

**UNDER THE HEALTH AND DISABILITY  
SERVICES ACT 1993**

**IN THE MATTER OF THE MINISTERIAL INQUIRY  
INTO THE UNDER-REPORTING OF CERVICAL  
SMEAR ABNORMALITIES**

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**EVIDENCE OF GEORGE ROBERT BOYD**

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**MINISTRY OF HEALTH**

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I, **GEORGE ROBERT BOYD** of Wellington say:

### **PROFESSIONAL QUALIFICATIONS AND EXPERIENCE**

1. My name is George Robert Boyd. I live in Wellington. I have been a registered medical practitioner since 1964 and I am currently vocationally registered with the Medical Council of New Zealand in the specialities of General Practice and Public Health Medicine.
2. I am employed by the Ministry of Health as Chief Advisor, Safety and Regulation and National Medical Officer of Health. I have held this position since 1997. Since joining the then Department of Health in 1980 as Assistant Director of the Clinical Services Division (1980-81); I have held the positions of Deputy Director (1981-86) and Director of that Division (1986-87); Manager of the Primary Health Care Programme (1987-90); Manager of the Therapeutics Section (1990-96); Assistant General Manager of the Implementation Group (1996-97) and Acting Director of Public Health during 1999.
3. From 1991 to 1999 I spent between three to six weeks each year in my vacation as a locum general practitioner in the Rangitikei, which included counselling women about the National Cervical Screening Programme, taking cervical smears and discussing women's results with them.
4. Immediately before joining the Department I was a partner in an Auckland general practice, President of the North Shore Division of the New Zealand Medical Association (NZMA), Convenor of the NZMA Maternity Benefit Negotiating Committee and, for four years until 1980, a member of the Medical Practitioners Disciplinary Committee.
5. Until 1987 the Clinical Services Division administered health benefits under the Social Security Act 1964, developed policy on primary health care and non-hospital specialist services such as laboratories, and

employed general practitioners to work in special areas (isolated rural localities). The Division also published a newsletter which was sent to all medical practitioners (Clinical Services Letter). Health benefits administered by the Division included the Laboratory Diagnostic Benefits under the Laboratory Diagnostic Benefits Regulations 1981. These are explained later in my evidence. Other health benefits administered by the Division included the Pharmaceuticals Benefit, the General Medical Services Benefit covering General Practitioners and Practice Nurses, Radiology and specialists' benefits. In the year ended 31 March 1987, these benefits totalled \$636 million, of which I estimate laboratory benefits comprised 8 percent of the expenditure.

6. The primary health care policy then became the responsibility of the Primary Health Care Programme until early in 1990. This included cervical screening initially, until a separate National Cervical Screening Implementation Group was established in 1989. Thus my direct involvement has been limited to the cervical screening programme initiatives under way prior to, and at the very early stages following, the publication of the Report of the Inquiry into Allegations Concerning the Treatment of Cervical Cancer at National Women's Hospital and into Other Related Issues ("the Cartwright Inquiry"). More particularly relevant to this Inquiry is my role as manager of Laboratories Benefits. At that time, quality issues generally arose and were dealt with according to the method of payment employed. I rely largely on the Ministry's documents to inform the evidence after 1989.

## **INTRODUCTION**

7. My evidence is in two parts. The first part is introductory and outlines the screening process and the early stages of the development of a national screening programme. The second outline the policy framework for the competencies and quality control of service providers at the relevant time and outlines the quality control process in place for laboratories at the

different times. The second part should be considered in the broader context provided by the evidence of Judy Glackin.

## **SCREENING PROGRAMMES GENERALLY**

### **“Population-based”**

8. While the idea of testing a group of individuals to separate out those who are well from those who have an undiagnosed disease or condition appears simple, population-based screening programmes are among the most complex interventions to implement. There are many components to a programme such as a national cervical screening programme. Population-based screening programmes target a large section of the population to identify those likely to have the disease. There are few diseases or conditions which are suitable for such large-scale screening. The World Health Organization has established the following criteria for a screening programme:

- 8.1 The condition should pose an important health problem.
- 8.2 The natural history of the disease should be well understood.
- 8.3 There should be a recognisable early stage.
- 8.4 Treatment of the disease at an early stage should be of more benefit than treatment started at a later stage.
- 8.5 There should be a suitable test.
- 8.6 The test should be acceptable to the population.
- 8.7 There should be adequate facilities for the diagnosis and treatment of abnormalities detected.
- 8.8 For diseases of insidious onset, screening should be repeated at intervals determined by the natural history of the disease.

