Senate Community Affairs Committee

Inquiry into Health Insurance Amendment (Pathology Requests) Bill 2010

Submission

The Australian Association of Pathology Practices (AAPP) represents pathology practices that provide pathology services to over 80% of the patients referred for pathology testing by their GP or specialist in Australia.

We have reviewed the proposed changes to the Health Insurance Act relating to pathology requests and considered their impact on patients and their referring doctors. We support the principle of patient choice of pathology provider and are happy to promote actions that achieve that outcome. However as medical practitioners, pathologists also have a responsibility to ensure patients remains safe within the complicated processes involved in contemporary healthcare.

We will address the proposed change in two parts.

Part 1: Is the proposed legislation in the best interests of patients?

In our considered view, this legislation gives patients freedom of choice to select a pathology provider (which we support); however the proposed approach seriously disrupts a major safety system in the Australian health environment.

Patient choice is a desirable goal but, in practice, assumes the patient has the knowledge and expertise to understand the complex process of pathology testing and the key elements that are necessary for a provider to be able to ensure a quality outcome for the patient.

Diagnosis of disease is a complex process requiring professional medical expertise from a team of medical specialists to understand the symptoms and test results that are essential to an accurate diagnosis. The medical team comprised of GPs, pathologists, radiologists and specialists work together in a way that is not visible to the patient. Because this interaction between treating doctors is not visible to patients, we believe they are not equipped to make an informed decision in the selection of pathology

provider. Importantly, price and location are not the only determinants of the best pathologist for a patient.

The relationship between referring doctors and the pathology practices to which they routinely refer, is a very important factor in ensuring that the patient gets the best outcome. This relationship assists in ensuring the correct test is performed, the sample is collected appropriately, the sample is delivered in a timely way to the right laboratory, the test is undertaken and interpreted by the appropriate specialist and the test results are communicated to the referring doctor in a format that he /she is familiar with.

There are well developed protocols established between pathologists and their regular referring doctors that are predictable for each individual doctor. The regular use of these processes ensures that they work reliably. If problems arise, the cause is identified and corrected so that the information exchange works well for both referring doctor and pathologists. The regular use of standard protocols for taking tests, delivering them to the laboratory and reporting the results back to the doctor is what makes them so safe. The laboratory staff get to know the referring doctor's habits and can readily contact them or their staff to ensure the correct information has been obtained, the right test is being ordered and can find the doctor when results need to be notified urgently or after hours.

A particularly important element of the reporting of results is cumulative reporting, i.e. showing changes in results over time. Cumulative reporting requires the use of the same laboratory on each occasion that the patient is tested as this ensures consistency of results and makes any variation over time more clear. The results from the same test performed on multiple occasions over time can then be presented, often in graphical form. This alerts the doctor to changes that are happening gradually or that an abnormal test result has been there for some time, is not changing and has already been investigated. It therefore does not need further analysis or referral to a specialist. This is especially relevant when the patient has a chronic disease and its progress is being monitored by a series of tests repeated at regular intervals.

Over 40% of pathology testing in Australia is for chronic diseases such as diabetes, cancer, drug monitoring, or warfarin (blood thinning) therapy, where cumulative reporting is important.

Another important part of the pathology relationship is the consistency of report format. Reference ranges and interpretative comments (*e.g." this result is often seen in a viral illness and should be repeated to see if it has returned to normal before being further investigated"*) tailored to the referring doctor requirements are also highly valued by the referring doctor. GPs and specialists become very familiar with the format used by their regular pathologist, and this familiarity helps ensure ease of interpretation of the results and reduces the risk of missing vital information that can arise if dealing with multiple providers, all with different reporting formats. Here again the regular relationship is the key to ensuring the result reaches the referring doctor in a standardised format with which the doctor is familiar.

The laboratory and referring doctor will also have worked together to put into place well developed internal checking and audit systems to ensure that all results are read and acted upon. The regularity of information exchange between pathologist and referring doctor, allows checks and balances to be built into the testing process so that samples or results do not go astray because of lack of familiarity with the logistics or delivery systems or because there is no IT link that normally supports well established referral relationships.

It is the unanimous view of all pathologists represented by the AAPP that the proposed change to the legislation removes a major safety element of the pathology testing process that underpins the quality and safety of pathology testing in Australia.

When patients change the advice of the referring doctor and make judgements about the suitability of a particular pathology practice to perform their test, then they must assume responsibility for the consequences that flow from that choice. If a sample is not received by the pathology practice of the patient's choice because there is no regular pick up by the selected provider at the patient location, or the result is not delivered to the referring doctor because the pathology practice's IT system does not link to the patients doctor, the patient's care may be placed at significant risk.

