role of manager that there would be no attempt earlier on in the programme to impose a minimum standard of how many smears were read by a cyto screener or a pathologist?

A: I don't think I was surprised or not surprised because I think to be honest I wasn't particularly expert in this area at all when I took on the job.

MS JANES CONTINUES XXN

MS JANES: You indicate at paragraph 125 of your brief that when you came in there were no national quality standards. Were you aware of the ones developed by the joint Regional Health Authority laboratory group for laboratories generally rather than just specifically for national cervical screening programmes?

A: No I wasn't but I think I became familiar with what we had available for the Breast Screening Programme and then as we analysed the Cervical Screening Programme because aware that those things were not in place.

Q: Would it be fair to say that throughout your brief you indicate almost as a reference point the Breast Screening Programme model as being one that is being worthy of following, is that your sense.

A: It's clearly not that, it has problems.

Q: I wasn't going to score that.

A: I think the structure is being more actively planned and I think of course in some ways it's easier because all components, well not all components are delivered from a central site, but it is more contained and

you don't have 6,000 smear-takers for example, there just aren't so many providers so in some ways it is easier to have a more simple model I guess.

Q: Are you surprised that no-one referred the Sylvia Sacs draft quality or national quality standards to you given that it had been two years in the development phase and had still not been implemented, is that not something that should have been passed to you in order that you could at least have a starting block in quality and then work from there to the Rolls Royce model if you like.

A: Possibly it should have been but I think in reality the Health Funding Authority was a new organisation, there were lots of new people trying to establish themselves in new roles and it was quite a difficult restructuring and so I think a lot of things that possibility should have happened didn't happen.

Q: So essentially not being aware of those particular standards that had been through a great consultation process, you understood that you had to start from the ground up and developed these quality standards?

A: Yes we did but I think we may have had to have done that anyway because our standards needed to be a lot more specific to the service we were thinking of.

Q: Would it have made it easier to know that laboratories were compelled to comply with a set of standards albeit that they were generic rather than specific to the National Cervical Screening Programme but at least there were issues like accreditation and external participation and quality control and internal quality control, a lot of that basic foundation work that would have ensured a level of comfort while you went on to develop more specific objectives or standards?

A: I think if we had known that we might not have felt quite so pressured

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but I still think we would have felt the need to do the work anyway.

Q: My concern, and it's certainly not leveled at you, but through the inquiry we have seen a lot of excellent documentation we have seen quality standards and draft this and draft that and if I may use the analogy of, you know, it's like a car race where you start off with something that's serviceable but you have to keep working on it and by the time you've got the Rolls Royce the race is run and you know it's over. It seems a little bit like a lot of excellent thought has gone into the programme there has been no shortage of good quality standards and documentation but every time we say has it been implemented there always seems to be an obstacle towards that. Now I understand however from your evidence that this is being monitored against now is that correct?

A: Yes, Dr McGoogan made the point that screening programmes need quality standards for each step of the screening pathway and although I agree there is a lot of documentation I don't believe they have ever been developed for each step of the screening pathway in New Zealand before now.

Q: And certainly looking at this, this addresses, as far as I can see, a lot of the concerns from previous expert groups as to what was required. When is it expected that this will be tied down, into contracts, and therefore we can breath a sigh of relief and say it is in the pipeline.

A: Hopefully by the end of the year.

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CHAIR INTERJECTS

CHAIR: Did it surprise you Dr Peters when you inherited the screening programme that although in the past there had been attention to many attempts at introducing standards etc. that in fact there were no quality standards set for every step of the programme given that it had been implemented in 1990?

A: As I said before I think when I took over this job I wasn't really aware of what there should be but, as time has gone on, I've become aware that that is a fundamental requirement.

CHAIR: Well, with the benefit of hindsight and your knowledge of looking at the UK experience, looking back now at what you inherited, does it surprise you that at the time you inherited the programme there were no quality standards set for each step of the programme?

A: Yes it does, but given the structure and the restructuring there've been and the divided roles and responsibilities I can see how that has happened.

Q: when you say "given the structure", what do you mean by that?

A: Well, the fact that national co-ordination is divorced really from the RHAs that did the funding so completely, whereas even though my office or team does not have a funding role we are close to where the funding occurs. We are physically close to that. And the fact that co-ordination was in public health while funding was in personal health. Again, even though we still have that division, we are physically closer to where that funding occurs.

Q: Is there a danger that, particularly if you don't get funding control yourself, because the programme is based in Auckland where the bulk of the Ministry is based in Wellington, that that will see you become isolated and

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therefore your influence weakened.

A: Well I've been assured that I will have funding control, and I guess that's a possibility, but I'm in Auckland now and we travel to Wellington a lot.

