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COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Reference: Health Insurance Amendment (Pathology Requests) Bill 2010

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SENATE COMMUNITY AFFAIRS

LEGISLATION COMMITTEE

Friday, 30 April 2010

Members: Senator Moore *(Chair)*, Senator Siewert *(Deputy Chair)*, Senators Adams, Boyce, Carol Brown and Furner

Participating members: Senators Abetz, Back, Barnett, Bernardi, Bilyk, Birmingham, Mark Bishop, Boswell, Brandis, Bob Brown, Carol Brown, Bushby, Cameron, Cash, Colbeck, Collins, Coonan, Cormann, Crossin, Eggleston, Farrell, Feeney, Ferguson, Fielding, Fierravanti-Wells, Fifield, Fisher, Forshaw, Hanson-Young, Heffernan, Humphries, Hurley, Hutchins, Johnston, Joyce, Kroger, Ludlam, Ian Macdonald, Marshall, Mason, McEwen, McGauran, McLucas, Milne, Minchin, Nash, O'Brien, Parry, Payne, Polley, Pratt, Ronaldson, Ryan, Scullion, Sterle, Troeth, Trood, Williams, Wortley and Xenophon

Senators in attendance: Senators Adams, Boyce, Moore and Siewert

Terms of reference for the inquiry:

To inquire into and report on:

Health Insurance Amendment (Pathology Requests) Bill 2010

WITNESSES

Committee met at 1.22 pm

JONES, Dr Paul, Australian Capital Territory Representative on Federal Council, Australian Medical Association

SULLIVAN, Mr Francis, Secretary-General, Australian Medical Association

CHAIR (Senator Moore)—This afternoon's hearing of the Senate Community Affairs Legislation Committee is into the provisions of the Health Insurance Amendment (Pathology Requests) Bill 2010. I welcome back witnesses from the Australian Medical Association. Dr Jones, where are you from?

Dr Jones—I am a GP in Canberra. I am also a representative of AMA ACT.

CHAIR—You did not have then far to go, then.

Dr Jones—That is right.

CHAIR—Information on parliamentary privilege and the protection of witnesses has been provided to you. We have your submission; thank you very much. I now invite either or both of you to make some opening comments, and then we will go to questions.

Mr Sullivan—Thank you for the opportunity to appear before you today.

CHAIR—Again.

Mr Sullivan—Again. The AMA has significant concerns with the bill from a clinical perspective, which we have set out in our submission to you, and Dr Jones will be able to take your questions on the clinical situations when a doctor will need the expert opinion of a particular pathology provider. As a result of the government's failure to properly index Medicare rebates over many years—not only this current government but all governments—and the budget cuts that were made to pathology fees last year, we have seen pathology providers starting to move away from bulk billing, so the government's main objective with this bill is to encourage patients to shop around for the cheapest price. The government is attempting to use the market to influence pathology fees without considering the consequences to the clinical safety and quality aspects of providing ongoing medical care. It is very important that the bill be amended to cover situations where a doctor requires a specific pathology provider to perform a test.

In terms of consultation on what is quite a significant change for doctors and their patients, not enough has been done to prepare them for this change. While the Department of Health and Ageing called for submissions on a discussion paper earlier this year, the bill was tabled in parliament before the submissions were due. In our view, that is token consultation. The department has not followed up with the AMA about any aspect of our submission. The legislation has been tabled and the department has assumed that busy doctors will simply add another task to their list of responsibilities: the task of explaining to patients these new arrangements and why all pathology laboratories are not the same.

Therefore, the amendment we propose is important to provide treating doctors with the safety net of being able to specify the pathology provider when it is clinically necessary. These arrangements could be implemented very simply and, as always, we provide you with a solution. A tick box could be added to pathology request forms that the requesting doctor must tick if he or she wants to ensure that a specific provider provides the service. This is similar to the tick box on prescriptions that the prescribed medication cannot be substituted with another brand. Medicare benefits would only be paid when that pathology provider is used. Both Dr Jones and I are happy to take your questions.

