

Response to Meeting Papers for the Pathology Review Consultation Committee, 9th November 2010

Executive Summary

1. The College believes that a review of pathology which is focussed on cost does not address many serious issues relating to future pathology services which require a comprehensive **National Pathology Plan**.
2. The **National Pathology Plan** should take into account the ageing of the Australian population with its attendant increases in cancer, obesity and chronic disease and thus **increased demand for and complexity of pathology services** and the ageing and **decline of the pathology workforce**.
3. In terms of funding arrangements, the College supports **strengthening of the Pathology Services Table Committee fee-setting model**. The Schedule should gradually move to more closely reflect both the **evidence basis for pathology tests** and the increasing complexity of testing with appropriate costs determined by the committee with **appropriate assistance and consultation**.
4. The **effects of recent changes to funding and Government regulations relating to pathology** need to be taken into account in determining any further changes.
5. The College supports funding for projects related to **evidenced-based pathology** requesting, which may include **episodic panels** provided wide consultation takes place. As the foremost professional and academic organisation in pathology in Australia, the College must have strong input into the selection of EBP projects through its clinical advisory committees.
6. **Tendering** for pathology services via geographical pilots is an **insensitive means of price discovery** which potentially creates adverse outcomes for patients. These include reduced patient choice of provider, reduced competition, reduced quality of pathology services, reduced technical and workforce investment and disruption of services.
7. The College supports a **comprehensive review of the appropriateness of initiatives such as Coning and the PEI** as cost control strategies but only in the context of careful modelling of the flow on effects to service provision. The College does not support **volume discounting**. The College believes that isolated changes will create unexpected volume and cost shifts that will adversely impact on patient care.
8. The College welcomes the commencement of **Federal funding for genetic tests** and the recognition of the differences between tests for heritable diseases and cancer genetics. The College may support an alternative (“non-MBS”) funding model for genetic tests, provided that: there is extensive consultation with the profession and consideration of issues of low and high volumes and complexity; that the funding is “quarantined” ; and, that the model includes dedicated funds for training, research and innovation. There should also be a timely process for “grandfathering” established tests and approving new tests for funding.

Introduction / Background

The first Pathology Review discussion paper was released in February 2010 and the College submitted a detailed response to this in April. There have been several meetings of the PRCC since and we have had informal meetings with the Review Team members to ensure that the College's position has been understood. An options paper with more detailed proposals for funding changes was expected by August, but this is still not available. We are concerned that the timelines for decision making by Government before the May 2011 budget are now very short and that we need to respond to these current discussion documents in writing promptly, to ensure that our views are heard.

We note that an examination of the drivers of test requesting was not part of the original brief of the Review, but in our initial response we argued that growth in demand is as important as test cost in an assessment of funding models and financial projections. We are pleased to see that in introducing evidence-based pathology requesting to the review process, this link is now recognised. The College strongly supports the development of the evidence base around testing and ensuring the appropriateness of test requesting and methodology. The ageing of the population and the projected increases in cancer, obesity and chronic disease is already placing further demands on pathology services, at a time when the pathology workforce itself is ageing and facing shortages.

With the significant challenges that lie ahead for the provision of pathology services, a review of funding for pathology services should be undertaken in the context of a more comprehensive **National Pathology Plan**. A simple funding review is both inappropriate and inadequate in that it fails to address the overall national pathology service demands. The Terms of Reference of a National Pathology Plan should address the pathology demand associated with population ageing, the increase in prevalence of cancer, the training and expansion of the pathology workforce, the increasing complexity of reporting and only then consider the appropriate cost drivers related to these demands. A review which addresses only the cost of testing will likely lead to conclusions which have unforeseen implications either for the ongoing provision of pathology services, in added costs elsewhere in Health, or negatively impact on outcomes for patients.

Sustainability of Pathology Services for the Australian Community

It is vital to plan for a sustainable pathology sector. Sustainability requires a pathology infrastructure and workforce that is able to meet the demands of an ageing and increasingly informed Australian population. The diseases of ageing, such as heart disease and cancer, and other chronic disease will drive the demand for and complexity of pathology services in all geographical locations. All general practice, specialist and hospital services will remain dependent on quality pathology information to drive efficient and effective clinical decisions. The College would like to make the following points regarding sustainability:

Demand and complexity of pathology testing

In Australia, the growth in overall demand for the pathology testing is estimated to be approximately 3% per annum. This is partly due to the ageing of the population (the sector of the population growing at the greatest rate are those aged 80 years and over) with its accompanied increase in burden of disease. Not only is the prevalence of cancer predicted to increase by over 30% over the

next decade, detection will increase due to campaigns aimed at participation in screening (such as breast cancer screening). The increase in cancer prevalence will particularly affect pathology because the diagnosis requires increasingly detailed structured reports and additional molecular genetic investigation in order to achieve improved patient outcome through individualised treatment regimes. Subspecialty roles for pathologists are likely to arise from this expanding field. Similarly, longer life expectancies and an ageing population will create a larger volume of pathology tests for monitoring disease status and progression.

