

Consumer choice and the National Bowel Cancer Screening Program

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The opportunity for informed choice in screening is limited

Commencing in mid 2006, the Australian Government will phase in a national bowel cancer screening program for men and women who turn 55 or 65 years of age, and for those who participated in the government's pilot screening program, conducted from November 2002 to June 2004.¹ Eligible people will be invited to complete an immunochemical faecal occult blood test (FOBT) in the privacy of their own home and mail it in for analysis.² Consumers will not be offered a choice of screening test. The government came to this position after commissioning a review of the costs, benefits and harms of different screening options³ and evaluating the pilot screening program.¹ The study by The Multicentre Australian Colorectal-neoplasia Screening (MACS) Group in this issue of the Journal (*page 546*)⁴ suggests that participation in screening does not differ significantly between different screening tests that might be offered. The implication is that consumer choice can be taken out of the equation if maximising participation is the primary objective of screening. If consumer choice does not influence participation, then why not offer a range of screening tests? This invites two prior questions — to what extent should the Australian Government be concerned about consumer choice and participation, and what criteria should be applied to determining screening options?

For decades, Australia has accepted the World Health Organization guidelines for evaluating the worth of screening. These guidelines, recently updated, state "...in screening there is an ethical responsibility to conduct programs that will be of overall benefit to those who are screened and will minimize harm and anxiety that will arise. It is not simply the offering of medical tests for people to accept or reject as they wish. This responsibility implies that if evidence is not available from valid studies on the effectiveness of screening, screening should not be offered."⁵

Although one in six participants in the MACS Group trial participated in a screening strategy other than FOBT,⁴ neither flexible sigmoidoscopy, computed tomography colonography nor colonoscopy meet the WHO criteria for a screening test. As yet, there is no trial evidence that any of these tests reaches an acceptable ratio of population benefits to harms and costs that would warrant their inclusion in a national screening program.

The results of the MACS Group trial raise important questions about whether participation in screening is an appropriate measure of success and whether participation itself is an adequate measure of consumer choice. The traditional view, one shared by the updated WHO guidelines, is that participation is a measure of success.⁵ All things being equal, the more people who are screened, the greater the reduction in bowel cancer mortality in the population. That line of reasoning is incontestable. What is contestable is whether people who participate in screening make an informed choice.

The MACS Group suggest that the one reason why their participation rates (averaging 20.9% over all screen tests) were

lower than the government pilot projects (45.4%)¹ and other international programs is that the Group were required to "present the invitation as a clinical research project with *due informed consent*" (our emphasis). This, argues the MACS Group, may have contributed to a lower participation rate. They then suggest that a "guided choice" following formal clinical review might improve participation.

The Australian Government should seriously consider providing a decision-support system that allows consumers to decide whether they want to take up the offer of screening, based on information of benefits, harms and the process of testing. This should include a guide to screening options. Not everyone will want or need a "guided choice". Our previous study of consumer choice of FOBT screening found that a third of the target group opted for screening no matter what the ratio of harms to benefits, 55% took up the offer of a guided choice (weighing up the benefits and harms), and 12% chose outright not to be screened.⁶ Even if 30% of the target screening group take up the offer of a guided choice by a general practitioner, based on the 75% Medicare rebate for a level-B GP consultation, the cost per life-year saved (LYS) of biennial FOBT screening without a routine GP consultation would increase from about \$13 500⁷ to \$21 000 per LYS. If 70% of the target population opt for a GP visit, the cost per LYS is \$31 300 — more than double the cost effectiveness ratio for a screening program without a routine visit to the GP. Even so, this figure is comparable to other cancer screening programs. The challenge is to develop an affordable decision-support system — one that is either self-directed or one that offers restricted access to an additional GP consultation. This applies equally to those aged under 55 years who will not be eligible for screening in the national program.

Unless the national program actively engages the community, GPs and pharmacists in screening and diagnostic assessment of people with a positive FOBT, the opportunity for an informed choice and participation is limited. A key question for the National Bowel Cancer Screening Program is whether setting participation targets and using them to measure the success of screening is appropriate. Falling short of a 70% target participation rate shouldn't be taken as a public health failure if it can be shown that consumers have had an opportunity to make an informed choice (alone or with their GP), using a decision-support system if they wish to do so.

Informed consumers making smart choices about screening — now that would be a public health success.

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