CHAIR—Dr Jones, would you like to add anything at this stage?

Dr Jones—No, I think our submission covers it pretty well.

Senator SIEWERT—There are a couple of issues that I would like to follow up. You may have heard my comments earlier, but I have never once been to a doctor who has said, 'Which pathologist would you like to use?' or explained that I even had a choice. You make the comment in your submission that there are some choices already in terms of having a conversation with your doctor. I am wondering how many doctors do have that conversation. As I said, I have never once had that conversation with a doctor. I did not even know as a patient that I actually had that choice. They just pull the form out and it has on it whoever it happens to be at the time. I can remember the last test I had because it was only a week and a half ago. I will not mention the organisation, but I did not get a choice. The doctor did not ask me. What is going to change in the system in that there is now a tick box? Will doctors all of a sudden start to have that conversation or will they automatically tick the box that says this is the one we want you to go to?

Dr Jones—The experience with a similar tick box on prescriptions has been with the change to whether or not generic brands can be substituted. It has not happened that doctors have just automatically ticked all boxes. There have been some changes for example in general practice to the software. I guess I can say that there is at least one GP here who routinely says to patients, 'Which pathologist would you like to go to?'

In the ACT we are fortunate in one sense because we have three different pathology providers, one of which is a ACT Health's pathology provider. In many instances I think people's choice is often based on geographical convenience in terms of location near their home, but there are a few situations where I specifically say to them, 'I'd like you to go to pathologist X.' There are a number of reasons why I might do that. One of them is that some tests use different methodologies different assay techniques for doing what appears to be the same test when you look at the result on the form.

One of the examples that we referred to in the submission was what is called beta hCG which is the hormone used to assess the progress of a pregnancy. It is quite sensitive to the assay method and it really would be meaningless to do beta hCGs in two different pathology laboratories if they were not using exactly the same methodology and you do not always know that. There are some situations where what you actually want is not so much a piece of paper with the result printed on it but the opinion of the pathologist about what is actually going on. That might apply for example to particularly haematology—the area of looking at people's blood films to decide whether they have things like leukaemia or those sorts of things. These are not frequent occurrences but we believe we need to have the option of doing that with those particular patients. For the vast majority of cases I think that most doctors will say to the patient, 'It doesn't matter where you have the test done.' But there are some specific circumstances where we think it is important.

Senator SIEWERT—I think it is your submission that uses the example of warfarin and having the same pathologist. I think it is yours—I have read all of the submissions, and sometimes you do forget who said what. What if you said to a patient, 'You really should go to this pathologist because of blah,' without needing to use the tick box? While you do the right thing, I am concerned that, as I said, I have never been to a doctor who has explained to me that I had a choice. Sometimes, depending on the doctor and the pathologist, I have had to chase quite a long way to go to the particular pathologist that the form says to go to. If I had known I had a choice, I would have made a choice. I am looking at the issues around enabling the doctor to make sure that you have consistency with your pathologist—because I do understand the arguments, and there will be some tests, as you have just said—and making sure that the easy option is not, 'You'll just go to this one,' for some of the other reasons that you have in fact raised in your submission: that is, you can read different results in different places on the charts et cetera, so it is just easier if the patient keeps going to the same one because you are used to dealing with them. How do we know that that is not going to happen?

Dr Jones—As I said, the experience with the changes that were made, for some similar reasons, to the generic prescribing arrangements is that there has not been, as far as we are able to see, an 'overuse' of the tick box provisions that apply to prescriptions, where I can, if I wish to, prevent the pharmacist from offering the patient a generic brand substitution drug. That does not happen very often, and the overall experience has been that most GPs do not. In the case of the warfarin that you were referring to, the INR test that is done to assess warfarin is actually standardised, in the sense that tests done in two different laboratories are actually comparable. From the point of view of the GP, who is usually the one who is managing these sorts of things, it is more a question of having serial results easily available and making sure that we are easily contactable from the point of view of the urgent results which can come from time to time—and then we are talking about pathology laboratories ringing us at eight, nine or 10 o'clock at night, saying, 'This patient's INR has gone up to three, four or five times what it should be,' in which case they are in imminent danger of bleeding and those sorts of things. As I said before, those are not frequent occurrences but they are important when they do occur.

