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Australian Association Of Pathology Practices Inc.
ABN 41 052 527 634

Commonwealth Parliamentary Inquiry into Health Funding
Submission to the Standing Committee on Health and Ageing

Key Points

- Pathology lies at the heart of all medicine and provides cost-effective, high quality services to the Australian community.
- The Pathology Quality and Outlays Memorandum of Understanding (MoU) caps Medicare pathology outlays and includes policy reforms, quality use of pathology initiatives and pathology workforce training.
- Pathology has led the way in adopting the benefits of information technology; governments must continue to support the adoption of an effective information management network across the entire health care system.
- Pathologists have a critical role in the identification of early disease and ongoing monitoring of treatment regimes, including drug therapies, in order to prevent the progression of disease, avoid unnecessary hospitalisations, and improve quality of life for patients.
- The profession recognises that principles of equity and efficiency are fundamental to our health system and has agreed, through the MoU, to consider patient affordability in setting its fees.
- The provision of high quality pathology services cannot be achieved without appropriately qualified pathologists to provide and oversee the services.
- Policy changes, for example to increase the role of general practitioners and practice nurses and to increase the private health insurance rebate, and the evolution of health care itself to cope with an ageing population, may result in greater than expected upward pressure on pathology services. These changes must be closely monitored and the pathology funding cap adjusted upwards as necessary.
- The lack of a Medicare Benefits Schedule (MBS) item for HIV serology, despite private laboratories performing the majority of HIV tests, remains a major deficiency in the Pathology Services Table (PST).
- Pathology is in the vanguard of quality assurance through adopting stringent accreditation and regulatory mechanisms to secure the quality and safety of the testing and diagnostic advice provided by pathology practices.
- Whilst appearing to represent a simplification of funding and administrative arrangements for pathology, the implications of global funding for the profession, for government, and most importantly, for patients, need thorough investigation, and any changes to current policy must be based on clear evidence of the benefits that would accrue from such change.
- Patients rely on the system working seamlessly, that is, on collaboration and cooperation between the different health care sectors, but the financial and administrative arrangements do not always support this. It is vital that reforms focus on building a health system based around the needs of the patient, rather than being solely reliant on the 'goodwill' and professionalism of practitioners.
- Maintaining an appropriate balance between public and private funding of health care is vital to ensure government outlays continue to be sustainable.

PO Box 158 (Unit 6, 2 Phipps Close)
DEAKIN WEST ACT 2600
Tel: (02) 6282 2277 ● Fax: (02) 6282 2953 ● E-mail: aapp@client-solutions.com.au

1 INTRODUCTION

1.1 AAPP Background

The Australian Association of Pathology Practices (AAPP) is the principal industry body for private pathology practice in Australia, representing over 90% of the private specialist pathology market.

AAPP members provide cost-effective, high quality pathology services to the Australian community.

The AAPP was established in the late 1980s to provide private practice pathology with organised and professional representation during high-level negotiations with the Federal Government.

Our aim is to promote the honourable and ethical practice of pathology and to promote the practice of private pathology within Australia. We seek to help the Government achieve its fiscal objectives, whilst safeguarding professional and economically viable pathology practice.

1.2 What is Pathology?

'An understanding of pathology is an essential prerequisite to an understanding of medicine.'[1]

Pathology is a medical speciality that focuses on understanding the mechanism of disease, the diagnosis and the monitoring of therapeutic modalities. The ultimate aim of pathology is to prevent and eradicate disease.

Pathology involves the examination and testing of body fluids (eg. blood) and body cells to identify what changes are occurring and to assist in selecting the best course of treatment. It is the diagnostic skills of pathologists that allows patients to know if they are pregnant, anaemic, diabetic, at risk of heart disease, or if their lump is malignant or not.

Pathology lies at the heart of all medicine. Its benefits include:

- Saving lives and health care dollars through detection and prevention of disease
- Improving patient welfare by allowing better and earlier diagnosis resulting in more efficient and effective treatment
- Improving the long term well-being of Australians by allowing precise monitoring of peoples' health (eg. tracking blood cholesterol levels)
- Increasing the effectiveness and efficiency of drug therapy and helping to prevent side effects.