In an emergency situation, an unexpected result may not be communicated to a doctor because he or she is not known to the pathology practice and the surgery at which they normally practice is closed.

A "lost" or delayed result may have serious health consequences such as delayed diagnosis of cancer, or a delayed diagnosis of an increased risk of bleeding in a patient on warfarin.

Importantly these situations will create a medical indemnity/negligence dilemma if the patient should later wish to seek redress for any adverse outcomes which may result from the unexpected change in pathology provider.

Case Study 1

A patient attended a cardiologist who referred him to the local private hospital for a cardiac procedure. The doctor ordered a number of tests which he would need to know for the procedure. The patient was referred to the doctor's usual pathology provider who always has the test results available within 2 days and these test results can be readily accessed by the doctor over the internet.

The patient chose to go to a different pathology provider without reference to the cardiologist. The patient arrived at the hospital for the procedure and was anaesthetised while the doctor looked for the test results. They could not be found. The cardiologist called his normal provider and asked them to find the results. They searched across many thousands of results and samples to see if the specimen had been misplaced before reaching the conclusion that the patient had gone to a different provider. Without the results, the procedure could not go ahead.

Eventually the patient was allowed to wake from the anaesthesia, the tests were repeated and the procedure rescheduled for another day.

The result was an unnecessary anaesthetic, a delay in treatment that may have injured the patient, and a waste of time, and resources, and patient and doctor frustration.

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Case Study 2

An elderly man with a strong family history of prostate cancer wanted his PSA tested regularly and with the support of his local doctor was having the test performed twice a year. At the last occasion he chose to go to a different pathology provider without discussion with his GP. This resulted in a PSA of a higher number than the GP expected for a normal result. The surgery was busy and when his GP saw this, he didn't realise the new lab used a different method with a different normal range. He became concerned and referred the patient to a urologist for further management and discussed his suspicion of prostate cancer with the patient. The urologist performed a prostatic biopsy which was normal.

The patient had unnecessary and uncomfortable tests. This caused needless anxiety to the patient and resulted in additional Medicare outlays.

This example highlights the increased risks when a patient goes to a pathology provider who is not the regular provider to the referring doctor.

Case study 3

A patient presented to her GP in August last year with symptoms of a significant flu like illness. The GP suspected swine flu and ordered the necessary tests. The patient chose a different pathology provider than that normally used by the GP.
The results were not clear cut, and the GP was not sure what they meant. She rang her normal provider but they had not performed the test so could not comment on the method used by the laboratory performing the test.
The GP rang the lab that did the test but no microbiologist was available to assist. The GP referred the patient to a specialist infectious diseases physician who made the diagnosis that the test results were not indicative of swine flu.
The patient was reassured but had incurred gap payments for the physician visit as well as further tests and had to lose an extra two days from work to get the final diagnosis.

Case Study 4

A patient who had noticed changes in his bowel motions went to his GP who ordered a number of tests including faecal occult blood testing.
He decided not to go to the pathology lab the GP suggested but went to one close to home instead. This pathology provider did not know the GP nor did they have a computer link to the practice.
The results were posted but never reached the referring GP. The patient phoned for results and was advised they had not arrived yet so postponed making another appointment until the results arrived.
Time passed and the patient forgot to make an appointment until three months later.
The tests were repeated and this time arrived and the patient underwent colonoscopy. A bowel cancer was detected but unfortunately had already spread through the patient's body.
The GP had a system in place with her regular provider that meant specimens were tracked to make sure the results were sent electronically to the referring doctor and acted upon. Had this happened the first time, the cancer would have been detected three months earlier which may have made a difference to his treatment options.

These case studies are included in AAPP's submission to demonstrate the very real impact on patient safety that is posed by the introduction of generic pathology request forms. We strongly believe that the existing legislation is the best means of protecting the patients' interests, minimising risk and ensuring a safe outcome on each occasion of testing.

Consequently, we urge the Government to reconsider the implications of the proposed changes to the legislation and undertake a full risk assessment before the new legislation completes its passage through the Parliament.

RECOMMENDATION

The decision about which pathology provider a patient should attend must be a decision that is made between the patient and the referring doctor.

Once made, the decision should be linked to payment of the pathology fee such that if the referring doctor indicates the need to go to a specified provider, then the fee is only payable to the chosen provider.

Part 2 of the submission:

Questions were posed by the Department of Health and Ageing in its discussion paper for consultation <u>after</u> the change in legislation had been announced.

In the following section, we have provided copies of the responses AAPP provided to the Department of Health and Ageing's discussion paper issued as part of a consultation process on these changes.

Unfortunately the discussion paper was issued after the decision to amend the legislation had already been made. We are concerned therefore that the decision was made without a full appreciation of the impact of these changes.

