

5.2 Repeat colonoscopy MBS services, all ages

Why is this important?

Colonoscopy is used to investigate bowel problems or symptoms. Repeat colonoscopy is mainly used to monitor for bowel cancer and its precursor, polyps (adenomas), in people with an increased risk of developing bowel cancer. Less commonly, colonoscopy is repeated to manage chronic inflammatory conditions of the bowel.

The first and third Atlases in the *Australian Atlas of Healthcare Variation* series found substantial variation in rates of colonoscopy according to where people live.^{1,2} Differences in adherence to surveillance guidelines were identified as a possible reason for the variation. Guideline recommendations on the timing of repeat colonoscopies are based on bowel cancer risk. There are limited reasons for repeating a colonoscopy after a period of less than three years.

The fourth Atlas examines rates of colonoscopy that are repeated within two years and 10 months of an earlier colonoscopy, using Medicare Benefits Schedule (MBS) data.

What did we find?

In 2018–19, there were almost 148,000 MBS-subsidised services for repeat colonoscopy performed within two years and 10 months in people of all ages.

The rate in the area with the highest rate was **19.9 times as high** as the rate in the area with the lowest rate. Rates were markedly higher in major cities than elsewhere. In major cities, rates increased with socioeconomic advantage.

What can be done?

More needs to be done to improve the consistent application of the national guidelines on bowel cancer screening and surveillance. A concerted focus by clinicians, medical colleges and health service organisations to drive implementation of the *Colonoscopy Clinical Care Standard* and national guidelines could reduce inappropriate requests for repeat colonoscopies and free up services for people at high risk of bowel cancer.³⁻⁵

Structured referral forms could aid assessment of requests for repeat colonoscopies against guidelines. Health service organisations could ensure that re-credentialing requirements for clinicians performing colonoscopy include clinical audit against guidelines to promote high-quality colonoscopies.

Wider consumer awareness about the impact of lifestyle on cancer risk is needed. Educating people on ways they can reduce their risk of bowel cancer and improve their general health should be an integral part of surveillance. Integration of data about cancer incidence and lifestyle into healthcare pathways, training guidelines and consumer resources could help prompt discussion between clinicians and patients and may reduce inappropriate repeat colonoscopy.

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Context

This item examines rates of MBS-subsidised services for repeat colonoscopy performed within two years and 10 months of an earlier colonoscopy for people of all ages in Australia in 2018–19.

What is colonoscopy?

Colonoscopy is the examination of the large bowel (colon) using a small, flexible tube with a camera on the end, called a colonoscope. It can also include removal of polyps (adenomas) or other abnormal growths, and a biopsy. Polyps can be precursors of bowel cancer and are a marker of increased risk.

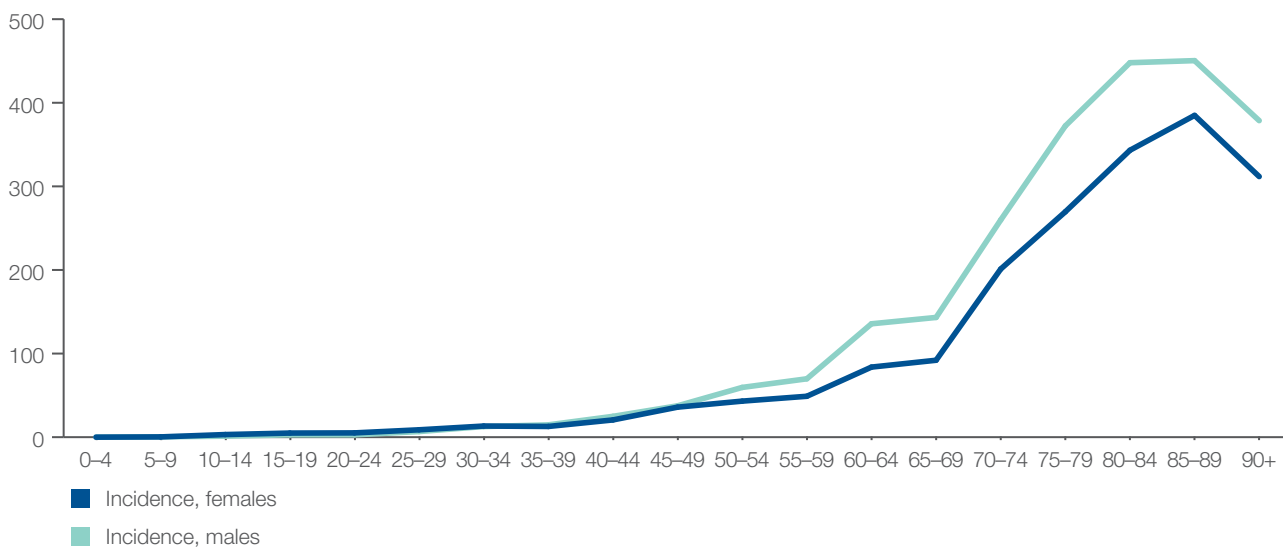
What is it used for?

Colonoscopy is used to investigate bowel problems or symptoms. It is also used to monitor for and detect polyps or bowel cancer (colorectal cancer) in people with no symptoms but with an increased risk, and to manage chronic conditions of the bowel, such as inflammatory bowel disease (IBD). Increased

risk of bowel cancer can be identified from a faecal occult blood test (FOBT) of a person's bowel motion (possibly done as part of the National Bowel Cancer Screening Program [NBCSP]), previous results of a colonoscopy, a family history of bowel cancer or a high-risk genetic condition.³ Bowel cancer is the fourth most commonly diagnosed cancer in Australia.^{6,7} After the age of 50, the incidence of bowel cancer steadily increases (Figure 5.10).⁴ About 55% of the bowel cancer burden in Australia can be attributed to lifestyle factors including diet (high in processed meat, red meat and sugar), physical inactivity, being overweight, smoking and alcohol use.⁷

While the age-standardised incidence of bowel cancer in Australia declined from 2001 to 2020* (from 66 to 51 cases per 100,000 people), the estimated number of people diagnosed with bowel cancer increased (from 12,806 to 15,494 people) because of the ageing population.⁸

Figure 5.10: Colorectal cancer rates (per 100,000 people), by sex and age group, 2020*



* 2020 incidence estimates are projections based on 2007–2016 incidence data.

Source: Australian Institute of Health and Welfare.⁸

When does a colonoscopy need to be repeated?