Q: So you don't think the physical location will make any difference?

A: I don't think so. I mean, it does, I guess, require a little more effort

Q: where was the Health Funding Authority located?

A: The Health Funding Authority has 5 offices, it's a decentralised National organisation.

Thank you.

PROFESSOR DUGGAN: Dr Peters, as we're on the item of quality control of every step in the screening pathway, I note in your document policy and quality standards there is not a segment on the information system.

A: We know that's one that we need to develop, yes, that is correct.

Q: so there will be a whole chapter 7 will be –

A: Are you on tab 40?

Q: 40, yes.

A: Yes. The register sites do have manuals and protocols that they work to so there is not no quality control, but I think some work we have done would suggest there are inconsistencies which do need to be addressed and that's something we will be looking at.

Q: And consideration will be given to such standards as the turnaround time for the delivery of information and previous encounters to the providers and so on?

A: Yes.

MS JANES: are there similar protocols in terms of the information management systems for both of the screening programmes at the moment?

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Or are they separate protocols?

A: oh no, they are completely separate.

Q: So there's no possibility of inputting errors or there at least are audits of inputting errors and other errors through that data entry phase for the cervical screening programme?

A: I think if you looked at the system critically, where there's data entry there's clearly room for error. The register sites are totally dependent on the quality of the information they receive from smear-takers and the laboratory and the accuracy of that, and to my knowledge there has been no formal audit of the accuracy of that information.

Q: Is that something that would be looked at. I know there are many authorities, but is that something that could be looked at?

A: I think quality control of data is something that is another issue.

Q: Particularly when so much reliance is placed on them.

A: that is right. It is something we would expect laboratories to have quality control of their data entry and the data they provide to the Register. We also need to make sure we've got quality control processes in place to ensure that we are inputting data correctly.

Q: and that's something that will be put into the work plan in the future?

A: Yes.

Q: Just while we are looking at the screening pathway, this is tab 40, chapter 4, p4.26, were you present when the women gave evidence?

A: Yes, I was.

Q: the issue I just want to discuss with you very briefly is standard 412 and specifically the section under that same women with signs and symptoms, and I don't know if you were here also when Dr Boyd gave his evidence, but essentially it was a golden rule that signs and symptoms took precedence

over any cervical screening result because it's not a diagnostic test.

A: Yes.

Q: How is that particular standard that any woman with any visible abnormality should be sent for further investigation? Is there any steps being taken by the cervical screening team to ensure that that message gets through to smear-takers, clinicians?

A: We have repeated it in many parts of this document because we want to be sure that that message is up there loud and clear, but we will also be developing easy to use material for smear-takers and also new information for women and it is certainly a message that we will want to be repeating.

Q: You also indicated in your evidence that you had a training event this year; is that a forum that this could be hammered home on a regular basis?

A: Yes, it is.

Q: Were you concerned as you listened to the evidence of the women to see how clearly in quite a few of the cases this was a standard that did not appear to be adhered to at the clinical treatment level, where great reliance was placed on the results of normal?

A: yes, to be honest I was. I guess without every aspect of a woman's history in front of you, and knowing exactly what has happened, it's difficult always to be sure what has happened because you are hearing, but I was concerned that it did seem to be ignored, yes.

Q: do you think it's an advantage having someone like yourself with a medical background heading the programme so that these types of issues can perhaps be conveyed with more weight because of the medical knowledge?

A: I don't think the person leading the programme has to be a Dr. I mean, clearly Julietta Patnick? in the UK is not a Dr, the non-medical manager, but certainly I think it's an advantage to me. And I've got a reasonably lengthy

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background in clinical medicine so I do understand some of these issues.

Q: Just very briefly: Accreditation is one of the issues that you have to report on in the quarter this coming September. You gave in your evidence that you believed that all laboratories currently were accredited, but in order to fulfil that reporting requirement under the funding agreement what steps will the Health Funding Authority/Minister of Health take at the appropriate time to ensure that they are all accredited?

A: this is a joint public health/personal health measure, although we are leading it. We will need to – I mean, I have been assured by my personal health colleagues that all laboratories participating in the programme are accredited but we will obviously need to have that documented.

Q: And will you seek that directly from IANZ at that point?

A: I haven't considered how we would do that.

Q: Would that seem to be an appropriate way.

A: I'm not sure that we can seek it from IANZ, we may need to seek it from the laboratories themselves.

Q: You may find that when IANZ gives evidence that that will solve your problem.

INQUIRY ADJOURNS UNTIL 9:30 A.M. TOMORROW MORNING,
THURSDAY 6TH JULY