Senator SIEWERT—The department's response to that is that all doctors have to have their contact numbers on the pathology forms, so it does not matter if you are in regular contact with the pathologists or not; you will have those contact numbers there so that they can get you.

Dr Jones—In the real world, for example when I am visiting a residential aged-care facility or one of those places, I might well scratch around to find any pathology forms, let alone one that has my name and address printed legibly on it—and my writing is probably better than that of most doctors. In an ideal world, what the department says might be true, but in the real world we are not always as easily contactable as it would like to think.

Senator SIEWERT—One suspects, though, that the issue raised with the aged-care facility is a broader issue that we need to fix anyway, whether this is introduced or not.

Dr Jones—I agree.

Senator SIEWERT—Could you just explain this to me. It sounds as if you operate a bit differently to some other doctors I have seen, but usually when I go to a doctor they have pads of forms from the pathologists that they use. Is it standard practice for them to have several? My experience is that a doctor has a relationship with a particular pathology service, and they are the ones they refer to. Is that not always what happens?

Dr Jones—My experience is that most GPs and, I believe, most specialists actually have a variety of those forms. I work in one of the corporate practices which has a specific relationship with a particular pathology provider, but I have all three of the ACT forms and, as I said, I ask that question of the patient: 'Where do you want to go?' It is usually geographically based in practical terms, unless I have that conversation with them.

Senator SIEWERT—Thanks.

Senator ADAMS—I will just continue on with that. With a patient with a chronic disease where you have to have pathology tests done every three weeks or so, you would really want continuity with that patient having their pathology tests at the same place so that you did not have any hiccups with things going up and down; is that right?

Dr Jones—That is right, and there are several reasons for that. One of them is that we do not yet have the universal health record that is going to be electronically nirvana as far as we are concerned. We currently have a situation where either different results are electronically transmitted into our in box and then incorporated into the patient's file, but each one then becomes a separate record, or paper copies arrive which are then scanned into the patient's file, again becoming separate records. Just on a practical level it is much more useful from my point of view to be able to see a row of seven tests going back 12 months, two years or whatever the number might be and to be able, at a glance, to give the patient the information that they need about how they are progressing with a particular condition. The other thing that becomes important is when our specialist colleagues are sharing the load in looking after that particular patient, knowing that each of us is getting all of the results from the tests that we are referring for, because often a specialist will order investigations that are supplementary to the ones that I have ordered or that I have not even thought of. It is very useful if we are both singing from the same songbook, as it were, and getting the results in the same way.

Senator ADAMS—We received evidence today—well, just a supposition. You said you are in a corporate medical service?

Dr Jones—I am.

Senator ADAMS—Some of those corporate services are owned by a pathology company; therefore the commitment for the general practitioners working within that corporate service would be—and a lot of them have their pathology service right next door, the pharmacy right next door and other diagnostic and radiology services all within that confine. You are saying that you still have your three forms for each of the areas, but most patients, I would think, would think: 'Great, this is a one-stop shop. I can go here and get my prescription done. I can go there and get my blood tests done. I can go there and have my X-ray or whatever.' But there is just this hanging over the top: do the people employed there have to refer to those specific services within their group? Could you comment about that?

Dr Jones—The short answer to that question is: no, they are not required to. It is in fact illegal for the arrangements to exist. My own experience has been that I have not once been asked by the head office—in my case, in Sydney—to refer to a particular provider. Common sense dictates that a lot of patients choose to go literally round the corner in the building to the pathology provider that is there or to the X-ray facilities that are there, but there are lots of situations where a particular test is not available in a particular lab—I should not say 'lots'; I should say 'some'—and, in that circumstance, I am perfectly free to refer them elsewhere and do so.