The most common reasons to repeat a colonoscopy are^{4,5}:

- Monitoring (surveillance) of the bowel after colorectal surgery or removal of polyps that can lead to bowel cancer
- Monitoring (surveillance) of chronic conditions of the bowel such as IBD
- Regular screening of people with a strong family history of bowel cancer, or a hereditary cancer syndrome that can lead to bowel cancer
- Removal (treatment) of previously identified polyps
- Onset of new signs or symptoms thought to be from the lining of the bowel
- Inadequate previous colonoscopy; for example, because of an incomplete colonoscopy or poor bowel preparation.

High-quality colonoscopy can detect about 95% of bowel cancers and polyps, but it is an invasive and costly procedure with a risk of complications.⁵ For this reason, colonoscopy for population screening is reserved for people with an increased risk of bowel cancer, if there is a higher chance of diagnosing significant disease.⁷ Similarly, recommendations for a repeat colonoscopy and its timing for greatest benefit are based on a person's risk of bowel cancer.

The national *Colonoscopy Clinical Care Standard* mandates that, if surveillance is required, colonoscopy is repeated at intervals consistent with evidence-based guidelines.³ Two Australian national guidelines address the need for and timing of repeat colonoscopy – one focuses on the use of colonoscopy in screening high-risk groups (that is, people with a family history of bowel cancer or a hereditary cancer syndrome), while the other focuses on the use of colonoscopy for surveillance.^{4,5}

If guidelines are followed, a small proportion of people who have an initial colonoscopy might be expected to need a repeat within three years. These would usually be people identified as having a high risk of bowel cancer or who have IBD. A poor-quality colonoscopy, or uncertainty about when a previous colonoscopy was performed, are also reasons a colonoscopy may be repeated within one or two years.^{4,5} However, the *Colonoscopy Clinical Care Standard* addresses the problem of uncertainty about the timing of a previous colonoscopy by stipulating that the results of colonoscopies are communicated to the person who had the procedure, the general practitioner (GP) and any other relevant clinicians involved in the person's care.³

Colonoscopy surveillance guidelines identify a person's risk of bowel cancer based on the results of their previous colonoscopy or colonoscopies.^{5,9} These guidelines apply to anyone who has had a colonoscopy, including participants in the NBCSP who had a colonoscopy because of a positive FOBT. The timing of the next colonoscopy, if needed, depends on the number, size and type of polyps removed.⁹ The greater the risk, the smaller the interval before repeating the procedure. People at potentially high risk will generally require a repeat colonoscopy every one to two years. Yearly colonoscopies are also recommended for high-risk people with IBD, and a repeat colonoscopy is also recommended within 12 months of bowel resection (surgery).⁵

A colonoscopy is also recommended every one to two years for people with, or at high risk of having, a hereditary cancer syndrome, such as Lynch syndrome, and may start at 25 years or younger for people with this syndrome.⁴

Repeat colonoscopies are also recommended for other groups, such as people with a strong family history and people otherwise at moderate risk of bowel cancer. However, for most people in these groups, the recommended intervals between colonoscopies are longer than that examined in this Atlas.^{4,5}

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Why examine repeat colonoscopy?

The first and third Atlases in the *Australian Atlas of Healthcare Variation* series examined MBS-subsidised services for colonoscopy and hospitalisations for colonoscopy, respectively.^{1,2} Although these Atlases used different datasets, each found substantial variations in colonoscopy rates according to where people live. They also found patterns of use that did not match the burden of disease. Outer regional areas and areas of socioeconomic disadvantage have the highest rates of bowel cancer incidence and mortality in Australia^{7,10}, yet both Atlases found the highest rates of colonoscopy in the most socioeconomically advantaged areas of major cities.

Clinical practice that is not supported by guidelines, such as repeating colonoscopies sooner than is recommended, was identified as a possible reason for the high rates of colonoscopy in some metropolitan areas. Differences in uptake of the NBCSP were also identified as a possible reason for the variation between major cities and other areas.^{1,2}

Little is known about the rate of repeat colonoscopies in Australia. This Atlas examines variation in rates of short-interval repeat colonoscopy using MBS-subsidised services performed in the same person in 2018–19. The interval of two years and 10 months was chosen to exclude services to people who present early for their three-yearly colonoscopy.

Data from this Atlas item should provide a baseline for evaluating changes to MBS items for colonoscopy introduced by the Australian Government in 2019, which included new item numbers with guideline-recommended surveillance intervals.¹¹ It should also be helpful for evaluating implementation of the *Colonoscopy Clinical Care Standard*, mandated in 2019, as part of the National Safety and Quality Health Service (NSQHS) Standards for the accreditation of all hospitals and day procedure services performing colonoscopy.^{3,12}

About the data

Data are sourced from the MBS dataset. This dataset includes information on MBS claims processed by Services Australia. It covers a wide range of services (attendances, procedures, tests) provided across primary care and hospital settings.

The dataset does not include:

- Services for publicly funded patients in hospital
- Services for patients in outpatient clinics of public hospitals
- Services covered under Department of Veterans' Affairs arrangements.

The dataset does not allow analysis by Aboriginal and Torres Strait Islander status.

Rates are based on the number of MBS-subsidised services for repeat colonoscopy per 100,000 people of all ages, age and sex standardised, in 2018–19.

Because a record is included for each service rather than for each patient, patients who receive the service more than once in the financial year will have more than one service counted.

In the patient count analysis, patient counts reflect the number of unique patients, regardless of the number of services the patient may have received in the year.

The analysis and maps are based on the patient's postcode recorded in their Medicare file and not the location of the service.

Rates are age and sex standardised to allow comparisons between populations with different age and sex structures.

What do the data show?

Magnitude of variation

In 2018–19, there were 147,875 MBS-subsidised services for repeat colonoscopy performed within two years and 10 months, representing 522 services per 100,000 people of all ages (the Australian rate).

The number of MBS-subsidised services for repeat colonoscopy across 324* local areas (Statistical Area Level 3 – SA3) ranged from 62 to 1,236 per 100,000 people. The rate was **19.9 times as high** in the area with the highest rate compared with the area with the lowest rate. The number of MBS-subsidised services for repeat colonoscopy varied across states and territories, from 191 per 100,000 people in the Northern Territory to 596 in Queensland (Figures 5.13–5.16).