8.9 The chance of physical or psychological harm to those screened should be less than the chance of benefit.

8.10 The cost of a screening programme should be balanced against the benefit it provides.

[Source: Forrest, P 1989: Breast Cancer Screening: Report of a working group. United Kingdom: Department of Health and Social Security]

9. Such a programme needs to define its objectives and define its target population. There needs to be:

9.1 a competent workforce to obtain the specimen to be tested;

9.2 a laboratory infrastructure to process the test and a specialised workforce to interpret it;

9.3 systems in place to record results and to recall the population being screened at appropriate times. In the case of negative results (i.e. no indications of disease) this should be done at regular intervals. In the case of positive results (i.e. evidence of disease), systems need to ensure that diagnosis is confirmed and appropriate treatment has been carried out. When the result is uncertain or the specimen inadequate there should be an effective system of recall. An information system that records this, and enables monitoring of these processes is an essential part of the screening programme. Population-based screening programmes are generally dependent upon on the professional competence of the health professionals involved, but must also contain quality processes such as national standards and monitoring of outcomes.

10. The targeted population has to be recruited to participate in the programme. This can be through health promotion campaigns or through personal invitations. At the same time the targeted population has to be informed that no screening programme is perfect but that through participation, people play their part in limiting the adverse consequences of

the disease. Even though there is individual benefit, the reductions in the number of deaths and preventable disease are measured as an effect on the whole eligible population. Most screening programmes require a high level of participation from the eligible population for a measurable effect in reducing the rate of deaths or disease.

### **Characteristics of screening**

11. Screening was defined in 1951 by the US Commission on Chronic Illness as:

“The presumptive identification of unrecognised disease or defect by the application of tests, examinations or other procedures which can be applied rapidly. Screening tests sort out apparently well persons who probably have a disease from those who probably do not. A screening test is not intended to be diagnostic. Persons with positive or suspicious findings must be referred to their physicians for diagnosis and treatment.”

12. The characteristics of a test to be used in screening include:
  - 12.1 Accuracy: the probability that the result represents the true condition;
  - 12.2 Reproducibility: a high probability that another qualified person will come to the same conclusion on viewing the sample;
  - 12.3 Sensitivity: the probability that a person having the disease will be correctly diagnosed. Numerically this is represented by the number of true positives divided by the number of true positives plus false negatives;
  - 12.4 Specificity: the probability that a person not having the disease will be correctly identified. Numerically this is represented by the number of true negatives divided by the number of true negatives plus false positives; and
  - 12.5 Validity: the extent to which the test measures what it purports to measure.

[ Reference: Dorland's Medical Dictionary, 1994]

### **“Opportunistic” screening compared with population-based screening**

13. Opportunistic screening is an approach to screening that exploits the opportunity presented by the patient consulting his or her doctor to undertake a screening test. It is not a systemised approach to screening a population group at risk from the disease. The benefit is to the individual being screened.
14. Systemised population-based screening is undertaken in an identified eligible population group, usually involving large numbers of people. The benefit is to the whole of the population group, and is measured by a reduction in incidence of overt signs of the disease being screened for (i.e. morbidity) and deaths attributed to that disease (i.e. mortality). Because screening by definition is carried out in a population which is basically healthy, as much care as possible must be taken to see that the benefits of screening outweigh the possible harm at all times.