Senator ADAMS—When you have filled out the form and said, 'Right, this is where you go for your pathology,' have you had many patients say, 'Look, I don't want to go there; I want to go here because they're better,' or 'because I've heard that they don't do the job properly' or anything like that? In your experience, have you had that happen?

Dr Jones—No. That is pretty rare with respect to pathology services because people in a sense view it as a place to go and have your blood taken and then your blood disappears off to the machine somewhere. The reaction I get from that point of view, when it does happen, is mostly around whether the person taking the blood is any good at their job. People will often choose pathology providers on the basis of how big a bruise they get—or the geography, as I said before.

Senator SIEWERT—How far they have to travel.

Dr Jones—That is right.

Senator ADAMS—The question was really about how many of your patients would query the pathology form or the request form, saying, 'I don't want this one; I want to go there.' Does that happen often?

Dr Jones—It does not happen often and, as I said, when it does happen it is usually around things other than the patient's perception of the quality of a particular pathology provider.

Senator ADAMS—You are in the ACT. I come from a rural area, and as I have said earlier the fact is that you have a service and can have your pathology done there and it gets back to the capital city or wherever it has to go to be reported on. Usually it is one tender for that particular service, and that laboratory carries it out in certain areas of the state. I think that if you have a choice it is great, but it is far better to have the service than not to have the service. I guess that is a comment.

Senator BOYCE—Could one or other of you explain to me how GPs or GP clinics currently relate to or interact in a business sense with pathology services. Do you have memorandums of understanding or heads of agreement?

Dr Jones—No. The arrangement is a little different depending on the kind of clinic that you are working in. In the one that I work in, which is one of the corporate practices, we have pathology services, a pharmacy and X-ray on site.

Senator BOYCE—Or with a common owner.

Dr Jones—Yes. When I say 'a common owner', it is probably one of those legal niceties; they are probably owned by different subsidiaries of the same parent. But, for practical purposes, there is a common owner.

Senator BOYCE—Yes.

Dr Jones—My relationship with them is that I have a contract to provide my services to them for a period of time under certain terms.

Senator BOYCE—And in a specific area?

Dr Jones—And in a specific area. But it does not contain anything at all about the way I practise my clinical medicine or to whom I am able to refer. My contract does not have any clauses in it which specify a particular provider, for example. In the case of someone who is in a—

Senator BOYCE—Could it?

Dr Jones—My understanding is that it could not.

Senator BOYCE—That is what I am asking. It would be illegal if it did include that, wouldn't it?

Dr Jones—Yes. In the other circumstance, where someone is in a smaller general practice owned by the practice principal, as people often call them, essentially the pathology providers rush around to them and give them bundles of forms and say, 'Please refer to us.' There is no business arrangement between them, and again it would be illegal for them to have one. I am certainly not aware of any practices here that have any kind of business arrangement with pathology providers in terms of preferential referral or any of this—

Senator BOYCE—I am not even talking about whether it would be preferential or not; I am just looking at the sort of relationship that you would have and whether it would be simply as a supplier or whether there would be some guarantees about the sort of service or an understanding about types of service—whatever.

Dr Jones—I guess you would have to ask the pathology companies that question but, in the GPs' or medical practitioners' perception of how that works, they are essentially asking us to refer to them, in the same way that our specialist colleagues in other areas do: a new orthopaedic surgeon arrives in town and sends out a letter saying: 'Here I am. These are my areas of interest. This is what I do. Please send me some patients.'

Senator BOYCE—We had some brief evidence this morning from the Consumers Health Forum suggesting that health consumers still have a sense—I am being careful—

Senator ADAMS—It is not just us, then.