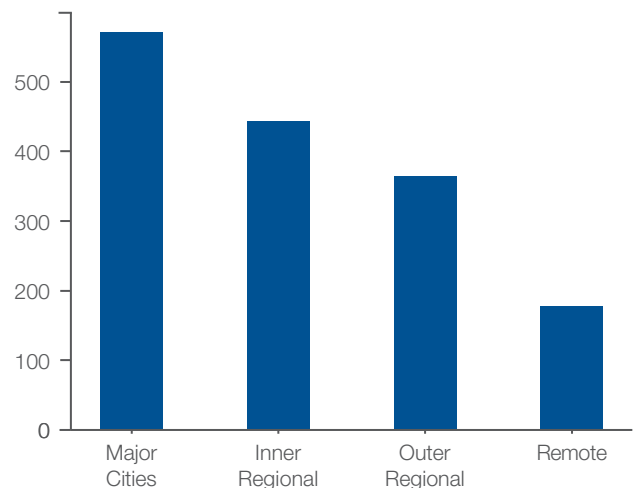
After the highest and lowest 10% of results were excluded and 260 SA3s remained, the number of MBS-subsidised services per 100,000 people was 2.7 times as high in the area with the highest rate compared with the area with the lowest rate.

Analysis by remoteness and socioeconomic status

Rates for MBS-subsidised services for repeat colonoscopy were higher in major cities than elsewhere. The rate for major cities was 3.2 times as high as the rate for remote areas (Figures 5.11 and 5.17).

Rates increased with socioeconomic advantage in major cities and overall. The rate in the highest socioeconomic group was 1.6 times as high as the rate in the lowest (Figures 5.12 and 5.17).

Figure 5.11: Number of MBS-subsidised services for repeat colonoscopy per 100,000 people of all ages, age and sex standardised, by remoteness of patient residence, 2018–19



The data for Figures 5.11 and 5.12 are available at safetyandquality.gov.au/atlas

* There are 340 SA3s. For this item, data were suppressed for 16 SA3s due to a small number of services and/or population in an area, or potential identification of individual patients, practitioners or business entities.

Notes:

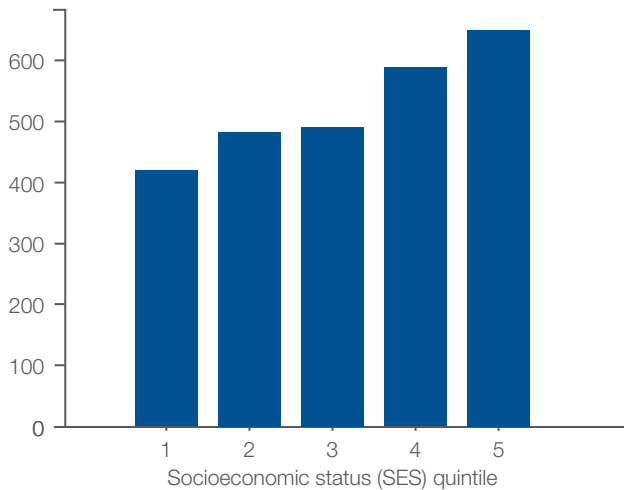
Some SA3 rates are more volatile than others. These rates are excluded from the calculation of the difference between the highest and lowest SA3 rates in Australia.

For further detail about the methods used, please refer to the Technical Supplement.

Sources: AIHW analysis of Medicare Benefits Schedule data and ABS Estimated Resident Population 30 June 2018.

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Figure 5.12: Number of MBS-subsidised services for repeat colonoscopy per 100,000 people of all ages, age and sex standardised, by socioeconomic area of patient residence, 2018–19



Analysis by number of people who had at least one repeat colonoscopy

In 2018–19, there were 139,072 people who had at least one MBS-subsidised service for repeat colonoscopy, representing 491 people per 100,000 people of all ages.

Analysis by number of repeat colonoscopy services without polyp removal

In 2018–19, there were 71,464 MBS-subsidised services for repeat colonoscopy without polyp removal, representing 257 services per 100,000 people of all ages (the Australian rate). The percentage of MBS-subsidised services for repeat colonoscopy without polyp removal was 49%, and varied across states and territories, from 35% in the Australian Capital Territory to 55% in Victoria and the Northern Territory.

The data and graphs for analysis by number of people who had at least one repeat colonoscopy, analysis by number of repeat colonoscopy services without polyp removal, and analysis by Primary Health Network are available at safetyandquality.gov.au/atlas

Notes:

Areas with a low SES (=1) have a high proportion of relatively disadvantaged people. Areas with a high SES (=5) have a low proportion of relatively disadvantaged people.

For further detail about the methods used, please refer to the Technical Supplement.

Sources: AIHW analysis of Medicare Benefits Schedule data and ABS Estimated Resident Population 30 June 2018.

Interpretation

Variation is warranted when it reflects variation in underlying disease and need for care; however, the rates of repeat colonoscopy do not appear to match this pattern, nor do they match the epidemiology of disease. There was widespread variation in repeat colonoscopy use, with rates much higher in major cities compared with elsewhere. Rates were also lower in areas of socioeconomic disadvantage.

These findings are consistent with the findings in the first and third Atlases, which examined rates of MBS-subsidised colonoscopy, and public and private hospitalisations for colonoscopy, respectively.

Variation in rates of repeat colonoscopy is likely to be due to the geographical differences in the factors discussed below.

Variation between areas may not directly reflect the practices of the clinicians who are based in these areas. The analysis is based on where people live rather than where they obtain their health care. Patients may travel outside their local area to receive health care.

Clinical decision-making

High rates of early repeat colonoscopy may be related to clinical practice that is not supported by guidelines. Australian and international studies have found that one-third of colonoscopies are repeated at intervals sooner than the guidelines recommend, with some reporting this to be as high as half.¹³⁻¹⁸ Difficulties in keeping up to date with guidelines and differences in clinical opinion on management may also contribute.¹⁹

Fear of litigation for not investigating symptoms may also influence clinicians' decisions about when and how often to provide repeat colonoscopies for the same person, particularly if they are unaware of current recommendations, or of evidence about the incidence of gastrointestinal (GI) cancers and the risk of symptoms leading to significant disease. Concerns about late diagnosis and subsequent litigation, and a lack of disincentives for over-testing, may also contribute to overuse.¹⁹

Some colonoscopies may be repeated because the previous report was not easily accessible or did not contain the information required to guide clinical decision-making.