### **World Health Organization criteria for successful screening programmes**

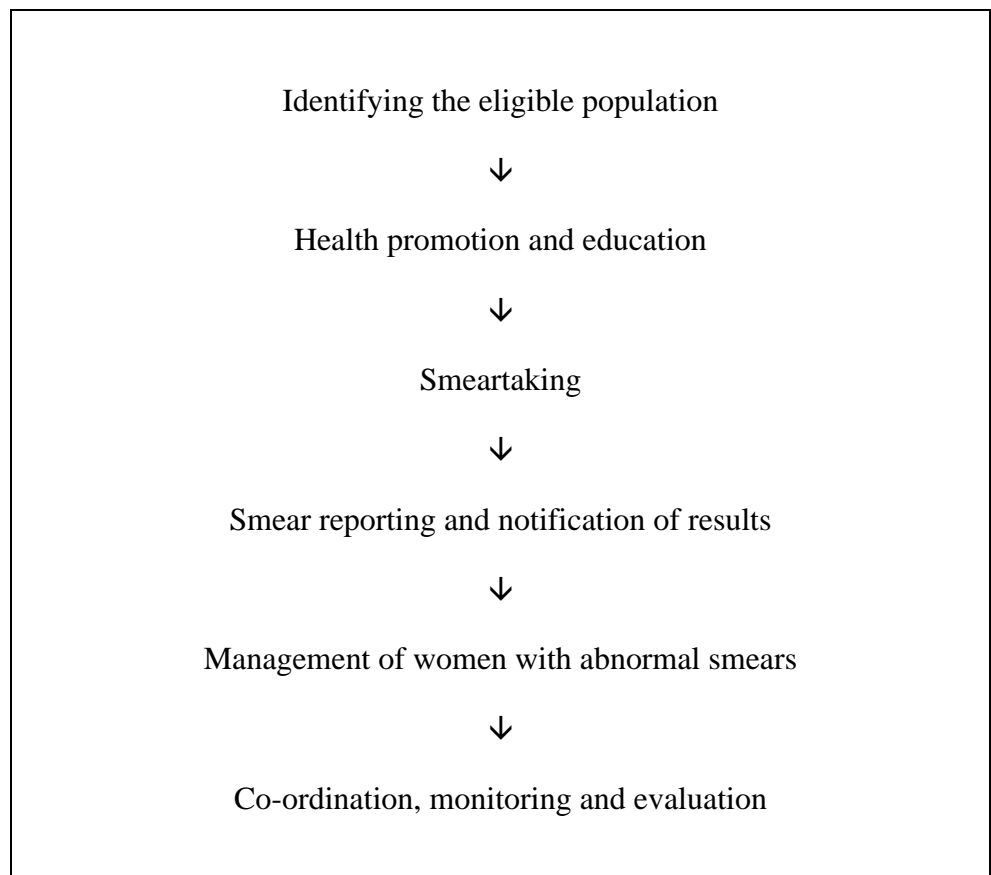
15. As well as the criteria for establishing a screening programme referred to previously, the World Health Organization has also developed criteria for the organisational requirements of population-based screening programmes. These are internationally accepted and have been used as a guide to the development of cervical screening and other screening programmes internationally and in New Zealand.
16. The key organisational requirements identified by the World Health Organization for a successful screening programme include:
  - 16.1 a central office or individual responsible for planning, co-ordinating and evaluating the programme;
  - 16.2 an agreed policy and set of objectives for the programme, against which to measure the programme;
  - 16.3 computer-based information systems;

- 16.4 extensive continuing coverage of the eligible population;
- 16.5 quality control of both the sample-taking and the sample-reading;  
and
- 16.6 measures to ensure that those with abnormal results are followed  
up and treated.

[Lunt, 1984]

### Screening pathways

17. The following screening pathway diagram describes the key organisational components of a population-based screening programme. It is taken from the National Cervical Screening Programme (NCSP) policy document of 1996. This document also contains the glossary of terms as used within the NCSP. These are the definitions which will be used throughout the Ministry's evidence from this point on. I produce this as document **GRB/MOH/0001**.



## SCREENING FOR CANCER OF THE CERVIX

### Cancer of the cervix: medical terms

18. At the inception of the NCSP it was postulated that roughly one in 100 New Zealand women develop cancer of the cervix. Prior to 1992, around 250 new cases and 100 deaths were reported annually.
  