1.3 History of reforms in pathology

For the past fifteen years, the funding and delivery of pathology services under Medicare has been under considerable scrutiny, due mainly to the inexorable increase in demand for pathology services and the consequent cost impact on Medicare. Over this period, the AAPP has been instrumental in the introduction of many, if not all, of the reforms in the profession aimed at containing costs whilst ensuring a continued high standard of pathology care.

For over eight years, the profession has accepted capped funding for pathology services provided under Medicare. Despite being a painful process for providers, both the profession and the federal Government have supported the agreements, which have delivered the following benefits:

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[1] Weedon D (2003), Whither pathology in medical education? *Medical Journal of Australia*; 178 (5): 200-202.

- Continued fee-for-service for this specialist medical service
- Certainty in outlays for government
- Massive savings to government through efficiency dividends built into the pathology funding Memorandum of Understanding (MoU)
- Bi-partisan political support
- Agreed annual growth rates
- Industry stability during a period of unprecedented consolidation and corporatisation
- Professional survival for pathologists and scientists
- Improved efficiencies in the delivery of services
- An improved Pathology Services Table (PST) through targeted fee adjustments and improved relativities between items of service
- Improved management skills – each agreement has delivered precise outcomes with the profession's active support.

There have been however, a number of downsides to this process, not least of which is the increasing difficulty of delivering progressive savings over a number of years against forward estimates. Some of the other negative effects of the MoU have included:

- Reduced margins for pathology practices
- Reforms being funding-based rather than aiming at best medical practice
- The potential to curtail excellence and encourage mediocrity – doing more for the same amount of money
- Discouragement of entrepreneurship by creating limits to return on investment
- The potential for central agencies to continually tighten the 'noose'
- Rapid fee cuts, whereas fee increases under a funding cap take much longer to implement
- Diminishing returns – it gets harder each year to deliver savings
- Opposition by the Australian Medical Association (AMA) and other medical specialties
- Absence of corporate memory in the bureaucracy and impending within the profession
- Tendency to institutionalise conflict between profession and government
- Likelihood of unsustainability in the long term.

1.4 Third MoU

In 2004, the profession negotiated a third pathology funding agreement (MoU), to run from 1 July 2004 to 30 June 2009. The MoU allows for approximately $8 billion in Medicare pathology outlays over the five-year term. It is a complex document, which covers not only outlays, but also policy reforms, quality use of pathology initiatives and pathology workforce training. A Fact Sheet on the MoU accompanies this submission. The complete MoU is available from the Department of Health and Ageing website, at http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/health-pathology-fin-mou.htm-copy3.

In this submission, AAPP will focus on key areas in health care delivery and funding that impact on the provision of pathology services.

2 REFORMING HEALTH CARE

Current arrangements for funding and delivering health care in Australia create artificial barriers between primary, secondary, acute and aged care services. The Australian health care system, with its mix of public and private health care arrangements, and different services and providers funded by different levels of government, is extremely complex even to industry insiders, let alone the consumers who have to navigate their way around it. Estimates of the cost to the Australian economy of inefficiencies resulting from the waste, duplication, and cost and blame shifting in the system range up to $1.1 billion per annum.[2]

Various proposals to rationalise the delivery of health care have been put forward, including consolidation through a single funder arrangement. The recent Podger review is the latest attempt. According to various reports in the media, it canvasses the establishment of clear funder-purchaser-provider roles that would see regional purchasing bodies 'competing' for health care resources and contracting providers to deliver the necessary services for their prescribed population.[3]

Notwithstanding the calls for radical reform, there is general agreement about the key areas where greater efficiency, quality and equity could be achieved within the current system, which include better coordination of care, an increased focus on prevention of disease, and equitable access to health care and resources.

2.1 Using technology for quality and efficiency

2.1.1 Coordination of care

Coordination between general practices, other community-based services, secondary care and hospitals is haphazard, and largely reliant on individual relationships among providers and services. Coordination of care must be supported by comprehensive information and communications technology and management systems that provide all health practitioners and care givers with access to accurate and timely information about an individual's treatment.

Pathology has led the way in adopting the benefits of information technology; through the MoU, pathology providers have agreed to participate in Health*Connect* to achieve greater integration and flow of information among health care providers. Governments must continue to support the adoption of an effective information management network across the entire health care system.