Quality of bowel preparation

High-quality bowel preparation is essential for a successful colonoscopy.⁵ In the United Kingdom, poor bowel preparation has been reported to account for up to 25% of failed colonoscopies.²⁰ Poor bowel preparation results in poor visualisation of the colon, and has been associated with up to 47% lower likelihood of detecting and removing polyps that can lead to the development of bowel cancer.²¹ For this reason, people who had a colonoscopy with poor bowel preparation require a repeat colonoscopy within a year.^{5,22} Poor bowel preparation also results in considerable inconvenience and waste. Australian guidelines recommend that successful bowel preparation should be achieved in at least 90% of colonoscopies.⁵

The training and experience of the colonoscopist may also contribute to variation. International studies report a three-to-six-fold difference in adenoma detection rate variability between colonoscopists.⁵

Consumer expectations

A person's understanding about their risk of bowel cancer and the rate of development of bowel cancer may drive anxiety and lead to more frequent surveillance. Anxiety about interval cancers – cancers that occur between routine surveillance – has been suggested as a reason for repeating colonoscopies at shorter intervals than guidelines currently recommend.²³ Lack of access to a GP, specialist or surgeon who is informed about the evidence to help allay a person's anxiety about their risk of developing cancer may also lead to inappropriate repeat colonoscopies.

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People often have incorrect perceptions of their cancer risk and the benefits of interventions such as screening and surveillance to detect GI cancer.^{24,25} These perceptions can influence their preference and demand for investigations, even when their risk of cancer is low.²⁶

Access to services and number of clinicians providing services

Access to clinicians may influence the likelihood of people seeking care and the rates of repeat colonoscopy. The practice styles of individual clinicians may be more likely to affect rates in areas with fewer clinicians, such as rural and regional locations, than in areas with more clinicians.

Availability and affordability of services may also influence patterns of use. Ability to pay out-of-pocket costs for services is likely to be lower in areas of socioeconomic disadvantage, and access is likely to be more difficult in areas with fewer services. Open-access endoscopy services, in which GPs are able to request colonoscopy without specialist review, may also influence patterns of use.

Financial incentives

Greater remuneration for providing a service rather than a consultation may lead to variation and over-servicing in some areas.

Promoting appropriate care

More must be done to improve the consistent application of the national guidelines on bowel cancer screening and surveillance. The Atlas shows a pattern of repeat colonoscopy use that is not consistent with the prevalence of disease, indicating possible overuse in some areas and underuse in others. Repeating the procedure in people who are unlikely to benefit puts them at risk of procedural harms and may reduce opportunities for people who are at high risk of bowel cancer and more in need of the procedure. It also results in inconvenience, cost and confusion to the individual and the health system.

A concerted focus by clinicians, medical societies and colleges, and health service organisations across Australia to implement the *Colonoscopy Clinical Care Standard*³ is needed to drive improvements in the appropriate use of colonoscopy, reduce inappropriate short-interval repeat colonoscopies and free up services for people at high risk of bowel cancer.

The *Colonoscopy Clinical Care Standard* aims to ensure colonoscopies are used appropriately and performed safely, and is mandated as part of the NSQHS Standards for the accreditation of hospitals and day procedure services performing colonoscopy in Australia.^{3,12} To improve the follow-up and reporting of a colonoscopy, it recommends that the clinician who performs the colonoscopy communicates in writing the reason for the colonoscopy, its findings, any histology results, and recommendations for management to the person having the procedure, the GP, and any other relevant clinicians, and documents this in the facility records. It recommends that, if surveillance colonoscopy is required, it must be consistent with the intervals in national evidence-based guidelines.

Health service organisations could improve the implementation of the *Colonoscopy Clinical Care Standard*³ by ensuring that credentialing requirements for clinicians performing colonoscopy include a clinical audit against the clinical care standard, and that they provide audit results to the hospital's clinical review meetings and re-credentialing committee. Resources for colonoscopists to support implementation include a colonoscopy report template and a template for follow-up letters to GPs and patients (see Resources).

The low rates of short-interval repeat colonoscopies in disadvantaged remote areas are concerning, because they suggest that people at high risk of bowel cancer could be missing out on appropriate surveillance. These low rates are consistent with participation rates reported in the NBCSP.⁷ Strategies to improve participation in the NBCSP and access to colonoscopy services for people living in remote areas are a priority.

Unwarranted variation in repeat colonoscopy could be addressed in the following ways.

Quality colonoscopy and clinical audit

Recertification of ongoing competency is now mandatory for all practitioners working in health service organisations that are assessed against the NSQHS Standards.¹² Only colonoscopists who meet the certification and recertification standards can perform colonoscopy independently in Australia. The quality indicator together with the standard for reporting should reduce the proportion of repeat colonoscopies performed because of uncertainty about the quality of another clinician's colonoscopy.

Clinical audit could be used more widely to support decision-making about repeat colonoscopies. Audits in this area could also be part of continuing education requirements for clinicians.

Structured referral forms and checklists outlining the appropriate reasons for, and frequency of, repeat colonoscopy for greatest benefit, as recommended in the *Colonoscopy Clinical Care Standard*³ and national guidelines, could aid assessment of requests that do not meet guideline-recommended intervals.

Clinician education

Educational programs for clinicians could improve the appropriateness of requests for repeat colonoscopies. Improving clinician familiarity with guidelines, with the evidence base for recommended surveillance intervals and with the consequences of overuse of colonoscopy could better equip them to manage requests for performing colonoscopy earlier than the guidelines recommend.

Consumer education and reassurance

Informing and reassuring people of their risk of developing bowel cancer, and that the rate of progression from polyp formation to bowel cancer is generally slow may reduce demand for more frequent surveillance. Improving a person's understanding about their cancer risk is important to reduce anxiety and dispel myths about cancer. Interactive tools that identify a person's cancer risk – such as the Australian Institute of Health and Welfare cancer summary data tool (see 'Resources' on page 282) – may aid understanding.⁸

Integration of data about cancer incidence and lifestyle into healthcare pathways and consumer resources could help prompt these discussions between consumers and clinicians.

Reducing risk factors

Wider consumer awareness about risk factors and the impact of lifestyle on bowel cancer risk is needed. Bowel cancer incidence could be significantly reduced with successful modification of the key population attributable risks – that is, addressing diet (21.8%), physical inactivity (16.5%), being overweight or obese (12.5%), smoking (7.4%) and alcohol use (5.5%).^{7*} Public health initiatives to address risk factors should be targeted to areas with a high prevalence of these.

Educating consumers on ways they can reduce their risk of bowel cancer and improve their general health should be an integral part of colonoscopy surveillance, and may reduce requests for colonoscopies to be performed sooner than the guidelines recommend.