19. There are two main types of cervical cancer:
  - 19.1 **Squamous cell cancer** accounts for around 90 percent of cases of cervical cancer. It arises from abnormal cell development in the transformation zone of the cervix, usually taking two to fifteen years to develop into invasive cancer. Abnormal cell growth on the surface of the cervix, known medically as **cervical intraepithelial neoplasia (CIN)**, goes through a number of stages. There are low grade (mild) or high grade (more severe) forms. Low grade abnormalities often revert to normal over time and high grade abnormalities do not always develop into cervical cancer. Illustrations showing the transformation zone and stages of abnormal cell development can be found in *Cervical Screening: Information for Health Professionals*. (Health Funding Authority. 1998. pp.29-31.) These pages are produced as document **GRB/MOH/0002**.
  
  - 19.2 **Adenocarcinoma (glandular cell cancer)** accounts for around 10 percent of cases. It arises from endocervical cells, is much faster developing than squamous cell cancer, and is more difficult to detect by screening because the cells are more likely to be hidden inside the cervical canal.
  
20. **Cervical intraepithelial neoplasia (CIN)** is the medical term given to abnormal growth in the surface cells of the cervix. There are low grade (mild) or high grade (more severe) forms.

20.1 **Low-grade Squamous Intraepithelial Lesion (LSIL):**

CIN 1 mild and/or changes related to human papillomavirus (HPV) infection.

20.2 **High-grade Squamous Intraepithelial Lesion (HSIL):**

CIN 2 moderate.

CIN3 severe/carcinoma-in-situ - the most severe pre-cancerous lesion.

**Diagnosing cervical cancer**

21. Diagnosis of cancer of the cervix and its precursor lesions by examining cells removed from the female genital tract became possible following the publication in 1943 of a paper by Dr George Papanicolaou of the United States.
22. Detecting the lesions on the cervix which are accepted as precursors of cervical cancer allows treatment at an early stage of the disease and so reduces the overall mortality rate from squamous cell cancer of the cervix. This will only be effective in the population as a whole if:
  - 22.1 sufficient women are induced to have the examination;
  - 22.2 it is repeated often enough;
  - 22.3 the collection of cells is optimal for representing the normal and abnormal cell population on the cervix at each examination;
  - 22.4 the specimen is adequately prepared for cytological examination;
  - 22.5 the specimen is correctly interpreted; and
  - 22.6 the information is relayed to the woman in such a way that she is encouraged to attend a follow-up referral.
23. Several methods of reporting on cervical cytology have been in use, starting with Papanicolaou's own system, a World Health Organization's

system and the CIN system referred to previously. In December 1988 a meeting convened at the US National Institutes of Health in Bethesda, Maryland came up with a system of reporting which has been adopted world-wide under the title “Bethesda system”. This system is discussed by the Council on Scientific Affairs of the American Medical Association. [JAMA. 1989; 262:1672-1679]. I produce this article as **GRB/MOH/0003**.

24. This system includes statements on the adequacy of the specimen and descriptive diagnoses including infection, evidence of cellular reaction or repair, epithelial cell abnormalities, non-epithelial cell cancerous changes and hormonal changes. Quite early after its development this system was recommended for adoption by New Zealand laboratories and had been a part of the NCSP since its inception. The Bethesda system was revised in 1991 in the USA and this new version was slightly modified for use in the New Zealand programme in 1993 following a meeting of private and public laboratory representatives convened by the NCSP.
25. I produce a bundle of documents from the Ministry files which provides a chronological history of the use and modification of the Bethesda code in the NCSP. It begins with an undated memo from the pathologists at the laboratory of the Chairman of Cytology Advisory Liaison Committee and finishes with a publication from the NCSP Register dated 30 April 1993 describing the modified 1991 code and how it was to be used in laboratories in New Zealand: **GRB/MOH/0004**.

### **Risk factors associated with cervical cancer**

26. The causes of cervical cancer are uncertain, although a number of risk factors have been associated with cervical cancer. These are the human papillomavirus (HPV); sexual behaviour; and smoking. Immunosuppression is a further identified risk factor.

