National Health Committee

An Overview of Screening in New Zealand

March 2015
National Health Committee (NHC)

The National Health Committee (NHC) is an independent statutory body charged with prioritising new and existing health technologies and making recommendations to the Minister of Health.

It was reformed in 2011 to establish evaluation systems that would provide the New Zealand people and the health sector with greater value for money invested in health.

The NHC Executive is the secretariat that supports the Committee. The NHC Executive’s primary objective is to provide the Committee with sufficient information for it to make decisions regarding prioritisation and reprioritisation of interventions and services. They do this through a range of evidence-based products chosen according to the nature of the decision required and timeframe within which decisions need to be made.

The New Zealand Government has asked that all new diagnostic and treatment (non-pharmaceutical) services, and significant expansions of existing services, are to be referred to the NHC.

In August 2011 the NHC was appointed with new Terms of Reference and a mandate to establish the capacity to assess new and existing health technologies. Its objectives (under Section 4.2 of its Terms of Reference – www.nhc.health.govt.nz) include contributing to improved value for money and fiscal sustainability in the health and disability sector by:

- providing timely advice and recommendations about relative cost-effectiveness based on the best available evidence;
- providing advice and recommendations which influence the behaviour of decision makers including clinicians and other health professionals;
- providing advice and recommendations which are reflected in resource allocation at national, regional and local levels; and
- contributing to tangible reductions in the use of ineffective interventions and improved targeting to those most likely to benefit.

In order to achieve its objectives under Section 4.2 and to achieve ‘Value for Money’, the NHC has adopted a framework of four assessment domains – Clinical Safety & Effectiveness; Economic; Societal & Ethical; and Feasibility of Adoption – in order that assessments cover the range of potential considerations and that the recommendations made are reasonable.

It is intended that the research questions asked will fall across these domains to ensure that when the Committee comes to apply its decision-making criteria, it has a balanced range of information available to it. When the NHC is setting those questions they will have the decision-making criteria in mind.

The 11 decision-making criteria will assist in the determination of the NHC work programme and in the appraisal and prioritisation of assessments.
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Introduction

Screening tests asymptomatic individuals (people with no symptoms) for a particular disease or condition in order to reduce future mortality or morbidity.\(^{(1)}\) There are two types of screening: screening for disease risk (an assessment of the probability that an individual may develop a disease in the future), and screening for a disease precursor or an early asymptomatic stage of disease that is amenable to treatment. Delivery of screening services may occur as part of an organised screening programme (national programmes) or opportunistically during contact with health services.\(^{(1)}\) In contrast to routine clinical practice where a patient seeks help from a service, screening is generally provider initiated. This results in an ethical requirement for robust evidence that screening is of benefit whilst ensuring that potential harms are minimised as well as providing informed consent and equity of access.\(^{(3)}\)

This document is intended to provide the National Health Committee (NHC) with an overview of current and potential screening programmes in New Zealand in order to inform decisions about whether to undertake further work on screening.
2 How screening is organised in New Zealand

National screening programmes are overseen by the National Screening Unit (NSU), Ministry of Health and include the National Cervical Screening Programme (NCSP), BreastScreen Aotearoa (BSA), Universal Newborn Hearing Screening and Early Intervention Programme (UNHSEIP), the Newborn Metabolic Screening Programme (NMSP), the Antenatal HIV (AHIV) Screening Programme and Antenatal Screening for Down Syndrome and Other Conditions. (3)

Opportunistic screening for chronic diseases, e.g. cardiovascular disease (CVD), diabetes and cancer are largely driven by primary care and hospital outpatient services.
3 Volumes and costs

3.1 National programmes

3.1.1 NCSP

Each year in New Zealand around 170\(^1\) women are diagnosed with cancer of the cervix and around 60 women die from cervical cancer.\(^4\) In 2010, cervical cancer accounted for 1.8 per cent of all female cancer registrations and 1.3 per cent of all deaths from cancer in women. In the three years ending December 2013, 879,862 women were screened with an overall coverage rate of 77.0 per cent of eligible women aged 25–69 years.\(^5\) The NCSP 2013/14 budget is $40.4 million, comprising laboratory costs ($16.2 million), colposcopy costs ($9.3 million), regional services including promotion and coordination, some smear taking and supporting women through screening ($7.0 million), and other associated funding including monitoring, audits, the Register including invitation and recall, social marketing and programme resources ($7.9 million).\(^2\)