As White (2003) notes:

> *'Despite changing laboratory practices, communication between clinical users and pathology laboratories continues to be by the test request and the report, be it paper or electronic. Thoughtfully used, these avenues can efficiently provide patient-focused information at the moment of need. However, their value in enhancing patient care, and minimising harm, needs renewed emphasis. There is much anecdotal evidence that use of the "clinical note" on request forms is waning. Without at least a brief indication from the requesting doctor of the clinical reason or expectation for the tests, the laboratory has little chance of checking results for "clinical fit", or value-adding with further relevant information. On the laboratory side, there needs to be a greatly improved use of the clinical note and the patient report to convey patient-specific test information and caveats, without creating visual indigestion. For the long term, there needs to be emphasis given in pathology teaching to the effective and appropriate use of laboratory tests in patient care, at both the undergraduate and postgraduate level.*

2 Davis M (2005), Federal system wastes $2.4 bn. *Australian Financial Review*, 14/3/05.
3 Uren D (2005), States out in health shake up. *The Australian*, 6/04/05.

Working together through improved patient-oriented communication, doctors and their laboratory colleagues create the opportunity to maximise the contribution pathology tests can make to safe, effective patient care.[4]

2.1.2 Prevention and early intervention

The changing burden of disease, with preventable chronic and co-morbid illnesses comprising a greater proportion of health needs and costs, means that the delivery of care must also change. Greater emphasis must be given to addressing the common risk factors for disease and intervening earlier in the disease path.

Pathologists have a critical role in the identification of early disease and ongoing monitoring of treatment regimes, including drug therapies, in order to prevent the progression of disease, avoid unnecessary hospitalisations, and improve quality of life for patients.

Moreover, this role is set to increase exponentially, as technology advances such as genomics continue to find their way into practice. For example, as reported in The Australian, a recent Australian study, published last week in the medical journal The Lancet, reveals a DNA test can detect a genetic predisposition to haemochromatosis, a potentially fatal disease that can cause heart problems and organ failure. Screening for the disease, which affects about one in 250 Australians and can be treated if diagnosed early, could save hundreds of lives.[5]

Whilst the development and implementation of new medical technologies has been identified as a major cost driver in health care, AAPP believes it is inevitable and, on balance, overwhelmingly beneficial to patients and the community at large. For example, recent technological advances in diagnostic testing have resulted in a decrease in the incidence of cervical cancer by around 50 percent due to the success of screening programs, and the performance of PSA testing on men over 50 years of age is already showing positive results in the early detection and cure of prostate cancer.

2.2 Keeping health care affordable

A number of studies over recent years have shown that Australians have a strong belief in health care as a public good, for which responsibility is shared across the community. There is overwhelming public support for Medicare, as universal public health insurance coverage for all Australians, paid for proportionately by all taxpayers through the taxation system.

Pathology stands out within the medical profession for its consistently high rates of bulk billing and schedule fee observance – respectively at 86 percent and 92 percent of services. Furthermore, the majority of the remaining eight percent is covered by no-gap arrangements with private health funds.

In addition, recognising that principles of equity and efficiency are fundamental to our health system, the profession has agreed, through the MoU, to consider patient affordability in setting its fees. The MoU thus includes provision for annual bonuses to the agreed level of outlays if patient contributions to the total cost of pathology services in the given year do not exceed a certain level (ranging from 9.5-11%) over the life of the agreement.

2.3 Ensuring access through workforce measures

The provision of high quality pathology services cannot be achieved without appropriately qualified pathologists to provide and oversee the services. The recent Australian Medical Workforce Advisory Committee (AMWAC) review of the pathology workforce revealed a

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[4] White GH (2002), Trusting numbers. Uncertainty and the pathology laboratory. Medical Journal of Australa 2002; 177 (3): 153-155.