There will be an expansion in personalised medicine utilising techniques such as molecular genetics, not only in cancer management but also in other chronic diseases. The pathologist will become increasingly central to health service delivery and must be included within multidisciplinary clinical teams, to assist in the design of patient care plans. Clinicians will become dependent on the complex interpretation of disease at a molecular level by subspecialist pathologists in order to give patients the quality and quantity of disease or symptom free survival that they will come to expect. Hence pathology and the pathologists will take on a more significant role in both diagnosis and treatment of cancer and other complex diseases in the next 5 years.

Proposed government initiatives such as episode panels, care sets, integrated care, nurse-practitioner requesting etc all have the potential to increase volumes of pathology ordering as a large range of practitioners apply “gold standard” models to patient conditions such as diabetes, congestive cardiac failure, prostate cancer etc. For a comprehensive College comment on demand management see the *Supplementary Submission on Options for Demand Management in Pathology* (Appendix 1) which was part of the Colleges previous two submissions to the funding review.

Other countries have recognised the need to increase, rather than decrease, investment in pathology resources to meet the increasing future demand. The Price Waterhouse Coopers report commissioned by the Department published earlier this year demonstrated that all countries are struggling with increased demand for pathology services and that drivers of demand are complex and not related to overhauls of funding arrangements.

Ageing pathologist and scientific workforce

There is a well-known global shortage of pathologists and scientists in pathology. A lack of forward planning has resulted in a workforce peak in the same age range as that of the general population, followed by a “dip” in subsequent age groups. The inevitable consequence of this is increasing retirement rates over the next 20 years in the context of increasing demand for services as outlined above. According to current RCPA statistics, although there has been a rise in total number of practicing pathologists, 12% of these are over 65 years and 23% over 60 (up from 10% and 20% three years ago). The Australian Health Workforce Survey (2003) identified a need for 500 additional pathologists, however only 141 additional training places have been funded to date. The medical workforce shortage is exacerbated by a similar depleted and ageing scientific workforce, also limited by career pathways and remuneration.

Pathologist workloads

Increasing workloads for pathologists have been an ongoing concern in an environment of a finite workforce and mounting demand. This prompted a study to be funded in 2009 through the Quality Use of Pathology Program (Appendix 2). This study of workloads in anatomical pathology, the results of which are with the Department awaiting general release, supports anecdotal reports of increased pathologist workloads. Also, in the last few weeks, the College conducted an online “snapshot” workload survey that clearly demonstrates mounting workload pressure among pathologists, which appears to be worsening since the 2009 study. Of 115 respondents from around Australia, 94 (82%) reported increased workloads over the past two years with 24% of these reporting an increase of 3-4 hours per week, 23% reporting an increase of 5-6 hours per week and 30% reporting an increase of 7-10 hours per week. A vast majority (88%) reported a decrease in the number of scientists/ technical staff in their laboratories over the past 12 months. Sixty five per cent reported that the current conditions have prompted them to alter their plans for staying in the workplace (ie are planning to leave). Although this is a self selected sample, a range of distressing comments were supplied by pathologists, particularly in regional areas. For example:

“We have had numerous redundancies and staff are not replaced when they go. The workload has gone up...by another 30-50% for each staff member ...Every time rebates are cut or policy changed adversely this equates to job losses in pathology. We no longer have positions involved in quality supported, eg quality control officer gone, safety officer gone, HR gone....”

“ I work in a private lab servicing a regional private hospital more than 1000km from the capital city...Due to non-replacement, three local pathologists are now down to one...Unfortunately with current funding cuts private labs are looking at all areas to save costs. It will create sub-standard conditions for regional patients... ”

“This increase in our turnaround times (doubled) is due to our overworked and stressed lab staffing issues. In addition, many of our staff are currently suffering repetitive strain injuries (including myself!!) which further slow them down.”