26.1 **Human papillomavirus (HPV)** has been linked to cervical cancer. However, it has also been found that HPV infection is common among young women with normal cervical smears and that there is

a small minority of cervical cancers unrelated to HPV. It is thought that there may be other factors, as yet undefined, that determine which women with HPV go on to develop cervical abnormalities.

- 26.2 **Sexual behaviour:** Studies suggest that the risk of cervical cancer and pre-cancerous changes is increased among women who begin sexual intercourse at earlier age and who have had multiple sexual partners, and whose partners have had multiple partners.
- 26.3 **Smoking:** A review of smoking and cervical cancer found women who smoke cigarettes have an increased risk of developing cervical cancer. Evidence suggest smoking facilitates the infection and aids persistence of HPV, as well as having a direct effect by causing modification of DNA in cervical epithelium.
- 26.4 **Immunosuppression:** One further risk factor in the development of cervical cancer that has been identified is immunosuppression. In New Zealand, this is most commonly related to the use of medicines to suppress the immune system in certain medical conditions, such as the prevention of organ-rejection following an organ transplant.

### **Strategies for reducing the incidence of invasive cervical cancer**

27. There are several strategies identified for reducing the incidence of invasive cervical cancer. These are:
- 27.1 **Cervical screening:** As noted previously, cells in the cervix go through various degrees of abnormality before they become cancerous. A cervical smear test can detect abnormal cell changes which are precursors of cervical cancer. If abnormalities are detected they can be readily treated. The success rate for adequate treatment of pre-cancers is 98 to 100 percent. Cervical screening is considered the most important strategy in reducing the morbidity and mortality from invasive cervical cancer.

- 27.2 **Safer sex (the use of barrier contraceptive methods):** Since sexual intercourse is the main way of transmitting HPV, barrier contraception methods offer some protection against transmission. The promotion of safer sexual practices may reduce the risk of developing cervical cancer.
- 27.3 **Reducing smoking:** Smoking has been identified as a risk factor. Policies and strategies to reduce smoking rates may help to reduce the risk of cervical cancer.

#### **THE DEVELOPMENT OF CERVICAL SCREENING IN NEW ZEALAND: 1960s TO APRIL 1989**

28. My evidence relates to the period before April 1989 while I had some responsibilities for cervical screening and laboratory services. The chronology is picked up from that point by Judy Glackin in her evidence.

#### **Early stages**

29. There are references in Ministry files to trials of cervical screening in Thames and Wanganui commencing in 1962. They continued until around 1965 when they began to fade due to divided medical opinion on the effectiveness of cervical screening. This was followed by over 10 years of opportunistic screening when cervical smears were taken as part of routine antenatal or postnatal care, family planning or visits to the general practitioner or hospital outpatients clinics (i.e. when the opportunity arose). This history was given in a report commissioned in September 1988 by the Department of Health from Azimuth Systems Limited and published in November 1988 on the establishment of a nationally co-ordinated New Zealand cervical screening programme. I was closely involved with the authors as they developed their report and I consider it reflects the Department's thinking at that time (produced as document **GRB/MOH/ 0012** later in this evidence).

30. During the 1970s there are references to cervical smears in a Department of Health publication series, the Clinical Services Letter (CSL). This publication was prepared on behalf of the Department of Health by the Clinical Services Division and was distributed to all medical practitioners.
31. The first reference was in 1971 in a list of laboratory tests for which a payment would be made to recognised pathologists pursuant to the Social Security Act 1964. A copy of the Clinical Services Letter No. 106, dated 10 April 1971 is produced as **GRB/MOH/0005**. The cytological examination of cervical smears attracted a fee of \$1.50 per case. My assumption from this wording is that even in 1971 some practitioners were sending more than one specimen from a cervical smear consultation to the laboratory, but that the Department would pay the same fee whether there was one or more than one specimen.
32. In 1977 the Department published guidelines for the frequency of taking smears. A copy of the Clinical Services Letter No. 163, dated 14 January 1977 is produced as **GRB/MOH/0006**.