[5] Pirani C (2005) DNA screening could rescue hundreds from chronic ills. *The Australian.* 7/5/05.

serious shortage of pathologists in Australia. In 2003, there were 1,290 pathologists in active practice, or one pathologist per 15,500 head of population.[6]

Weedon (2003) argues that 'with the currently decreasing staffing levels in academic departments of pathology and lack of formal rotations into pathology in the immediate postgraduate years, there is every likelihood that future recruitment of Australian graduates into pathology will be difficult.'[7]

Lack of access to pathologists has the potential to affect the care provided to patients by other medical specialties that rely on their services. The RCPA notes:

> *'If this trend persists, pathology services may even become the capacity-limiting process for many clinical activities: diagnosis and staging of diseases, screening for disorders, quality control of clinical management, education at undergraduate and postgraduate levels, research on clinico-pathological issues, development of cellular and molecular methods and pathogenesis, and patients may face long waits before hearing a final diagnosis, or they will have to endure uncertainty about the diagnosis, as the expertise needed is not available.*[8]

Greater emphasis needs to be given to pathology training during medical undergraduate and internship years, and to the development of incentives that will encourage private pathology practices to undertake more education and training of medical students and graduates.

2.4 Integrating funding arrangements

It has been noted that the current health care system 'has little or no rationality. Some services, such as those offered by public hospitals, are free. Some, such as prescription pharmaceuticals, are subject to co-payments, but these are capped. Some, such as ambulatory services, are subject to open-ended co-payments where the consumer bears the risk. And some important services, such as dentistry and physiotherapy, receive no public insurance cover at all.'[9]

Pathology is a secondary medical service. That is, a requesting practitioner orders it on behalf of a patient. Consequently, pathology providers have little direct control over the volume and frequency of services requested of them. Whilst the MoU makes provision for minor variances in outlays, recent policy changes, and the evolution of health care itself to cope with an ageing population, may result in greater than expected upward pressure on pathology services. In addition, the heightened profile of medico-legal issues may result in medical practitioners ordering more tests to avoid litigation resulting from misdiagnoses.

Thus, a key driver of demand for pathology services is requestor-induced. Recent general practice policies have been designed to boost GP numbers, enhance the role of general practice in the primary care of patients, support the prevention of disease and early intervention, and enable better management of chronic diseases. Furthermore, it was recently reported that new proposals are being considered to expand the GP-based Australian Sentinel Practice Research Network (ASPREN) to provide early warning of pandemic influenza or other emerging disease outbreaks and to undertake a monitoring role as part of a new national biosecurity surveillance system.[10]

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[6] Royal College of Pathologists of Australasia (RCPA) (2003), http://www.rcpa.edu.au/applications/documentlibrarymanager2/inc_documentlibrarymanager.asp, accessed 9/5/05.

[7] Weedon, op cit.

[8] RCPA, op cit.

[9] McAuley (2003), Funding health care – taxes, insurance or markets? Paper for Health Insurance Summit, Sydney, 12-13 June 2003. Canberra: University of Canberra, p. 14.

[10] Rouse R (2005), GP monitoring of disease threats may be boosted. *Medical Observer*, 6/5/05.

Whilst these are undoubtedly desirable advances, in the capped funding and highly regulated environment for pathology, any impact on services provided in general practice will have a flow on effect to secondary providers.

Recent policy has also meant an increasing role and greater scope of practice for nurses: specific MBS items have been introduced for cervical screening, immunisations and wound care performed by a practice nurse under the direction of a general practitioner. The potential to substantially increase the number of Pap smears undertaken, whilst having a significant impact on health outcomes, will also clearly have implications for pathology services. While general practitioners have been found to have lower utilisation rates of investigative, outpatient, and specialist services for primary care consultations in emergency departments,[11] there is some evidence that nurse practitioners order tests at a higher rate than GPs.[12] As the role and scope of nursing practice in Australia continues to expand, the flow on effect of this on secondary services must be closely monitored and adjustments made to pathology funding arrangements as necessary.

It is also likely that pathologists will be required to play a back-up role in the roll out of the Point of Care Testing (PoCT) trials, and will need additional capacity to ensure that quality controls are in place to ensure best patient care in both the collection and testing of samples, and the interpretation of results.

The MoU prescribes that 'budget measures relating to workforce supply will only be relevant if they are intended to increase, and actually result in a measurable increase in, the per capita supply of full time equivalent ordering practitioners'.[13] In this environment, providers tend to compete on level of service, comprehensive and state of the art practice, accurate results and fast turnaround times. These efforts are not cost-neutral.