* Attributable burden from multiple risk factors cannot be combined or added together due to the complex pathways and interactions between risk factors.

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Triage systems

Many states and territories are introducing evidence-based triage systems for prioritising and allocating people for gastroscopy and colonoscopy, with the aim of reducing variation in use of these procedures:

- Victorian health services require clinicians to refer people for colonoscopy according to the categorisation guidelines²⁷
- Tasmania has adopted the Victorian categorisation guidelines and formed a statewide endoscopy network to monitor the quality of its services²⁸
- New South Wales has developed categorisation guidelines to support the appropriate use of colonoscopy across all healthcare settings²⁹
- Queensland and Western Australia have introduced clinical prioritisation criteria for many clinical areas, including gastroenterology, to triage patients referred to public specialist outpatient services.³⁰⁻³²

Wider use of such systems could result in more appropriate prioritisation of colonoscopy, as well as gastroscopy.

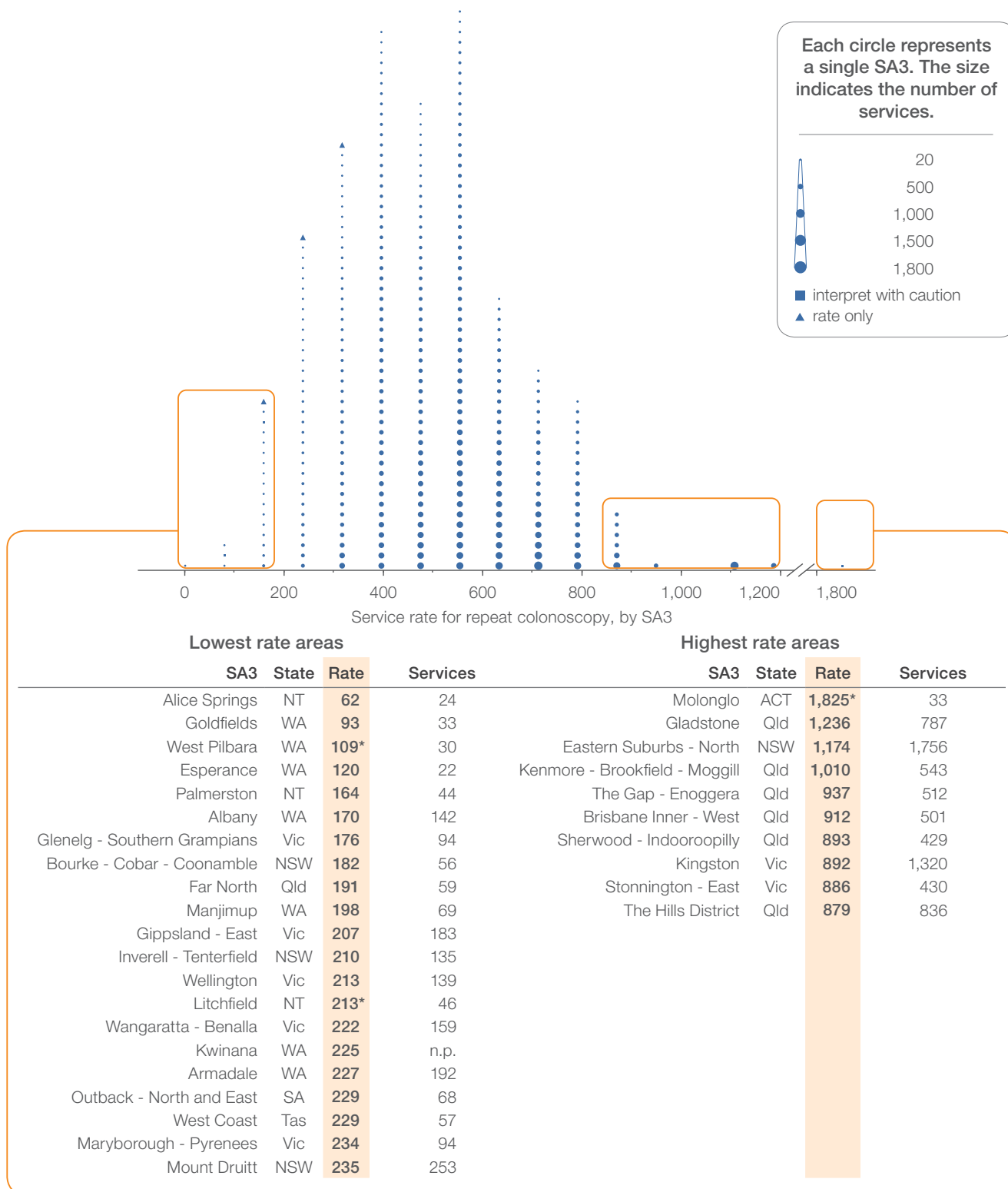
Promoting existing initiatives

As part of the Choosing Wisely Australia initiative, the Gastroenterological Society of Australia made the following recommendation in 2016, to promote the appropriate use of surveillance colonoscopy³³:

- Do not repeat colonoscopies more often than recommended by the National Health and Medical Research Council–endorsed guidelines.

Rates by local area

Figure 5.13: Number of MBS-subsidised services for repeat colonoscopy per 100,000 people of all ages, age and sex standardised, by Statistical Area Level 3 (SA3) of patient residence, 2018–19



Notes:

Squares (■) and asterisks (*) indicate rates that are considered more volatile than other published rates and should be interpreted with caution.

Triangles (▲) indicate SA3s where only rates are published. The numbers of services are not published (n.p.) for confidentiality reasons.