3.1.2 BSA

Breast cancer is the third most common New Zealand cancer, and most common cancer in women, accounting for around 2800 new cases and around 650 deaths each year.\(^4\) In the two years ending February 2014, 495,635 women were screened with an overall coverage rate of 72.5 per cent of eligible women aged 45–69 years.\(^6\) The BSA 2013/14 budget is $60.0 million, comprising screening and assessment ($48.3 million), regional recruitment, coordination and support, and supporting women through screening ($5.6 million), and other associated funding including monitoring, the rollout and support of a national digital picture archive and communication system, social marketing and programme resources ($6.1 million).\(^3\)

3.2 UNHSEIP

Each year approximately 170 New Zealand babies are born with a moderate or severe hearing loss. In the period April 2012 to December 2012 approximately 83 per cent of babies born across the country completed newborn hearing screening. This resulted in 672 (1.7 per cent) of babies being referred for further audiology testing with 42 resulting in a diagnosis of permanent congenital hearing loss.\(^7,8\) The UNHSEIP 2013/14 budget is $5.3 million, comprising screening costs ($4.4 million) and other associated funding including audits, monitoring and quality improvements ($0.9 million).\(^4\)

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\(^1\) 180 in 2010
\(^2\) Personal communication NSU Group Manager
\(^3\) Personal communication NSU Group Manager
\(^4\) Personal communication NSU Group Manager
3.3 NMSP

The Newborn Metabolic Screening Programme (NMSP) screens for rare but potentially serious metabolic disorders using a blood sample taken from a baby’s heel at 48 hours of age (the ‘heel prick’ or ‘Guthrie’ test). The NMSP screens for over 20 metabolic disorders, identifies approximately 45 babies a year with a metabolic disorder and has a 2013/14 budget of $2.3 million, mostly comprising laboratory screening costs.\(^5\)

3.4 Antenatal HIV screening

Since 1995 there have been no New Zealand cases where a mother with HIV diagnosed prior to giving birth has had an infected baby (AIDS Epidemiology Group, 2013). In children born in New Zealand from 2000 to 2007, where their mother’s HIV status was not recognised during the pregnancy, 18 have since been diagnosed with HIV. No New Zealand-born children born since 2008 have been diagnosed with HIV infection through mother-to-child transmission. Since 2010, all pregnant women have been offered HIV screening through the Antenatal HIV Screening Programme. Between 2011 and 2012, three women were diagnosed with HIV through the programme. In the period January to June 2013, around 87 per cent of women who had blood tests taken during pregnancy had an HIV test as part of this.\(^{11,12}\) The Antenatal HIV Screening Programme 2013/14 budget is around $1.4 million.\(^6\)

3.5 Antenatal screening for Down syndrome and other conditions

Antenatal screening for Down syndrome and other conditions has been part of an NSU quality improvement programme since 2007. Risk results for Trisomy 13, 18 and 21 are provided along with information on other rare genetic conditions. Two screening options are currently available:

- First Trimester Combined Screening combines the result of serum markers (pregnancy associated protein A (PaPP-A) and beta-human chorionic gonadotrophin (β-hcg)) and a nuchal translucency ultrasound scan, along with other information (e.g. age and weight), to calculate a risk result
- Second Trimester Maternal Serum Screening – this option combines the results from serum markers (β-hcg, alfa-fetoprotein (AFP) unconjugated oestriol (uE\(_3\)) and inhibin A) with other information to calculate a risk result.

Further diagnostic testing is offered in the case of increased chance results. In 2012 over 47,000 pregnant women chose to participate in either first or second trimester screening. Approximately 2 per cent of women received an increased chance\(^{13,14}\) result. The 2013/14 budget for antenatal screening for Down syndrome and other conditions is around $4.6 million.\(^7\)

\(^5\) Personal communication NSU Group Manager
\(^6\) Personal communication NSU Group Manager
\(^7\) Personal communication NSU Group Manager
3.6 Opportunistic screening

3.6.1 CVD risk assessment and diabetes checks
The current DHB-based health target, ‘More Heart and Diabetes Checks’, includes a diabetes test as part of an overall CVD risk assessment, i.e. history including risk factors examination including blood pressure and serum lipid profiling. Coverage targets were set at 60 per cent by July 2012 and 75 per cent by July 2013. While there has been an overall trend of increasing CVD risk assessment over time (at the end of the last quarter of 2012/13 the national assessment rate was 67 per cent), there was considerable variability between DHBs (from 32 per cent to 81 per cent) and only four DHBs met the 75 per cent target. Overall performance was better in eligible Pacific populations but worst for Māori compared to other ethnic groups. For the 1.4 million New Zealanders currently undiagnosed with IHD, best practice screening at five-year intervals including cost of clinical encounter is approximately $10.50 per person per annum, or $14.7 million.\(^{15-17}\)

