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7 April 2010

Ms Naomi Bleeser
Committee Secretary
Community Affairs Legislation Committee
PO Box 6100
Parliament House
CANBERRA ACT 2600

Dear Ms Bleeser

Re: Inquiry into Health Insurance Amendment (Pathology Requests) Bill 2010
Royal College of Pathologists of Australasia Submission

The Royal College of Pathologists of Australasia (the College) appreciates the opportunity to make a submission to this important Inquiry into Health Insurance Amendment (Pathology Requests) Bill.

The Bill amends the *Health Insurance Act 1973* to allow patients to take a pathology request to an approved pathology practitioner or authority of their choice. The minister in her speech referred to the two drivers for this legislation, patient choice and the introduction of competition in price for pathology services.

The College is firmly in support of patient choice but believes that this should be informed choice. The pathologist has a duty to both the patient and the doctor requesting the test. The requesting doctor has a responsibility to follow up the results of testing that he/she orders and this must be considered in the equation. We believe that the capacity for patient choice already exists and the choice of pathology provider should be made jointly, at the time of the consultation with the doctor, taking into account the patient's preferences on convenience and cost, but also the scope of testing, methods used by the laboratory and specific expertise that a particular pathologist may offer.

The following comments are grouped according to the issues that have been identified for the Committee to examine during the inquiry:

The onus being placed on patients to choose the pathology practitioner

The College is not concerned that the legislation places an onus on patients to choose a pathology provider. Rather the concern is about patients exercising choice without having access to professional advice that could help them in their decision, and potentially without realising that such advice could be beneficial to them. Patients should not be put in a position where they are able (or even encouraged) to make decisions that increase the likelihood they will experience an adverse event.

Possible problems arising between unknown referring doctors and pathology practitioners - resulting in delays

In the opinion of the College, the greatest risks in regard to this proposal relate to traceability of results. This can lead to delays in the delivery of results to treating practitioners, or even an inability to deliver the results at all.

If the referring doctor does not know where the pathology testing has taken place it could be difficult or impossible for them to trace a late or unreceived report. The responsibilities of

doctors in following up results has been examined in the Kite vs Malycha case in the SA courts. Delays or failures to deliver results can have life-threatening consequences. Pathology tests are regularly requested to determine if a patient is in the early stages of conditions such as a heart attack, leukaemia, or serious infections that could have implications for those in contact with the patient. In such circumstances, lost hours can make a crucial difference to the patient's health outcome.

When faced with an abnormal result of this nature, pathologists have been known to expend considerable effort trying to track down the referring doctor so that urgent treatment can be instituted for the patient; this will be infinitely more difficult if the referring doctor is unknown, which in turn creates a very real risk for patients.

The application of this initiative for histopathology specimens obtained in operating theatres introduces a further complication. Currently, if a specimen arrives at a laboratory with a request form for another laboratory, it is identified as an error and the specimen is transferred. With the advent of forms stating that the specimen can be taken anywhere, there will be no way for a laboratory to know if an error has occurred or if this is what the patient wants. It would be legally acceptable, in fact, for a courier to collect specimens intended for a range of laboratories, and take them all to one laboratory for processing and diagnosis, and surgeons would not know whom they should to contact for results.

The proposal has been likened to the arrangements in place for diagnostic imaging (DI), but this fails to recognise fundamental differences between these two specialties. The patient can usually take the result of a DI consultation (for example the x-rays, CT scan or ultrasound films) with them to give to the referring practitioner, so there is no issue of trying to trace where a patient has gone to have their investigation.

Problems that may arise as a result of the inconsistent measurement series and reference ranges used by different pathologist practitioners

Some serial tests need to be performed using directly comparable assays in order to provide meaningful information for the purposes of monitoring a patient. A good example of this is INR monitoring for patients taking warfarin. Just as it is important for a patient on warfarin to take the same brand month to month and to have a stable diet, so too, it is important for INRs to be done using consistent methodology and reference intervals.

Patient choice of pathology provider can still be preserved by making that decision in the course of the consultation the referring practitioner is able recommendation, comparison of serial samples in chronic illness or use of a particular laboratory for certain tests. The choice made at the time of the consultation can take into account billing practice and convenience of collection centre locations, as well as continuity of serial results or a specific pathologist's expertise / test repertoire, and any other factors of importance to the patient (such as previous experiences with a pathology provider).