Of most serious concern is that both surveys clearly point to decreased participation in quality activities and standards as a result of increased workloads, with pathologists claiming that time pressures prevent them completing quality assurance programs (QAP) modules . The College views this as a very serious issue as participation in QAP is regarded as essential for maintaining standards and is mandated by the NATA RCPA Laboratory Accreditation Program. The maintenance of continuing education is also regarded as essential. Similarly the surveys point to increased operational workloads resulting in decreased investment in research, training and innovation.

The opposing forces of increased workloads and decreased workforce create a “pressure cooker” environment where sustainability is threatened. The worsening situation over the last year reflects the front line effects of the tightening financial pressures on practices and the measures that they have taken to respond to these after the 2009 funding cuts and changes to other regulations. It is essential that the effects of these earlier measures are researched to inform the review process. Unless a proper comprehensive review is done, and a National Pathology Plan developed, gaps will open up in geographical and specific discipline areas of pathology skill supply in the near future.

Modelling Funding Changes in the Context of a National Pathology Plan

In assessing the impact of changes to the existing funding system, the College has a strong view that apart from seeking transparency around the cost, other questions need to be asked:

- Does the model improve access to testing for patients?
- Does the model enhance the sustainability of the provision of pathology services?
- Does the model support quality improvement and a culture of innovation?
- Does the model support the other aspects of the pathologist's role in multidisciplinary care, training, laboratory supervision, professional activities and research?
- Does the model support the exponential growth in genetic testing and the increasing complexity of pathology reporting and pathologist time?
- Does the model support diversity within the profession and the possibility of entry of new providers?
- Does the model support the Government's other initiatives in Health?
- Does the model support the Government's priority for increasing patient choice in pathology provider?

The College believes that the above questions can be answered through evolution of the current fee-for-service model within a National Pathology Plan. For many years, fees have been analysed and set via the Pathology Services Table Committee. Recently, the ongoing functioning of the PSTC has hampered by the expiration of the Memorandum of Understanding under which it previously operated and currently the role and function of the PSTC is under review.

The College supports the strengthening of a PSTC model, developing a fee schedule based on best available evidence of effectiveness, utility and cost. The College makes the following specific comments relating to strengthening the PSTC model. We support the proposal that each part of the schedule has its own advisory committee, with membership of advisory committees determined by relevant scientific, technical and medical expertise supported by appropriately qualified department staff. The Department should consider dedicating more resources such as a health economist/business analyst as well as an EBP research officer. The Committee and its membership should be guided by current principles of clinical and corporate governance, for example to ensure procedural fairness and transparency in priority-setting and separation of applicant and assessor of new items.

The College reiterates that it does not support a piecemeal approach to pathology planning. However in the spirit of cooperating with the context of the current discussions, provides the following comments on the specific issues currently under consideration by the Funding review.

Specific Issues Currently under consideration

1. Trial of Tendering for Pathology Services

The current documentation does not provide very specific information regarding a proposed tender model which might be considered. This makes detailed modelling very difficult. The responses to the previous discussion paper were almost universally opposed to this option. "Price discovery" is stated to be the chief aim of a proposed trial of tendering and the ability to deliver this has to be weighed against other government priorities such as sustainability, access to services and patient choice in provider.

Tendering for Pathology Services has been undertaken previously in some jurisdictions in Australia but mostly within the confines of hospitals rather than on a large scale in the Community. The current funding climate has allowed community pathology practice in Australia to evolve into diverse forms, ranging from large private practices with a comprehensive service owned by listed companies or not for profit organisations, public practices active in the community, smaller privately owned comprehensive practices and small practices which provide very specific services, often at a high level. This differs significantly from some overseas countries where pathology is largely state owned or where a few large private practices dominate. Given the complexity in service provision in Australia, experiences in other countries cannot necessarily be applied in the Australian context.

The current paper suggests tendering on a geographic rather than pathology test group basis. It may be thought that limiting tendering to a small area could “discover” price at minimal risk to the remainder of the pathology system. However in a limited geographical area, a large practice may tender at a low level to gain market share, supporting this approach by cross-subsidising from other activities. The benefit of this to the large provider in the longer term would be to eliminate smaller local providers. The price then would not be sustainable for the sector as a whole, if the cost estimates were rolled out to broader tenders of tendering otherwise used to set fees. This “loss leading” by larger providers to eliminate competition therefore makes this model an inaccurate instrument to use for “price discovery” and can have the secondary effect of leading to a reduction in the overall number of providers over time. Further, reducing the number of available providers or limiting patient choice to the successful tenderers within an area, works against the philosophy of more patient choice in selection of pathology provider, a key element of recent government legislation.