3.6.2 National clinical genetic health services
Genetic Health Service New Zealand (GHSNZ) delivers services from three hubs (Auckland, Wellington and Christchurch) and 17 outreach clinics. GHSNZ provides information and education, risk assessment and clinical management, diagnosis and laboratory testing for a wide variety of inherited and/or congenital conditions. The national price for clinical genetic testing is $608.76 for the 2011/12 year with the modal price for 2012/13 year being $582.63.\(^{18}\)

3.6.3 Pre-implantation genetic screening
Of the 62,540 women who gave birth in New Zealand in 2009, approximately 2 per cent received some form of assisted reproductive technologies (ART) treatment. Of 5606 ART treatment cycles reported in 2009, 27.6 per cent resulted in a clinical pregnancy and 21.2 per cent in a live delivery (1270 liveborn babies, 961 singletons). Pre-implantation genetic diagnosis (PGD) is a procedure in which cells from the embryo are removed and analysed for chromosomal disorders or genetic diseases before embryo transfer. In 2009, PGD was performed in 34 cycles, representing 0.7 per cent of cycles in which embryos were created (31 out of 2906 fresh cycles) or thawed (4 out of 1869 thaw cycles).\(^{19}\)
4 Emerging technologies and potential programmes

4.1 Prostate cancer screening

Prostate cancer is the most common male New Zealand cancer (around 3000 men each year) and the third most common cause of male cancer death (around 600 each year).\(^4\) Māori men are about 25 per cent less likely to be diagnosed than non-Māori men but are more than twice as likely to die from prostate cancer.\(^20\) Each year approximately 40 per cent of men over 50 years of age have a PSA test. The PSA test, however, is not highly sensitive for prostate cancer; not all men with prostate cancer have a raised PSA and not all men with a raised PSA have prostate cancer.\(^21\) Reliance on PSA testing alone therefore poses risks of both under-diagnosis and harm caused by unnecessary treatment. A 2011 Health Committee report did not support the establishment of a national prostate screening programme but recommended the establishment of a prostate cancer awareness and quality improvement programme (AQIP).\(^22\) The Ministry of Health is rolling out this prostate AQIP to be funded at $4.3 million over four years.\(^23\)

4.2 Colorectal/bowel cancer screening

Colorectal cancer (cancers of the colon and rectum, also called bowel cancer) is the second most common cancer and cause of cancer deaths in New Zealand. Each year more than 2800\(^8\) people are diagnosed and more than 1200 die from the disease.\(^4\) A four-year $24 million Waitemata DHB area bowel screening pilot commenced in 2011 to gather information about demand and capacity in order to determine whether a bowel screening programme should be rolled out nationally. The pilot offers bi-annual screening to 50–74-year-olds using an at-home kit where a bowel motion sample is collected and then posted for laboratory FOBTi testing which, if positive, is followed up with the offer of a diagnostic colonoscopy. In the first year of the pilot around 29,500 screening kits were returned, a 54 per cent participation rate with around 2200 people offered a diagnostic colonoscopy and cancer was detected in 60 people. Most eligible participants (86 per cent) were offered a diagnostic colonoscopy within 10 weeks of a positive test. The pilot is also detecting many non-cancerous polyps which require removal and future regular colonoscopy surveillance. No decision will be made on implementing a national programme until all monitoring and evaluation data from the pilot has been analysed. The cost of a national bowel screening programme for people aged 50–74 years has been estimated at $60 million a year, with additional costs to establish a supporting information system.\(^24,25\)

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\(^8\) 2988 in 2010
4.3 Modifications to NCSP

In New Zealand HPV immunisation of 12–13-year-old girls commenced in 2009, with a catch-up available for up to 20-year-olds. HPV immunisation confers some protection against cervical cancer related to HPV, approximately 70 per cent of cervical cancer and 90 per cent of genital warts is related to HPV. Cervical screening is less sensitive in women immunised against HPV, hence internationally the implementation of HPV immunisation programmes is driving a change from cytology screening to HPV testing as the primary cervical screening test. The Ministry of Health is contributing to an Australian pilot initiative which is looking at a time and motion laboratory study for HPV testing as the primary cervical screening test. Approval is being sought to commence policy development work to consider whether the NCSP should be changed to introduce HPV testing as the primary screening test.