Yet as noted in the Medical Journal of Australia:

> *'The Commonwealth government has sought to reduce Medicare outlays for these services by restructuring the relevant sections of the [MBS], by informing those requesting these services of their patterns of use, by licensing and reducing the number of pathology collection centres, and by limiting the number of pathology services allowed per episode (i.e. per patient each day) that attract benefits.*
>
> *Such measures are effectively cost-cutting activities, and are seen to be imposed by the funders, often without effective incentives for the users or providers to change. Passive information and educational material accompanying these activities is usually prepared by the funders, and may be seen by the users as of little relevance or of poor quality. Moreover, such measures may not prevent the development of further distortions in use of services (through, for example, inappropriate use of other clinical procedures or marketing of other pathology services).*[14]

In addition, the lack of an MBS item for HIV serology, despite private laboratories performing the majority of HIV tests, remains a major deficiency in the PST. Because there is no rebate

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[11] Dale J, Green J, Reid F, Glucksman E, Higgs R (1995), Primary care in the accident and emergency department: II. Comparison of general practitioners and hospital doctors, *British Medical Journal* 1995; 311: 427-430.

[12] Venning P, Durie A, Roland M, Roberts C, Leese B (2000), Randomised controlled trial comparing cost effectiveness of general practitioners and nurse practitioners in primary care, *British Medical Journal* 2000; 320: 1048-1053.

[13] Australian Government Department of Health and Ageing (2004), Pathology Quality and Outlays Memorandum of Understanding, http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/health-pathology-fin-mou.htm-copy3, accessed 10/5/05.

[14] *Medical Journal of Australia* (1999), Editorial. 1999; 170: 8-9

for this service, private labs are often required to refer these tests to a public hospital laboratory. Consequently, large numbers of samples are being transferred between unrelated laboratories, which do not have electronic connectivity, resulting in serious errors of sample and patient identification and transcription mistakes in result reporting. Further, the NATA/RCPA laboratory accreditation system uses potential denial of Medicare benefits to a laboratory and its patients for a failed test or test class to enforce standards, therefore the practice of HIV serology testing can escape regulation whether performed in public or private laboratories. The contrast with Hepatitis C serology is stark: this item is on the MBS, is well regulated and therefore well performed, and in most laboratories in Australia, results are available on a same day basis. It is time this situation was fixed, with items added to the PST for the HIV antibody EIA test and the Western blot test. Funds that are currently directed to the state governments for this testing would need to be added to the Pathology MoU targets.

Funding for pathology services, as with other medical services, is derived from federal and state/territory governments and private sources, through rebates for items in the Pathology Services Table (PST) of the Medicare Benefits Schedule (MBS), through public pathology services and through patient co-payments. This results in cost shifting and conflict between the public and private sectors, and ultimately confusion for patients.

The MoU provides for consideration by the profession and federal and state governments (including under the Australian Health Care Agreements) of global funding arrangements for pathology services. Whilst appearing to represent a simplification of funding and administrative arrangements for pathology, the implications of such arrangements for the profession, for government, and most importantly, for patients, need thorough investigation, and any changes to current policy must be based on clear evidence of the benefits that would accrue from such change.

2.5 Maintaining quality care

Australia has significant safety and accountability mechanisms in place for pathology services, supported through the MoU. Pathologists are required to undertake five years of postgraduate education to obtain specialist qualification and undertake ongoing continuing professional development in order to meet the requirements of the Royal College of Pathologists of Australasia (RCPA). There are stringent accreditation and regulatory mechanisms in place to secure the quality and safety of the testing and diagnostic advice provided by pathology practices.

It has been noted that:

> *'Pathology laboratories have achieved significant improvements in the timely provision and quality of diagnostic tests. Automation, commercially produced reagents and computing are providing clinicians with an ever-increasing menu of rapid, cost-effective tests. Operational advances in pathology have occurred in consort with analytical developments that measure many types of molecule with specificity and in ever-decreasing amounts, revolutionising the routine assay of many molecules of clinical diagnostic value. Coupled with this progress, pathology services in Australia meet stringent technical, management and quality-assurance standards to hold government accreditation for pathology testing.'*[15]

Pathology is in the vanguard of quality assurance through measures such as:

- Regulation – of pathologists, pathology companies and of pathology laboratories
- Standards development through the National Pathology Accreditation Advisory Council (NPAAC)
- Assessment and accreditation of pathology laboratories by NATA/RCPA Peer review system
- Quality Assurance programs:
    - Externally through the RCPA – QAP Pty. Ltd.