A model using a defined area such as those suggested in the Hunter Region or ACT also has the potential to set public against private providers for tendering, particularly in areas like the ACT where there are two main providers and one of these is a public pathology service active in community pathology. This may have a secondary impact on hospital services supported by this outside income if the public sector loses the community tender. College Fellows located in the ACT have strongly expressed their opposition to the suggestion of tendering in their geographical region. Public practice providers, who currently supply community pathology services may also be excluded from tendering, either by the tender process or their own administration. They may not have sufficiently detailed financial information to assemble an appropriate tender submission, they may lack established collection centres and courier systems, and will likely be unable to make new investment in infrastructure or staff. They may also be precluded from tendering due to competitive advantage issues arising from cross-subsidisation by State funding. If public practices lose tenders and are closed, as happened in Victoria, they can be difficult to reinstate, once again compromising public health sustainability, academic practice, training and research. It is also difficult to see how independent practices that currently provide a highly specialised service, such as those limited to specific areas of anatomical pathology, would function within this system, which appears to focus only on comprehensive pathology services.

Creating excessive pressures on the margins of business, inevitably results in cost cutting and pressure to reduce staffing establishments, increased workloads and the curbing of quality and research activities. Tendering creates disincentives to investment and innovation because of the risk of dismantlement at the end of the contract period. It creates “minimalist” and short term business

planning which is not suited to a health care system, dependent on scientific standards and development. Short term contracts also reduce staff commitment as lack job security and other incentives related to permanent employment. This would likely result in a net loss of scientific staff into other fields at a time when pathology scientists are in short supply. With an ageing scientific workforce, changes of this nature may induce early retirements, exacerbating staff shortages. Tendering also causes disruptive transitioning issues, with successful tenderers having to rapidly upscale operations while unsuccessful operators dismantle services and implement staff redundancies as occurred with geographic tendering in Auckland, NZ.

The Government and the College are both opposed to monopoly supplier arrangements however tendering reduces diversity and numbers of providers. The elimination of local competition means that a change in providers at the end of a tender period is unlikely and deskilling of particular areas of testing can occur, as in cervical cytology in Ireland. The creation of a few dominant providers also impacts on quality, due to lack of competitive pressures during the period that the tender contract is in place. Competition only occurs at times of tender renewal. Even then, competitors struggle to launch viable tender submissions, as they have been out of the market for the period of the contract.

The design of the Tender is crucial to ensuring continuity of high quality comprehensive pathology services and this requires substantial input from the pathology profession. The College is concerned that the profession will be asked to assist with developing specifications for Tender processes that it does not support. The College is also concerned that, as cost reduction is such a strong consideration for Government, that Tender evaluation committees would award contracts to providers offering the lowest price submission, despite an inability to fulfil other tender criteria essential to pathology services. Similarly the Government, without substantial assistance from the profession, may not be able to supervise compliance with the tender specifications as a low price provider struggles to provide adequate service delivery and quality at low margins. The College is very concerned that in a tendering situation, the government is separated from the profession in the negotiation and may lose sight of the elements of service provision essential to patient safety and quality care.

Thus the College believes that the proposed geographic tendering trial is not likely to provide reliable information on the cost of pathology services and that large scale tendering poses a threat to the overall safety and sustainability of the pathology sector.

2. Introduction of Volume discounting

This is a new option, not presented in the first discussion paper, to which the College is opposed. The College believes that it would create a disincentive to further economies-of-scale or implementation of automation where this is possible. Implementation of volume discounting would be likely to create perverse incentives whereby practices avoid tests where a volume discount is applied. It is also possible that a laboratory will reallocate testing between laboratories within a company or that laboratories will, once a threshold is reached, no longer accept bulk-billing for that test.

3. Removal of Coning

It is not possible to consider changes to coning, PEI or fee schedule changes in isolation as changes in one may influence the significance of the other. The College believes that these should be

considered together and that changes are implemented which do not impact disproportionately on any particular sector of pathology practice.