4.4 Modifications to BSA

A 2012 NSU literature review on the evidence for routine age extension for breast cancer screening for women over 70 found no new consistent high-quality scientific evidence about the benefits of such screening. Internationally some breast screening programmes are extending their upper age range into the 70s; however the evidence and international changes are being monitored in New Zealand at this time. In addition the NSU is currently revising its position statement on the benefits and harms of BSA. A Cochrane Collaboration systematic review found that breast cancer mortality was an unreliable outcome that was biased in favour of screening. However this Cochrane study did not adequately account for reduction in morbidity resulting from national breast screening programmes or that the perception of ‘harm’ from the perspective of the Cochrane review may not be seen as a harm by women screened as emerging in the qualitative literature.

Digital breast tomosynthesis (DBT) is a technology for breast imaging in the early stages of testing and clinical use which may be able to improve diagnostic accuracy in the early detection of breast cancer. Further evidence is required, e.g. completion of two major trials (Malmo 2014 and Oslo 2015), before the consideration of any widespread implementation of DBT in routine screening practice.

4.5 Modifications to antenatal and newborn screening

4.5.1 Gestational diabetes mellitus

GDM is defined as ‘carbohydrate intolerance resulting in elevated blood sugar of variable severity with onset or first recognition during pregnancy’ by the World Health Organization and is inclusive of those women with previously undiagnosed diabetes. A presentation at the 2013 New Zealand Society for the Study of Diabetes Conference indicated that the number of pregnancies associated with gestational diabetes had increased from 1.3 per cent in 2001 to 2 per cent in 2006 and to 4.9 per cent in 2012, an average annual increase of 13.9 per cent. In 2012 there was wide

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9 Personal communication BSA programme NSU
variation in total GDM rates between DHBs with even greater variation between ethnic groups. The Ministry of Health has commissioned a national clinical guideline for the screening, diagnosis and management of gestational diabetes in New Zealand. The draft guideline recommends universal antenatal blood screening before 20 weeks gestation using HbA1c testing followed by oral glucose testing at 24 to 28 weeks for women not previously diagnosed with diabetes.\(^{(32)}\)

### 4.5.2 Pre-implantation genetic diagnosis
There is emerging capability and capacity for embryonic genome sequencing in the IVF space with a view to screening for a wide range of genetic diseases and risk factors.\(^{(33)}\)

### 4.5.3 Screening for pre-eclampsia
Antenatal placental growth factor screening for pre-eclampsia, a potentially life-threatening disease of pregnancy characterised by hypertension, oedema and proteinuria is under consideration in Australia. The prevalence of pre-eclampsia in the New Zealand general population is around 3–5 per cent of pregnancies and disproportionately affects Māori. The clinical utility of screening for pre-eclampsia is unclear as the standard treatment is induced or medical delivery.\(^{(34)}\)

### 4.5.4 Severe combined immunodeficiency syndrome (SCID)
SCID is a genetic disorder with an incidence of between 1 in 50,000–100,000 live births affecting the production of T cells critical to the immune response to infectious diseases. USA pilot studies to diagnose SCID in newborns utilising polymerase chain reaction (PCR) are under way.\(^{(35)}\) The NSU is in the process of seeking a feasibility and cost effectiveness analysis.

### 4.5.5 Lysosomal storage diseases (LSDs)
LSDs are inherited metabolic disorders of variable severity that affect cellular organelles (lysosomes) resulting in organ deposition of waste materials afflicting approximately 460 New Zealanders.\(^{(36)}\) LSDs may be screened for by enzyme assay or genetic mutation analysis.\(^{(35)}\) LSD screening has been referred to the NSU. However, diagnostic criteria across LSDs are unclear and not all can be treated. NSU maintains a watching brief.

### 4.5.6 Pulse oximetry screening for critical congenital heart disease (CCHD)
Up to 25 per cent of babies with severe forms of congenital heart disease are discharged post-delivery from hospital undiagnosed. Polynesians and Māori have disproportionately high rates of CHDs.\(^{(36)}\) The incidence of severe congenital heart disease requiring expert cardiology care is 2.5–3.0 per 1000 live births.\(^{(37)}\) Pulse oximetry measures blood oxygen levels by measuring the absorbance of light utilising a non-invasive sensor placed on a thin part of the body (e.g. finger, ear or foot). A 2012 systematic review of pulse oximetry screening (POxS) for CCHD in newborn babies found it to be highly specific, moderately sensitive and meet the criteria for universal screening.\(^{(38)}\)

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Pulse oximetry is commonplace in clinical settings and relatively cheap. The NSU has received enquiries about, and maintains a watching brief on, POxS screening.