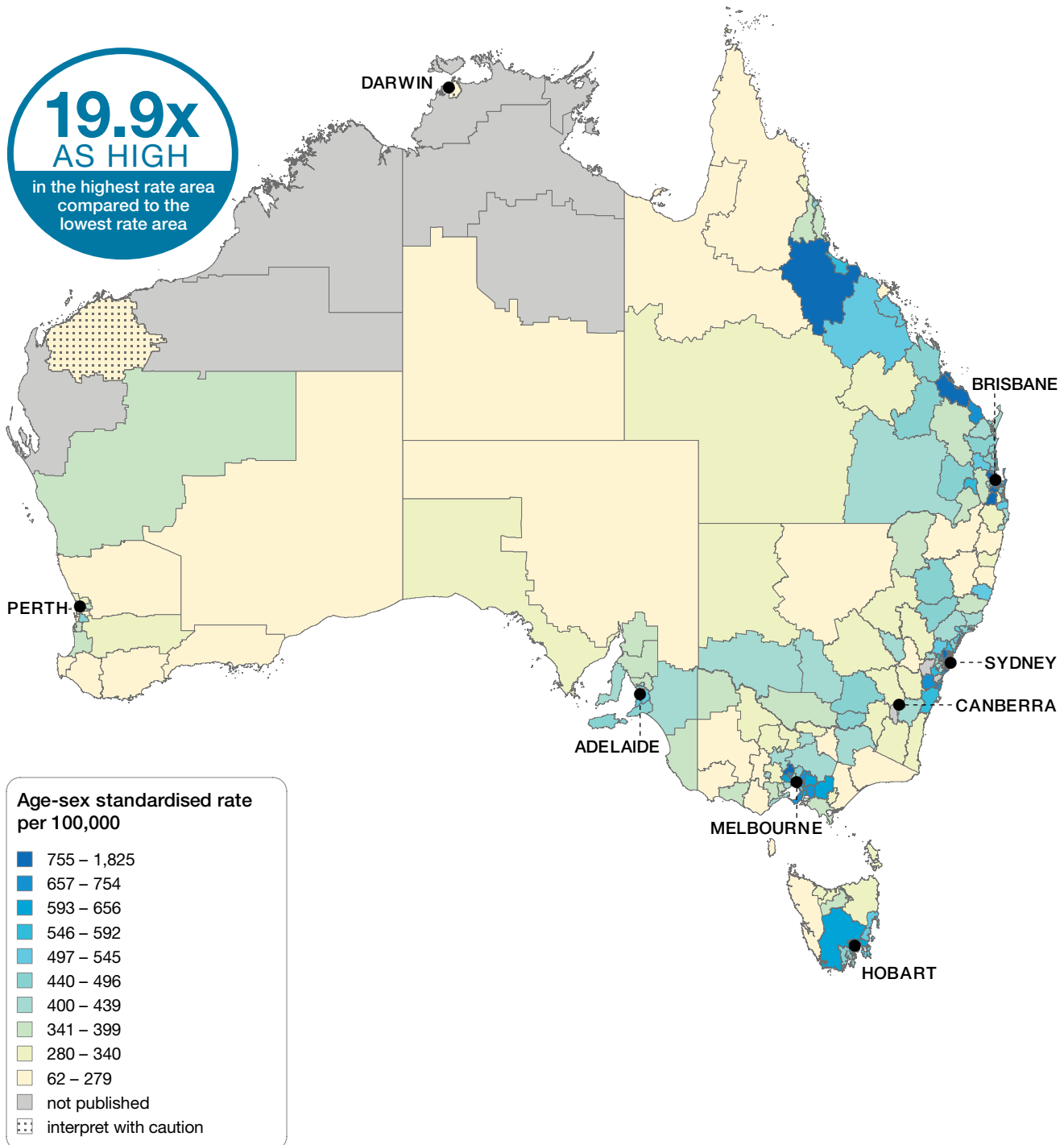
For further detail about the methods used, please refer to the Technical Supplement.

Sources: AIHW analysis of Medicare Benefits Schedule data and ABS Estimated Resident Population 30 June 2018.

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Rates across Australia

Figure 5.14: Number of MBS-subsidised services for repeat colonoscopy per 100,000 people of all ages, age and sex standardised, by Statistical Area Level 3 (SA3) of patient residence, 2018–19



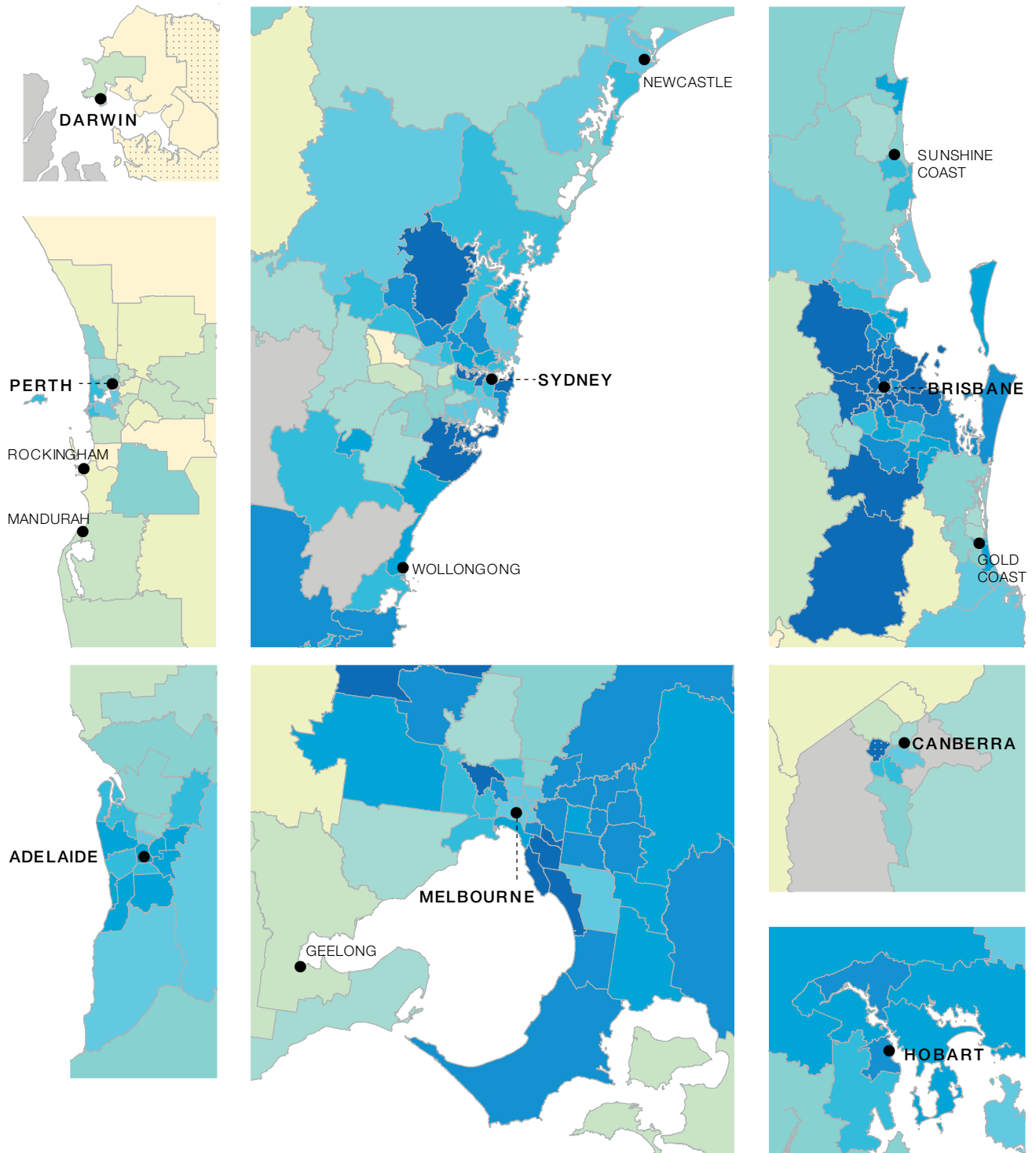
Notes:

Dotted areas indicate rates that are considered more volatile than other published rates and should be interpreted with caution. These rates are excluded from the calculation of the difference between the highest and lowest SA3 rates in Australia. For further detail about the methods used, please refer to the Technical Supplement.

Sources: AIHW analysis of Medicare Benefits Schedule data and ABS Estimated Resident Population 30 June 2018.

Rates across capital city areas

Figure 5.15: Number of MBS-subsidised services for repeat colonoscopy per 100,000 people of all ages, age and sex standardised, by Statistical Area Level 3 (SA3) of patient residence, 2018–19



Notes:

Dotted areas indicate rates that are considered more volatile than other published rates and should be interpreted with caution. For further detail about the methods used, please refer to the Technical Supplement.

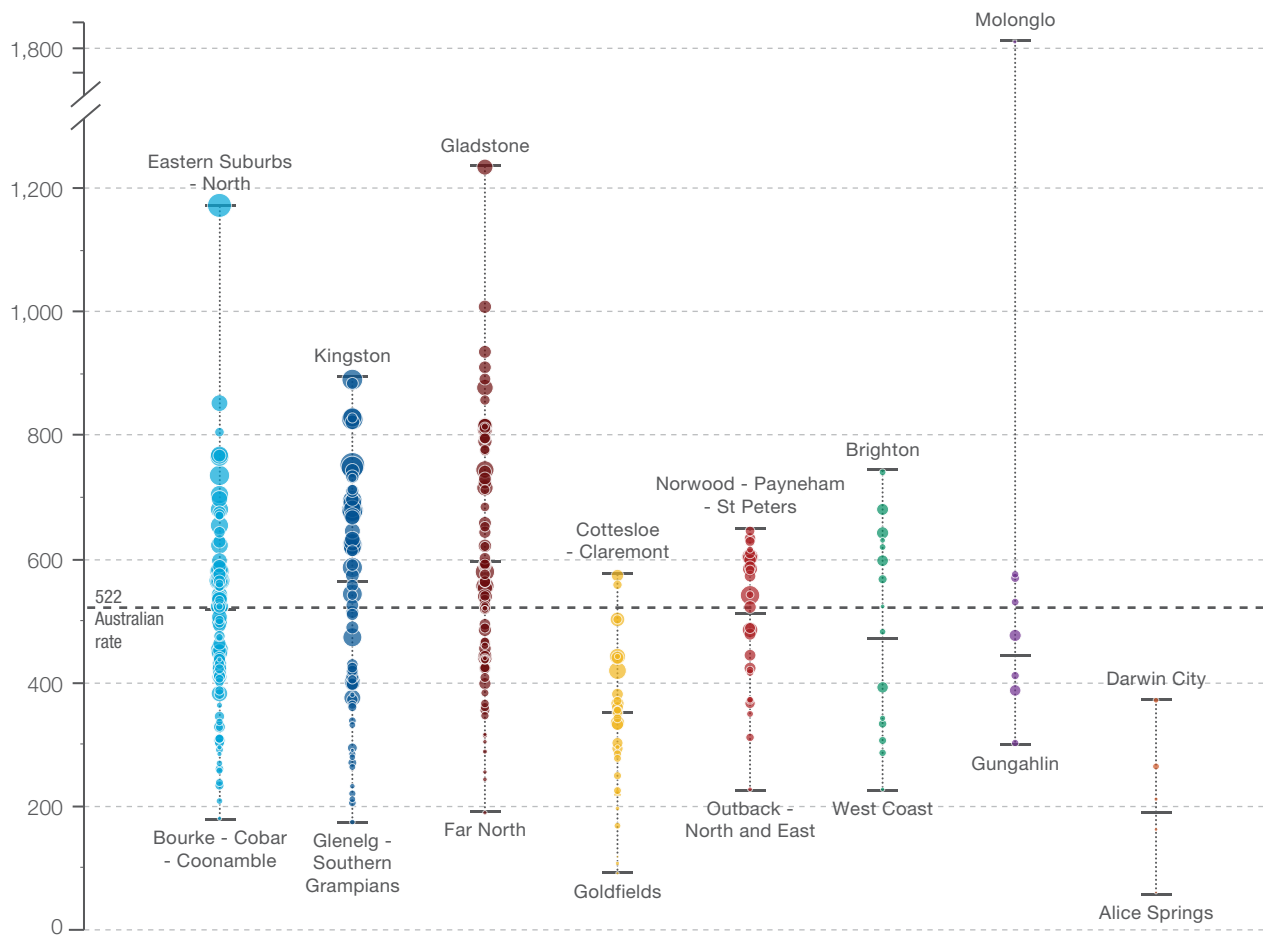
Sources: AIHW analysis of Medicare Benefits Schedule data and ABS Estimated Resident Population 30 June 2018.

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Rates by state and territory

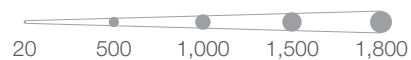
Figure 5.16: Number of MBS-subsidised services for repeat colonoscopy per 100,000 people of all ages, age and sex standardised, by Statistical Area Level 3 (SA3) of patient residence, 2018–19

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT
Highest rate	1,174	892	1,236	575	647	742	1,825*	373
State/territory	517	562	596	352	513	472	443	191
Lowest rate	182	176	191	93	229	229	304	62
Total services	47,257	40,377	33,629	9,977	11,002	3,331	1,884	391



Each circle represents a single SA3. The size indicates the number of services.