#### **The Skegg Guidelines and subsequent meeting**

33. In 1985 a working party convened by the Department of Health and the Cancer Society and chaired by Prof. David Skegg of Otago University published updated guidelines in the New Zealand Medical Journal. *The Skegg Report* New Zealand Medical Journal, 1985: 98:636-39 is produced as **GRB/MOH/0007**. These were the subject of a meeting called by the Department and the Society in November 1985. I produce a copy of the Proceedings of the meeting as **GRB/MOH/0008**.
34. The meeting participants included pathologists, representatives of the NZ Society for Colposcopy and Cervical Pathology, general practitioners, Cancer Society, consumer groups, Ministry of Women's Affairs, Medical Advisors from the Department of Health, NZ Society of Cytologists, and health education advisors.

35. The discussion at the time referred to the results of mathematical modeling which predicted a sharp increase of cervical cancer in women born after 1935. This had already been observed in Australia and the United Kingdom. Furthermore, good evidence had been established for the effectiveness of cervical screening as a preventive measure. This evidence was in contrast to the prevailing opinion of the 1970s when effectiveness of cervical screening was controversial.
36. While Prof. Skegg et al in their published guidelines focused mainly on improving the coverage of screening and describing the screening intervals, the meeting took a wider view. It considered the following:
  - 36.1 how to set up an effective national programme;
  - 36.2 how to improve facilities for screening;
  - 36.3 how to improve quality control of smears;
  - 36.4 how to improve facilities for diagnosis and treatment; and
  - 36.5 ways of evaluating and monitoring the programme.
37. Several general practitioners at the meeting described the use of patient registers in their practice to invite women to have cervical smears and to recall them for repeat examinations.
38. The meeting recommended evaluation of the existing pilot studies, exploration of cultural differences in attitudes to screening, expansion of colposcopy services and better promotion of cervical screening, with the aim of designing a national screening programme by 1989.
39. In a specific reference to quality control in laboratories the meeting recommended attracting more people to become competent smear-readers (cytologists) by better remuneration, career structures and training. It also recommended that each laboratory should develop its own quality control by examining each abnormal smear at least twice by two different people of differing seniority, and by establishing close links with treatment groups

so that biopsies obtained at colposcopy may be reviewed by the same laboratory group that examined the original smear.

40. Following the publication of the proceedings, the Cancer Society continued its pilot studies in the Waikato and Otago. More medical practices developed patient registers and recall systems which were used for sending reminders to patients to attend for cervical smears, and immunisations. These patient registers (also known as age/sex registers) were becoming more prevalent as general practices became computerised and as more practices switched to a “capitation” form of payment. A practice receiving capitation was paid its government subsidy monthly based on the number of registered patients, rather than having to claim for each service provided. An evaluation of the Otago pilot study is produced as document **GRB/MOH/0009**.
41. In 1987 the Department of Health Primary Health Care Programme facilitated the development of some pilot sites for offering cervical screening to lower-income women from the Primary Health Care Initiatives Fund. These pilot studies in Nelson, Kawerau and Wanganui all had evaluations built into the project. Also funding was provided for an Oamaru-based project establishing a common recall register for all the local general practices.

### **The Cartwright Inquiry**

42. The Inquiry into Allegations Concerning the Treatment of Cervical Cancer at National Women’s Hospital and into Other Related Matters (Cartwright Inquiry) began in June 1987. The Inquiry was set up following the publication of an article by Phillida Bunkle and Sandra Coney in Metro Magazine. The Inquiry looked into the treatment of a group of women who had precancerous conditions of the cervix, yet who were not treated for the disease but “monitored” over a twenty-two year period. In that time twenty-six of the women died.
43. In August 1988 the report of the Cervical Cancer Inquiry by Judge Cartwright included a wide range of recommendations covering treatment

protocols for gynaecological disease, ethical assessment for research, patients rights and the need for advocacy, revisions of medical disciplinary procedures and improvements in teaching practices. The Inquiry also recommended the urgent establishment of a nationally planned, population-based cervical screening programme. A summary of the recommendations made by Judge Cartwright can be found in *Women's Health: What Needs to Change: A Summary of the Recommendations of the Cervical Cancer Inquiry and a Practical Guide to Action*, published by the Ministry of Women's Affairs, which I produce later in my evidence as **GRB/MOH/0015**.