### 4.6 Ultrasound screening for abdominal aortic aneurysms (AAA)

AAAs is a localised ballooning of the abdominal aorta, by more than 3 cm of its normal diameter with smoking as a key risk factor at some point in their lifetime (over 90 per cent of AAA sufferers) and in men. The larger the aneurysm the greater the risk of rupture\(^{(39)}\) with a commensurate mortality rate of up to 90 per cent. Using single encounter abdominal ultrasound and taking into account mortality associated with case treatment, benefits outweigh risks for defined groups of men, but are more contentious for women due to lower prevalence.\(^{(40)}\) The impact of a New Zealand AAA screening programme on the New Zealand health system would include a 2–3 times increase in operative repairs required (currently around 263 per annum) and an ongoing requirement for radiological surveillance of individuals with AAAs less than 5.5 cm (potentially around 90 per cent of AAAs detected).\(^{(39)}\) NSAC considered that the question of AAA screening requires counterfactual modelling to balance benefits of lives saved (given the very high mortality of ruptured AAA) versus programme cost for the New Zealand population.

### 4.7 Screening for hepatitis C (HCV)

HCV is a chronic viral infection that, via cirrhosis, may lead to liver failure and/or cancer. There is no vaccine for hepatitis C. Of 50,000 New Zealanders with HCV infection, approximately 20 per cent have been diagnosed and 5 per cent have accessed drug treatment. All patients treated by a hepatitis C treatment service require regular monitoring during and after treatment. Without treatment, between 5–15 per cent of those with HCV will develop cirrhosis and 3 per cent will develop liver cancer. Forty percent of those with cirrhosis will be referred for liver transplantation. It has been estimated that HCV-related deaths and transplants will triple by 2030.\(^{(41)}\)

The Hepatitis Foundation of New Zealand (HepFNZ) has been supported to provide an implementation plan for a potential three-year programme to promote the targeted testing of specific ‘at-risk’ groups. This programme would encourage early HCV diagnosis and treatment options for at-risk groups. The case detection component of the HepFNZ programme includes the development of educational resources to risk stratified groups that will support better case management.\(^{(42)}\)
4.8 Screening for rheumatic fever/heart disease

Rheumatic fever is a consequence of the autoimmune response to throat infection by *Streptococcus pyogenes*, with a New Zealand rate of approximately 15 cases/100,000 children aged 5–15 years of age, comparable to that of a third world country. The longer term management of rheumatic valvular disease often requires invasive cardiac intervention. It is not possible to screen for the disease ‘rheumatic fever’. Echocardiography has been trialled for detecting asymptomatic rheumatic valvular disease; there is however no clear evidence that this is effective. The Ministry of Health is rolling out a programme to reduce the risk of developing rheumatic fever and ensuring best practice management. This includes a communications campaign to raise awareness of sore throats and rheumatic fever among vulnerable communities and health professionals with a view to offering a package of housing-related interventions (Auckland region), symptomatic school-based throat swabbing services in the 10 DHB areas with the highest incidence of rheumatic fever, providing access to rapid sore throat management in areas where there are large numbers of cases (particularly where there are no school-based services) and improving the management of sore throats in high-risk children across the country. Programme progress is monitored by the ‘Government’s Better Public Services target for rheumatic fever’ to reduce the incidence rate to 1.4 cases per 100,000 people by June 2017.

4.9 Screening for osteoporosis

Osteoporosis is a skeletal disease characterised by low bone density and disruption of bone architecture with an associated increased risk of fracture (particularly fractures of the hip and vertebra). As the number of older New Zealanders increases, their quality of life will decrease and there will be an increase in premature mortality and demand on health systems attributable to osteoporosis. The total cost of osteoporosis in New Zealand in 2007 was estimated to be greater than $1.5 billion with an estimate of a 30 per cent increase in expenditure by 2020. As recommended by ‘Osteoporosis New Zealand’, Best Practice Advocacy Centre New Zealand recommends that bone densitometry (dual energy X-ray absorbitometry – DEXA) only be undertaken when the result of this testing will have an impact on clinical decision making and therefore treatment. There is unresolved international debate as to whether all women 65 years of age should be screened for osteoporosis. The *Burden of Osteoporosis in New Zealand: 2007–2020* study recommended publicly funded DEXA scans for women over 50 with low trauma fractures supported by awareness campaigns to increase public and health professional awareness.
4.10 Lung cancer screening