The proposed option to remove coning may ultimately be supported by the College but presents a serious risk to practices that have mainly specialist referrals and currently do not have coning of tests. Pathology requests from specialist referrals should not be targeted for a reduction in rebates or funding. The Department has, from data provided to it, estimated that there would be an increase in outlays of 10-12% if it removes the cone on GP services, however, there is no equivalent data to model the potential effect of a sliding scale of rebates which would include specialist referrals. In a practice where there is a substantial amount of hospital and complex specialist work, the impact is very likely to be significant and adverse. In all areas where funding of complex services are not protected by the model, practices will seek to reduce their exposure to complex work. In particular, work that requires allocations of individual specialist time are universally at risk and likely to fall back to State funded public laboratories, which cannot absorb the increased workload. Often this complex work (eg cancer histopathology) requires fast turnaround times which inevitably are impacted in environments of increased demand and workload shifting to avoid cost.

4. Changes to Patient Episode Initiation

The current PEIs do not cover the costs of collecting specimens and if the PEI is to be maintained there should be an intention by government to increase the associated fees (whatever the format for this may be). Secondly, "in-hospital" collections should not be considered "indirectly collected" as most pathology services, public and private, have teams of collectors based in hospitals and incur significant associated expense (specimens are less and less commonly collected by doctors and nurses in current hospital practice).

Another question the Department must consider is the whole-of-health funding and, if PEIs are to be excluded from GP-collected specimens, what would be the likely impact on general practice, both in collection practices and in bearing increased costs?

5. Introduction of Episodic panels

The development of evidence-based panels of tests in relation to specific disease groups, in conjunction with decision support software is a worthwhile endeavour however it will require extensive consultation with requestors to ensure clinical independence is preserved. It will also require improvement in the clinical information provided by requestors to ensure that data is appropriately interpreted. An additional problem may arise if coning is removed and episodic panels are introduced, tests that would not previously have been requested will be ordered through the panel, which may impact on both funding and the GP's clinical decision-making.

6. Evidence based pathology / Decision Support Tools

The College strongly supports the introduction of evidence-based practice and decision support tools around pathology requesting. As outlined in the funding review documents, the College is in the final stages of developing and implementing a number of web-based pathology decision flowcharts to assist requestors in managing some frequent clinical scenarios. These are awaiting final approval of

our authors and advisory committees and will be uploaded to the *RCPA Pathology Manual* website, which already contains a large volume of high quality information for requesters. Although these projects have been generously supported by Federal funding, much of the clinical input has been provided voluntarily by College Fellows. As acknowledged in the discussion papers, refinement and uptake of clinical decision support tools is a complex and continuing process that requires ongoing resources. The College has met with the RACGP regarding cooperation with the RACGP initiative “Oxygen” and the possible positioning of the *RCPA Manual* link within the *RACGP Primary Care Side Bar*, which allows interaction and utility for GPs regardless of their operating practice software. These are key steps towards the unique patient –held electronic health record and integrated evidence-based electronic pathology requesting. It would now be realistic to fund a project to translate the intellectual content of the tools into an integrated application for the side bar so that it becomes more than a source of information and part of an electronic Request-Test-Report cycle. This too will require funding for development and maintenance.

7. Funding for Genetic Testing

The College welcomes the commencement of funding for genetic tests and the recognition of the differences between tests for heritable diseases and genetics testing in cancer. The College may support an alternative funding model (non-MBS) for genetic tests which takes account of the need for separate funding for innovation, training and research as well as non-MBS elements such as allied health services. The College does not support en-bloc tendering for genetic testing. A method that seeks expressions of interest for eligibility to provide certain genetic tests at appropriately set “prices” may be acceptable to the College although the same adverse incentives (such as where low volume complex testing becomes non-viable via a tendering process) must be taken into account. Once again, detailed specification of service requirements with extensive input from the profession would be required. The College also supports a process of consultation to monitor clinical utility/ evidence-based practice/ ongoing data collection that takes into account available resources. The levels of evidence and other processes required by MSAC may be excessive for genetic testing, particularly the raft of existing proven genetic tests. The College would support some exemptions for genetic tests from this process. The funding for genetic tests should be “new” and not be taken from the rest of the pathology budget and should be protected or “quarantined”.

8. Vitamin D

The College recognises that there is a review process underway of Vitamin D testing in Australia. The demand for Vitamin D testing has increased significantly on the background of the clinical evidence of its importance to various aspects of maintaining health and preventing illness. Although traditionally linked to bone disease, recent research has also linked Vitamin D deficiency to other disease processes such as cancer, autoimmune diseases, diabetes, depression and dementia. The College understands that there is currently a National Prescribing Service study underway into the drivers for demand for Vitamin D testing. In terms of funding, the College supports the recently proposed PSTC process whereby a methodology for assessing the real cost of particular assays (both direct and indirect) is to be developed and subsequently applied to Vitamin D assays.