Senator BOYCE—Yes, I was going to go a bit further, in terms of kickbacks or rewards et cetera between pathologists and GPs. There is certainly the view that that happens in the pharmaceutical industry as well—that GPs get taken on holidays and things like this. Are you aware of this concern? What has been done about it, in the AMA's—

Dr Jones—I am aware of the perception that there is something to be concerned about, and I wish I was as aware of the lurks and perks that my patients assume I have had over the years. In the case of pathology, again, as I understand it, it is completely illegal for them to offer us any blandishments, and in fact there are quite tight controls around, for example, a small general practice providing rooms to pathologists as a collection centre. I can say with my hand on my heart that I have never seen a kickback or an inducement from a pathology provider for me to refer to them, and I am not aware of any of my colleagues who have been offered that. I am not saying that it has never happened, but certainly it is not my experience at all.

Senator BOYCE—Does the perception concern the AMA?

Mr Sullivan—There are a few things about that. Firstly, as Dr Jones was saying and you rightly know, there is prohibitive practices legislation that governs this whole area and it is quite clear about what the law will and will not tolerate. But that aside, we would be blind if we had not seen for some time the media reports particularly about the pharmaceutical industry and the relationships and the like and you know that the industry body that looks after the big pharmer in Canberra has its own code around education programs and the like. But as a profession we also have not only our own code of ethics, but we deliberately put out position statements formally endorsed by the federal council about the relationship of the profession to industry per se, whether it is pathology or anything else.

Its concern is correct, but also it is frustrating. That is the thing I find with most of the doctors: they are very frustrated with the way this particular issue and narrative is cast as if they are doing something wrong. I can understand that maybe a group may raise a perception, but it is a bit awkward when you have to deal only with perceptions rather than facts.

Senator BOYCE—But again, in the business world there is the case you raised earlier, Dr Jones, where a pathology firm actually owned a corporate practice. That certainly would lead to the potential for at least a perception of conflict of interest. How is that dealt with in terms of trying to appear transparent to the outside world? Is there any way that the outside world gets any sense about transparency?

Dr Jones—In a practical sense, I guess the only way that can be done is via the legislation and the enforcement of that legislation. As Mr Sullivan says, it is very difficult for us as a profession to say that these reports are all nonsense and the conflicts do not exist. But as for inducements, if that is the right word, we just do not see them. I remember one of my colleagues having a go at one of the drug company representatives, saying, 'You people are trying to influence us with a box of tissues and a handful of labelled pens,' and even those things are disappearing under the new code of conduct.

Senator BOYCE—But there are a lot of educational dinners and things like that as well, aren't there? I am not criticising them—

Dr Jones—I am not saying that they do not happen, but I think that one of the issues that is coming up for a lot of the colleges is that in fact they have moved to, in a sense, remove that nexus between drug companies or other sponsorship, and education. For example, the vast majority of invitations that I get for 'drug company' dinners, so-called—which I do not have time to go to and which do not particularly interest me; maybe some of my colleagues are not that interesting and that might be the problem—do not have the continuing professional development points allocated to them, which did happen perhaps 10 years ago, but no longer happens. So if people want to have a social function and someone else is going to pay for it, then they may be able to do that, but in terms of education that nexus is being very much broken.

Mr Sullivan—The interesting thing here too, and the irony of it all, is that the direction of government policy is towards centres where you have an agglomeration of services. So in a sense, the perception that you go to a one-stop shop is what is evolving in people's minds, and the difficulty you are raising is how you make sure that people can be clear that conflicts of interest are being appropriately managed. That is exactly at the heart of the position statements the AMA has been putting out, because in every life circumstance you have conflicts of interest.

Senator BOYCE—Absolutely. It is the not so much the conflict of interest or the perception; the issue is how you manage that. We are talking here about private companies who, presumably, in most cases do not have a need to report, so there is really no way for the public to be assured that this conflict of interest has been recognised and managed.

Mr Sullivan—The profession does have an obligation within itself to put upon its members a standard of behaviour that is in accord with what you would understand to be a professional ethic. That is why at times

those position statements are put out on why we support the prohibited practices legislations. We are probably more of a barracker of that than other groups.

Senator BOYCE—But does the AMA itself have an active program of looking for failure to meet those standards or would this be a reactive approach once someone brings an apparently illegal behaviour to you?