▲ rate only ■ interpret with caution



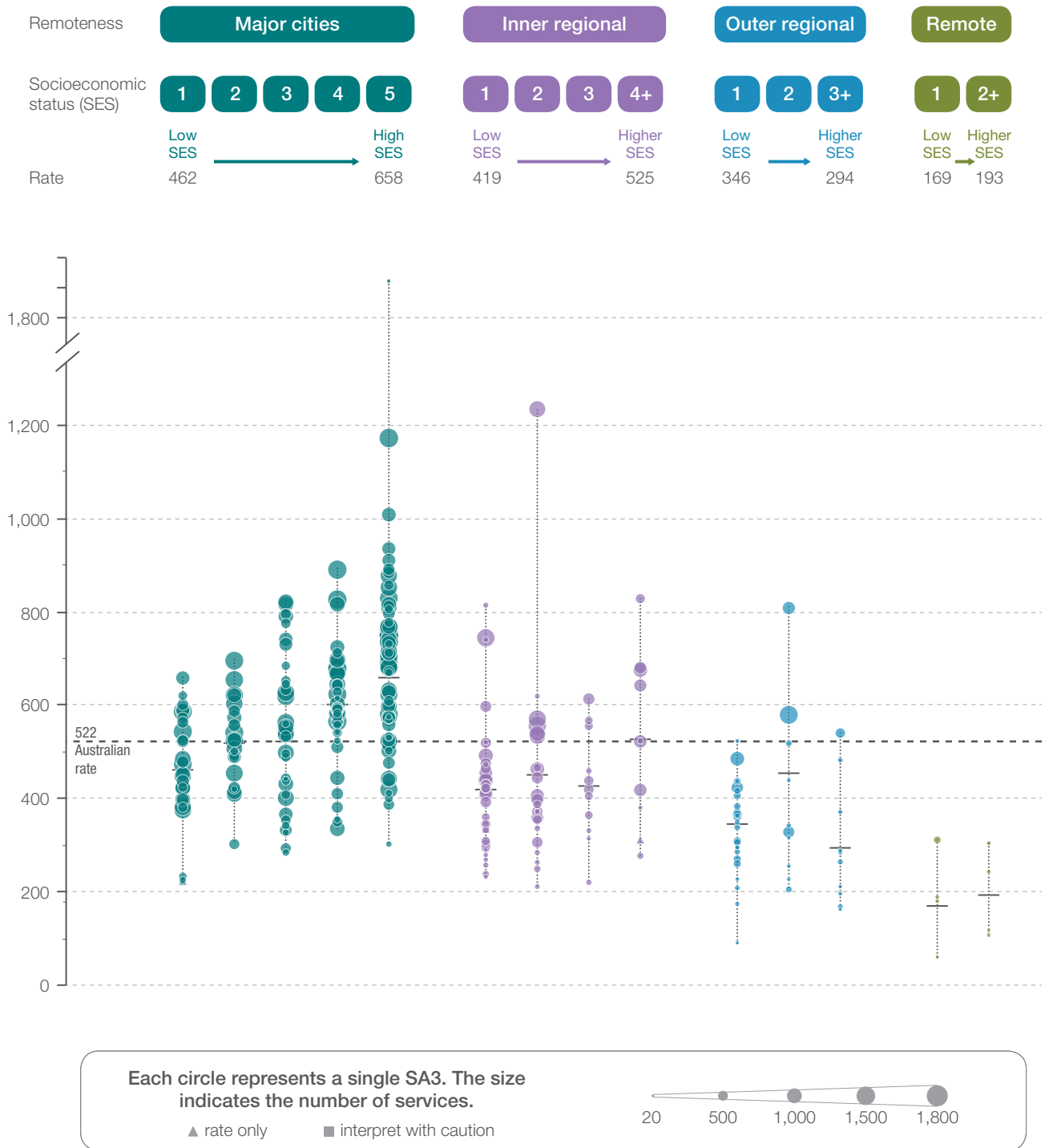
Notes:

Squares (■) and asterisks (*) indicate rates that are considered more volatile than other published rates and should be interpreted with caution. Triangles (▲) indicate SA3s where only rates are published. The numbers of services are not published for confidentiality reasons. For further detail about the methods used, please refer to the Technical Supplement.

Sources: AIHW analysis of Medicare Benefits Schedule data and ABS Estimated Resident Population 30 June 2018.

Rates by remoteness and socioeconomic status

Figure 5.17: Number of MBS-subsidised services for repeat colonoscopy per 100,000 people of all ages, age and sex standardised, by Statistical Area Level 3 (SA3) of patient residence, 2018–19



Notes:

Squares (■) and asterisks (*) indicate rates that are considered more volatile than other published rates and should be interpreted with caution. Triangles (▲) indicate SA3s where only rates are published. The numbers of services are not published for confidentiality reasons. For further detail about the methods used, please refer to the Technical Supplement.

Sources: AIHW analysis of Medicare Benefits Schedule data and ABS Estimated Resident Population 30 June 2018.

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Resources

- Australian Commission on Safety and Quality in Health Care, *Colonoscopy Clinical Care Standard*³
- Cancer Council Australia, *Clinical Practice Guidelines for the Prevention, Early Detection and Management of Colorectal Cancer*⁴
- Cancer Council Australia, *Clinical Practice Guidelines for Surveillance Colonoscopy*⁵
- Australian Institute of Health and Welfare, Cancer summary data visualisations⁸, aihw.gov.au/reports/cancer/cancer-data-in-australia/contents/cancer-summary-data-visualisation

Australian initiatives

Information in this chapter will complement work already underway to prevent inappropriate repeat colonoscopy in Australia. At a national level, this work includes:

- Australian Commission on Safety and Quality in Health Care, *Colonoscopy Clinical Care Standard*³
- Gastroenterological Society of Australia, Choosing Wisely recommendation 1: Do not repeat colonoscopies more often than recommended by the National Health and Medical Research Council–endorsed guidelines.³³

Many state and territory initiatives also aim to improve colonoscopy use, including:

- Clinical Priority Category: Colonoscopy²⁹, Agency for Clinical Innovation, New South Wales
- *Colonoscopy Categorisation Guidelines*, Victoria³⁴
- *Endoscopy Action Plan*, Queensland³⁵
- Clinical prioritisation criteria: endoscopy³⁶ and Clinical prioritisation criteria: gastroenterology³⁰, Queensland
- *Referral Guidelines: Direct access gastrointestinal endoscopic procedures*, Western Australia³¹
- *Urgency Categorisation and Access Policy for Public Direct Access Adult Gastrointestinal Endoscopy Services*, Western Australia³²
- Statewide endoscopy care network, which monitors and assesses the quality of endoscopy services, Tasmania.²⁸

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