44. Immediately after Judge Cartwright made her recommendations the Minister of Health, Hon David Caygill, stated the Government's commitment to cervical screening and its intention to have a nationally co-ordinated, population-based screening programme operational by mid 1989. This was well reported in the media at the time. In September 1988 the Minister and the Director-General of Health met with the Chairs of Hospital Boards and Area Health Boards (the transfer of functions from Hospital Boards to Area Health Boards did not occur simultaneously in all areas) to discuss the implications of the Cartwright report. A background paper for the meeting was provided by the Department. A copy, entitled *Towards a More Effective Cervical Screening Service for Women in New Zealand*, is produced as **GRB/MOH/0010**.
45. The meeting agreed that a national population-based cervical cancer screening programme would not be beyond the Department's and Boards' resources if good use could be made of community facilities, training were provided and colposcopy services were made more efficient. The Department would provide national co-ordination and the boards would each provide one person to co-ordinate the regional aspects of the programme. A copy of notes of that meeting dated 9 September 1988 is produced as **GRB/MOH/0011**.
46. Also in September 1988, the Department of Health sought a proposal from Azimuth Systems Limited, Systems Consultants, to define the

requirements of a nationally co-ordinated New Zealand Cervical Screening Programme. This included a detailed functional specification for a computer system to support the management of the programme. Azimuth reported in November. I have referred to this report earlier in my evidence and I now produce a copy as **GRB/MOH/0012**.

47. In December 1988 the Department arranged a workshop for approximately 100 people broadly representative of the groups and organisations concerned with the provision of an appropriate cervical screening service (“the Workshop”). The objectives of the Workshop were to:
- 47.1 provide information relating to the current rationale of the National Cervical Screening Programme (NCSP);
  - 47.2 provide details on the current stage of development of the NCSP;
  - 47.3 identify the values and principles upon which to base the next steps;
  - 47.4 seek agreement on the priorities for the next steps including identification of specific needs in terms of personnel resources, and the timetable;
  - 47.5 seek specific recommendations to go forward from the Workshop; and
  - 47.6 seek agreement on the procedures for setting up a steering committee.
48. The report from the Workshop took the form of the outcomes of small group discussions, recommendations from a plenary session, a report from the Maori Women’s workshop, a report on the needs of Pacific women and an information package on cervical screening from the Ministry of Women’s Affairs. I produce a copy of what is called the *Draft Report of the National Cervical Screening Workshop*, 6-8 December 1988 as **GRB/MOH/0013**.

49. A meeting was held between the Minister of Health and officials to discuss the Workshop's recommendations on 15 December 1988. The Minister did not support the Workshop recommendation of a "free" service at point of contact. The Minister wanted any further announcement on the outcomes of the Workshop to await funding decisions. He did not accept the Workshop's recommendations of control by an executive group, nor two National Co-ordinators. Planning of the next stage of the programme was to proceed on the basis of the decisions at that meeting which are attached to a memorandum. I produce a copy of the Workshop recommendations and minutes of the meeting on 15 December, which are attached to a memorandum to the Minister dated 20 December 1988, as **GRB/MOH/0014**.
50. One month after the Workshop the Ministry of Women's Affairs published a booklet giving a practical guide to action on cervical screening called *Women's Health, What Needs to Change*, referred to earlier I now produce a copy as **GRB/MOH/0015**.
51. In April 1989 the Department of Health established a National Cervical Screening Implementation Unit outside the Primary Health Care Programme for which I was responsible. The chronology of the programme developed by that Unit will be covered later in the Ministry's evidence by Judy Glackin.