Mr Sullivan—No. The history of this, particularly in the pharmaceutical debate, is that, as I said earlier, Medicines Australia has its own code which it monitors and polices and has its own set of penalties.

Senator BOYCE—For the suppliers, so to speak.

Mr Sullivan—Sure. Doctors have raised concerns, particularly over the way they have been approached by drug company representatives in the past, and they have done that through the appropriate mechanisms of that code. We support the code and we support Medicines Australia seeking compliance above 95 per cent and so on. I think we have tried to be proactive in a very pragmatic way about how those codes can work and we have made it very clear that the whole purpose of doctors' engagement in those events is about education. As you know, this is obviously something that is debated around the clock, but we certainly do not just wait to find out if there is a problem.

Senator BOYCE—Wherever there is a standard and wherever there are human beings there is going to be someone who is not doing the right thing, so I guess my question was around what efforts were being put into assessing that.

Mr Sullivan—That is what I mean by position statements and education issues like that.

Senator BOYCE—But that is around telling your members what the standard is and what is expected of them.

Mr Sullivan—Professions base behaviour on a set of ethics. Our position statements are based on our code of ethics, which is recognised everywhere, and humans' behaviour is based on their sense of ethics. But a profession has a clump of ethics where individuals within it need to come to terms with what it means to be in the profession. All professions weigh heavily upon their members to uphold those.

Senator BOYCE—I guess I still do not have a sense of what you are doing other than telling people what they should be doing to ensure they are behaving properly. I realise there are government bodies that are supposed to be doing this, but I presumed it would be something the association would also be interested in.

Mr Sullivan—Associations like ours would always seek to educate wherever we can, of course. There are many mechanisms used to educate individuals as members of a profession beyond them understanding the law.

Dr Jones—The other thing that we do, and it is fortunately rare, is that within the limits of what power is available to us we actually sanction our members if they stray too far across those ethical boundaries. In the ACT we have not long ago removed one of our members from his AMA membership as a result of his behaviour in other areas where he did cross those boundaries. So within the limits of what sanctions are available to us we certainly do do that.

Senator ADAMS—I would like to go back to your opening statement, Mr Sullivan, on the consultation and also on the legislation. This is an ongoing occurrence, unfortunately for the committee, and probably the cigarettes today would be one because we do have a committee inquiry into that. You said there was no consultation with the department. Could you elaborate on that statement, that you did not have any consultation from the Department of Health and Ageing?

Mr Sullivan—The point of the exercise was that there was a consultation period announced and submissions called for and unfortunately the bill was put into the parliament before the submission due date had been met. So that is a pretty bland situation for us when you want to talk about the capacity to influence. Secondly, once our submission has gone in we have had no contact back. Maybe in defence of the department they would take the view that once a bill is in the parliament it is no longer the precinct of the department but it is now the legislature. I understand that and probably I would say that if I was asked that question in another role. But my point would be that, although earlier today you may have sensed that we were quite constructive in our criticism, this time I think we need to be rather blunt. We believe this process could easily have been short-circuited. I think you may agree with us that what we are putting forward as amendment is a bit of a no-brainer. I take the senator's point about how things may happen in some surgeries sometimes, but even if that is an issue you would not want to deny the fact that we would want to have a provision whereby a doctor can seek a particular referral. So I would have hoped that if the process had worked properly this could have been raised, we could have shown the department that we were actually making a change that really did not make

much sense and we probably would not be here, and neither would you, and that would be good, I suppose, on a Friday arvo.

Senator BOYCE—Some of the submissions we have received that suggested that it should be a requirement that doctors note discussions around which pathologist to use in the patient's records. What is the view of the AMA on that?

Mr Sullivan—We roll our eyes and we sigh because—

Senator BOYCE—It is one more thing to have to write down.