***Q1*. "This policy is already in place for diagnostic imaging, why is it a problem for pathology?"**

In diagnostic imaging, the number of tests per encounter that a patient has performed is much fewer than in pathology.

Imaging examinations are performed with the patient present and the films are given to the patient. Imaging is only occasionally used to monitor chronic disease conditions or medication treatment. When monitoring does occur, because the patient is given the films, the next radiologist can compare results over time.

In pathology, the number of tests is much greater and therefore the risk of error is higher, for example, what appears as a simple "blood test" may involve a laboratory testing for anaemia, liver function tests and evidence of a viral infection. The patient does not carry the results, instead, they are sent electronically or in writing to the GP.

Q2. What are the most effective strategies for ensuring that patients are informed? in choosing their pathology provider, and understand the importance of keeping their requesting practitioner informed of their choices?

The most effective strategy is to have a statement on the request form advising patients that while they can change pathology provider, they must advise their referring doctor prior to making any such change to ensure their results are made available to the doctor.

Q3. What factors currently influence patient choice of provider? What impact will increased choice (through more collection centres) or greater variability in billing practices between providers have on patient preferences?

Patients are currently guided by their referring doctor. This is common practice in health – for example, patients rely on the guidance and referral of their GP to specialist doctors. It is reasonable to assume issues such as location, price, convenience, and familiarity will all impact on a patient's choice of pathologist. To what extent this will occur is unknown and information from the Quality Use of Pathology Committee project being conducted by the Consumer Health Forum on consumer satisfaction will more scientifically inform this question.

However the more important point which has not been raised in this discussion paper is what are the key elements in ensuring a test is performed to the highest standards to ensure the patient gets the right result and that result is acted upon by the referring doctor.

Q4.How can a patient be given the opportunity to choose their pathology provider without impacting patient safety*?*

If the patient exercises choice without informing the referring doctor, errors will occur. Should the patient notify the referring doctor before or after the test is collected? In our view for the sake of safety, the patient needs to consult with the referring doctor before they choose a pathology provider.

Referring doctors should be encouraged to give the patient the opportunity to raise concerns before they leave the consultation. However in reality this is not simple as there are so many issues to be discussed in a short time frame and the doctor and patient will be more focussed on the diagnosis and treatment rather than a discussion about which provider should perform the test.

Thus any required statement, on the request form needs to make it clear to patients that they need to discuss the choice of a different pathology provider with their referring doctor.

Q5. Are there collection scenarios where the patient's intention regarding a preferred provider is not clear? How should those be managed?

There are scenarios where the patient does not or is unable to handle or sight the request form and hence won't see the statement on the form. For example, where the patient is unconscious, anaesthetised, very unwell, confused or demented, has literacy or language barriers.

In these situations it is important to leave the decision with the referring doctor. It becomes impractical to try and find relatives if they are not present and in our health system, there is a long standing practice of trusting a patient's personal doctor to guide the patient through the health system.

Q6.How can effective professional relationships between requesters and providers of pathology be maintained where patients choose providers other than those preferred by requesters?

Again the relationship can be maintained if the patient discusses the choice of provider with the referring doctor. Where a patient chooses a provider with no links to the referring doctor, there is significant risk of error and increased likelihood of repeat testing.

Once again the solution reverts to the wording on the form raising patient awareness of the importance of contacting the referring doctor before making a change.

Q7. Wording on the pathology request form

We would suggest a modification to the proposed wording followed by a tick box to indicate the outcome of the discussion between the doctor and patient.

"The tests requested by your doctor do not have to be performed by the pathology service listed on this form to be eligible for Medicare Benefits. If you wish to go to a different pathology service, it is important for safety reasons, that you talk to your doctor first. Your doctor will note your decision on the request form.

Q8. What is the most effective way to notify patients of their right to choose their pathology provider and make them aware of their responsibilities? How can this be? done with minimal impact on those who produce pathology request forms?

The most effective way is to encourage requesting doctors to explain this to patients as they are generating the request forms. This will stimulate the necessary discussion to allow informed patient choice.

Finally, we must also raise serious concerns about the Government's consultation process for this change. Proper consultation should have occurred before the final decision to change the legislation was made. We are deeply concerned that although well-intentioned, the Government has introduced a legislative change with the potential for a significant impact on patient safety into the Parliament without understanding the risks of this change for the patient. There has been consultation about the details of implementation after the decision was announced but not about the original decision to change the legislation.

Appearance before the Inquiry

The AAPP would be pleased to discuss these matters directly with the committee if that would be of benefit to Senators as they consider the complex issues involved in this decision.

We would also welcome the opportunity to organise a site visit to a pathology lab if this would be of assistance

For further information or queries regarding this submission please contact

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