This is another important difference between pathology and DI. DI is rarely used to monitor chronic conditions, so continuity of test methods/ assays/reference intervals is not an issue. Whilst DI and pathology have historically been subject to similar funding arrangements, they are quite different medical specialities, and there is no imperative to manage the referrals to each specialty in the same way.

Potential impacts on arrangements between GPs and pathology providers relating to emergency and out of hours contacts

The inability to deliver life-threatening results, as described above, would be exacerbated in after hours situations, particularly as it is common for GPs not to provide out of hours contact details, relying instead on locum services to address issues that arise.

It remains to be seen who will be held legally responsible for adverse outcomes that arise when results are not communicated because a patient chose to go to a different pathology provider from the one on the form. Given this decision would be beyond the control of the referring practitioner or pathology practice, one option might be to warn patients of the risks on the request form, and require patients to document that they accept responsibility if they change their minds after leaving the consultation, in the same way as patients must 'sign themselves out' if they leave hospital against medical advice.

The College considers that the best way to facilitate patient choice without compromising safety is for the choice to be made during the consultation with the referring practitioner. This will enable traceability of results to be maintained and, if the patient is willing to accept the referring practitioner's recommendation, comparison of serial samples in chronic illness or use of a particular laboratory for certain tests. The choice made at the time of the consultation can take into account billing practice and convenience of collection centre locations, identified by the Minister for Health in the second reading speech as important considerations for patients, as well as continuity of serial results or a specific pathologist's expertise / test repertoire, and any other factors of relevance to the patient (such as previous experiences with a pathology provider).

Rather than create risks by introducing an option for patients to change their minds after agreeing on a provider during the consultation, choice could be assured if the legislation included a requirement for requesters to inform patients that they have a choice. Any recommendation made should be based on objective (generally clinical) criteria and this should be documented in the health record. Clearly it would be inappropriate for a requester to recommend a particular provider on the basis, for example, that they were employed by the same parent company or derived benefit from renting space to a collection centre, and it should be mandatory to declare any potential conflicts of interest such as these.

The alternative (and in many ways safer) mechanism to prevent the risks associated with traceability of results would be to defer this initiative until a universal electronic health record is established and implemented. In this way the referring practitioner will be able to obtain results regardless of which pathology practice the patient has attended.

The Department of Health and Ageing (the Department) document "Pathology Request Forms Discussion Paper" noted many of the concerns the College has raised about this initiative over the last several months. It was gratifying that the Department acknowledged these concerns, but alarming to learn that these risks had not been given due consideration before the draft legislation was presented to Parliament, as the consultation process for the discussion paper had not yet closed. It is to be hoped that this Inquiry will now provide an opportunity to examine the issues more carefully.

There is possibly the perception that all pathology testing is the same and if the results are all of equal quality then why not force competition on price? The problem with this premise is that the current high quality of pathology service in this country, where reliable results can be delivered consistently and in a timely manner, is precisely due to the climate of competition in this area, on quality of reliability of results and the delivery of service. The competitive differentiators between pathology practices are in the professional quality of the pathologists' work, their range of expertise and the efficiency with which their reports are handled.

Mechanisms which compete for cheaper service will inevitably lead to the need to eliminate more costly aspects of pathology practice, leading to fewer quality measures, increased pathologist workloads, elimination of some tests and disincentives for training, research and allowing pathologists to participate in professional activities. There will be in effect a disincentive to invest in the strategies which have supported the success of the NATA/RCPA laboratory accreditation program in raising pathology quality in this country to its current high level.

Pathologist workloads are already of concern with long hours leading to the increased risk of error and the inability to perform other professional duties such as performance in quality assurance programs and continuing education. It was because of the real concern that this was leading to both patient risk and the shortening of the professional lives of pathologists that the College sought to commission a report on workloads in anatomical pathology which has now been funded by DoHA under the QUPP. The DoHA is now in possession of this detailed report.

The quality of pathology results underpins the quality of the entire medical system. If the original pathology results cannot be relied upon, then even the highest level of care downstream can be worthless or cause patient harm. For instance, if the original biopsy result is incorrect, the best surgery and aftercare will not prevent the consequences of the inappropriate removal of an organ.

We would welcome the opportunity to discuss our concerns directly with the Senate Committee

Yours sincerely,

Associate Professor Paul McKenzie
President