[15] White, op cit.

- Other systems providing internal QAP programs

The quality use of pathology is also a key ingredient of the current MoU with approximately $2 million per annum allocated for studies into the appropriate ordering of technology. This approach is supported by a systematic review undertaken by Beilby and Silagy in 1996, which demonstrated that the provision of education and feedback to general practitioners on their ordering practice (with and without cost information) could improve the appropriateness of diagnostic testing.[16]

2.6 Building an integrated system

It must be recognised that the health care system indeed operates as a system – changes to policies for the funding or organisation of care in one part will affect other parts, as the examples of cause and effect in the growth in pathology services demonstrated earlier. Unfortunately, pathology has been largely excluded from relatively recent policy initiatives, such as the Divisions of General Practice, the More Allied Health Services program, the Enhanced Primary Care MBS items and so on, which have attempted to address the lack of integration among different health sectors and increase the focus on prevention and better chronic disease management.

As the Productivity Commission noted in its recent progress report,

> *'In the private sector, the currently limited ability of private health funds to influence the uptake of new technologies could place pressure on premiums and Australian Government expenditure via the... rebate. Provision of new technologies to privately insured patients in turn would place pressure on public hospitals to adopt these technologies. Differential access to advances in medical technology (between private and public, higher and lower income, and non-Indigenous and Indigenous patients) is likely to be heightened if existing health system arrangements exist.'*[17]

In a single episode of care, individuals may require services from providers in both the public and private sectors, with funding coming from both public and private sources including Medicare, health funds, or their own pockets. Patients rely on the health care system working seamlessly, that is, on collaboration and cooperation between the different sectors, but the financial and administrative arrangements unfortunately do not always support this. It is vital that reforms focus on building a health system based around the needs of the patient, rather than relying solely on the 'goodwill' and professionalism of practitioners.

2.7 Ensuring private insurance complements public health care

While it is recognised that there is potential for simplification of health funding and delivery arrangements, it must be acknowledged that Australia has generally performed well in containing the costs of new medical technologies and health care costs overall. The 8-9% of GDP we currently spend on health care is in the middle range of most OECD countries and well below that of the United States. The Australian system of fee for service for medical practice accompanied by downward pressure in the marketplace is well positioned for the future. There is growing acceptance of some 'user-pays' elements for those who can afford it and recognition that our mixed model actually works better than most. There is, however, international evidence that an over-reliance on private funding increases health care costs overall, including public expenditure.[18] Maintaining an appropriate balance between public and private funding of health care is vital to ensure government outlays and individual costs continue to be sustainable.

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[16] Beilby J, Silagy C (1997), Providing costing information to general practitioners -- will this intervention change behaviour and create cost savings? *Medical Journal of Australia*; http://www.mja.com.au/public/papers/beilby/beilby.html#refbody20, accessed 9/5/05.

[17] Productivity Commission (2005), The Impact of Advances in Medical Technology in Australia, www.pc.gov.au, accessed 9/5/05/

[18] McAuley I (2004), Stress on public hospitals – why private insurance has made it worse. A discussion paper for the Australian Consumers' Association and the Australian Healthcare Association. January 2004.

The number of privately insured patients utilising the public sector as public patients is increasingly being raised as a contributing factor in the unsustainability of public hospitals, with ideas being canvassed such as making private beds available for public hospital patients, through contracts with state governments.[19] The private health insurance industry is also keen to restart the debate around amending the legislation to allow private health funds to provide gap insurance for out of hospital primary care services (as floated in the "Fairer Medicare" proposals in 2003). This could have a significant effect on government outlays under the "MedicarePlus" Safety Net arrangements, as well as on uptake of general practice services, with commensurate flow on effects to the private pathology capped funding arrangements.

As with the introduction of the 30 percent private health insurance rebate, the effect of the 35 and 40 percent rebates (for PHI holders over 65 and 70 years respectively) on government outlays for pathology will also need to be taken into consideration, and the funding cap increased accordingly.

[19] ABC Health Online (2005), Govt urged to investigate public hospital use by insured patients, 8/05/2005. http://www.abc.net.au/news/newsitems/200505/s1362434.htm, accessed 9/5/05.