## **POLICY ON SERVICE PROVIDERS**

52. This section of the evidence covers the policy issues for the Department of Health, later the Ministry of Health, relating to the various health care providers involved in cervical screening. The principal message from this section is that the NCSP was superimposed on to an existing system of service delivery in which the Government subsidised services provided to patients and in which quality and safety depended on the professional integrity of the provider (usually a doctor).

53. In dealing with each of the providers chronologically there will necessarily be some duplication in the evidence because advice could come from the same source which dealt with several topics at the same meeting.

#### **Method of payment for services**

54. One of the most significant factors determining how health services are delivered in New Zealand has been the level of government contribution towards the cost of providing each individual service. Because this impacts on each of the clinical components of cervical screening it will be dealt with first.
55. Unless there is specific reference in the evidence to some other method of payment, the government contribution towards clinical services relating to cervical screening in the period covered by the Inquiry was provided for under Part II of the Social Security Act 1964 until the Act and its associated regulations were repealed and replaced by the Health and Disability Services Act 1993.
56. Publicly owned services, i.e. those provided by hospital boards, area health boards (AHBs) and crown health enterprises (CHEs), were bulk funded. In the most part, private practitioners or private laboratories were paid a subsidy on a “per service” basis. The level of subsidy under the Social Security Act was set nationally by Cabinet through amendment to the regulatory regime. It usually followed negotiation with representatives of the professional group providing the service.
57. These subsidies were usually referred to as “health benefits” and for the most part general practitioners were entitled to charge a fee over and above the amount of the subsidy. Pathologists in private laboratories had to accept the government subsidy or “benefit”, in full satisfaction for any services included in the schedule of laboratory tests published by the Department of Health. I understand this prohibition on charging an extra

fee continues to this day under the HFA contracting system. Laboratories can only charge for services not included on the schedule, for example, tests for travel, employment and insurance purposes.

58. Government policy around the provision of services outside of hospitals, including the quality of the services, up until the formation of the regional health authorities, was primarily focused around those that were subsidised. Subsidies were almost universally paid to a named registered medical practitioner (for example, a pathologist), even when the service was provided in a laboratory by a cytologist or cyto-technologist, or from a clinic or when the subsidy related to services provided by a practice nurse. The expectation was of appropriate supervision by the responsible named practitioner. So, for example, the head pathologist at a laboratory received payment for services at that laboratory. He or she was looked to to ensure adequate service.
59. Advice on the general administration of health benefits under Part II of the Social Security Act 1964 was obtained from a series of Ministerial advisory committees comprising representatives of the professional groups receiving the benefit payments and chaired by a senior officer of the Department.
60. One of these committees was the Laboratory Services Advisory Committee (LSAC) which, among other aspects of the Laboratory Diagnostic Services Benefit, advised on its administration and on adding new tests to the schedule of subsidised tests. Complaints about the quality of service at a laboratory which came to the notice of the Department could be taken to this committee for advice. They could also be referred to the Medical Council as a complaint against the supervising pathologist. I am unable to locate any terms of reference for this Committee. However, I produce a letter from the chair of the Committee in 1967 to a new appointee setting out the functions of the committee as **GRB/MOH/0016**.

*Payments to laboratories for cervical smear examinations by non-medical smertakers*

61. In 1987, prior to the inception of the NCSP, the Government, in order to promote the access of women to the cervical smear examination, removed one of the barriers to non-medical smertakers by amending the Social Security (Laboratory Diagnostic Services) Regulations 1981.
62. Traditionally, smear examinations were provided by general practitioners, obstetricians and gynaecologists, and resident medical staff in hospitals, and later by midwives. There has never been a specific health benefit for providing this service and it has been subsidised only as part of a medical consultation or a maternity service provided by a doctor or midwife. Consequently, there were no quality or competence requirements relating directly to the cervical smear examination itself until the regional health authorities took over subsidising the services under their contracting system.
63. This amendment to the Regulations provided a laboratory benefit (i.e. payment to the laboratory) for the cytological examination of a smear taken by anyone as long as they held the approval of the Medical Officer of Health as having the competence to take cervical smears.
64. The chronological development of the NCSP is taken up by Judy Glackin in her evidence.