Each year 1600 New Zealanders die from lung cancer, representing 19 per cent of all cancer deaths and is therefore the leading cause of New Zealand cancer deaths.\(^4\) Tobacco smoking causes up to 90 per cent of lung cancer cases. Tobacco control and smoking cessation are therefore the single most effective and cost effective lung cancer preventative interventions.\(^48\) Recommendations of the Northern Cancer Network endorsed research, “Identification of barriers to the early diagnosis of people with lung cancer and description of best practice solutions”, could be regarded as recommendations for opportunistic screening and may benefit from regional and/or national service improvement programmes. Recommendations include improved health literacy; increasing primary care awareness of lung cancer, its risk factors and the benefits of early treatment; routine recording of smoking status with appropriate follow-up; improved GP utilisation of chest X-rays; appropriate follow-up of patients with ongoing symptoms, abnormal results and did not attends (DNAs) and to improve access to timely outpatient CT scans for suspected lung cancer.\(^49\) The five-year survival of surgical tumour resection for local disease at up to 70 per cent compares to 15 per cent for those with locally advanced disease and to 3 per cent if metastases are present at the time of diagnosis. Early diagnosis, combined with timely appropriate cancer care, therefore has the potential to improve lung cancer survival outcomes.

Screening with a yearly low-dose CT scan has demonstrated decreased mortality in a randomised trial of patients with increased risk due to smoking.\(^50\) However a 2010 meta-analysis noted that for every 1000 asymptomatic smokers screened, nine curable Stage 1 lung cancers would be detected, while 235 “false positive” nodules would be found and four thoracotomies would also be performed to determine if a screened positive lesion was benign.\(^51\) Better risk stratification of smokers, which may include spirometry, presence of emphysema on CT, family history and genetic susceptibility, may result in a reduction in the current high false positive radiological screening rates. Many screening studies have also failed to evaluate whether smokers would be willing to participate in screening outside of the context of research.\(^52\)
5 New Zealand service development and issues

Maintaining a watching brief on emerging screening technologies and extensions and/or modifications to existing screening programmes may remain of interest to the NHC. These include the place of NCSP HPV primary screening, the age extension for BSA, the roll-out of the prostate cancer awareness and quality improvement programme, the outcome of the colorectal/bowel cancer screening pilot, publication of the final New Zealand national guideline to GDM screening and roll-out of the HepFNZ hepatitis C early detection programmes. The National Maternity Monitoring Group has recommended that the Ministry of Health and the maternity sector develop a clinical guideline for the diagnosis and treatment of hypertension and pre-eclampsia in pregnancy.

Conversations within the New Zealand screening community indicate little interest in disinvestment in currently existing screening initiatives. Interest has been expressed in screening for postnatal depression, melanoma and alcohol abuse, but in particular in ultrasound based screening for AAA.

The essential features of a quality national screening system include a central agency to lead and co-ordinate the screening pathway, clinical leadership, infrastructure and systems for programme, management, continuous quality management monitoring and improvement. A screening programme displaying these characteristics ‘lifts the screening game’ for the programme concerned. The challenge to national screening programmes is to maintain this quality by working more closely with the wider health sector in a time of fiscal constraint.

The commensurate challenge for opportunistic screening is to ‘lift the screening game’ without incurring the financial costs that national programmes require.

Quality initiatives might be undertaken for primary care driven opportunistic chronic disease screening. Many screening programmes are underperforming for Māori, Pacific, Asian and economically deprived populations. Unless carefully planned, health interventions tend to increase inequalities. The NHC executive may see itself as mitigator of health changes affecting vulnerable groups. Work is currently under way by DHBs and the Ministry of Health to reduce wait times, including:

- DHBs now reporting through the Colonoscopy Diagnostic Wait Time Indicator through the electives work programme
- publication of National Referral Criteria for Direct Access Colonoscopy, which will provide consistency in access and waiting times for patients referred for colonoscopy
- a National Endoscopy Quality Improvement Programme, now rolled out to all 20 DHBs, will lead to improvements in quality and efficiency of colonoscopy services over time
- Health Workforce New Zealand are looking into options to increase workforce capacity.

11 Personal communication Principal Advisor Maternity Ministry of Health
References


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