Mr Sullivan—It is only one more and it seems like a trivial thing, but when you add it to the minute and a half you have to spend on the phone to DOHA to get approval to prescribe the drug and so on and so on it becomes bigger than Ben Hur, so to speak. We would much rather spend our time talking to patients about the clinical issues and the health problems that they have rather than dealing with administrative issues. I think most doctors would be very comfortable with patients being adequately informed and adequately educated about what their options are. I just do not think I am convinced, and I do not think the AMA is convinced, that it is the department's role to transfer the responsibility for that education to us when they are making what is effectively an administrative change.

Senator BOYCE—You mentioned in here the concerns you have about a situation where the referring doctor and the pathologist service are not known to each other and do not actually have a protocol for getting information from point A to point B. We are told that the universal health-care identifier system is going to kick in from 1 July. If that were to happen, would that allay those fears?

Mr Sullivan—The problem with that is that the health identifier might kick along on 1 July but the infrastructure in terms of the information technology to actually allow all these things to occur is still years away. We still have a whole lot of silos—

Senator BOYCE—Given that the legislation to allow for the identifier still has not passed the Senate—and I would be interested to see that happen too—we might be talking five years time.

Dr Jones—Yes.

Senator BOYCE—Is this legislation in a way a companion piece to that e-health system? If so, is its introduction and passage now somewhat premature?

Dr Jones—In the long term, in some senses parts of this legislation might well be made redundant by that system. If that system were in place, some of those concerns we have would not necessarily exist. I think some of them still would because we would still be thinking in terms of the pathologists. I guess because I get to talk to these people who are pathologists, whereas most people view pathologists as a shopfront you go to get your blood taken and it goes off and gets analysed by a machine, I am still very conscious of the fact that the pathologist is a specialist like all other specialists, who gives me opinions about particular problems. I do not think that concern will go away, but some of the information concerns will certainly go away. But is that five years away, 10 years away? I do not know.

Senator BOYCE—Good question.

CHAIR—I want to know where the responsibility lies with the testing process. You mentioned in your submission legal cases that have occurred because of doctors not following up effectively on pathology tests. As it works now, when you send off tests to be done by a pathologist, whose responsibility is it to return those tests to the doctor?

Dr Jones—It is the pathology provider's responsibility to return those tests to the doctor, but that does not absolve the doctor of their responsibility, particularly in important matters, to follow up. For example, I get letters from specialists saying, 'Mrs Bloggs had an appointment but did not keep that appointment,' and it is a way of informing me that this person's ongoing care, their management, may not have taken place in the way that I had anticipated. There is certainly lots of medico-legal precedent to suggest that it is my responsibility, if I order the test, to make sure that it is done and that I know what the result is. It is the pathologist's responsibility to do their bit to get it back to me, but I still have a responsibility to follow it up.

CHAIR—In terms of the kinds of issues that you have raised, about communication and difficulties in getting information if the system were to change, I still cannot get my head around why, if a client chooses a registered pathologist to have their test done, there would be any issue at all as to their confidence as a patient that the pathologist would communicate with the doctor and the doctor would communicate with the pathologist. I just do not see that, if people are acting under the law.

Dr Jones—In the vast majority of instances, that is exactly what happens.

CHAIR—So where would it go wrong, and whose fault is it? In your submission, you are actually impugning fault, saying that by changing this legislation somehow the system is going to break down. So I want to know exactly where you think it is going to break down.

Dr Jones—One of the situations might be—to use the case that we were talking about before with INRs and warfarin—if I provide someone with a referral to get an INR done and they do not have it done and I do not know which pathologist to ring to try and track down the result. Then there are some issues for us in terms of finding out whether the person's care has actually been followed through. It is a situation where we are not just responsible for following up those abnormal results that are reported to us but we are responsible for making sure in some sense that things are actually done.

CHAIR—So legally—and your submission spent several paragraphs on this—if you ask me, as a customer, to do something and I do not do it, I would imagine the fault would be on me.

Dr Jones—Well, not entirely.

CHAIR—Under this provision, it is a straightforward situation where the client has a choice as to which pathology place they go to for their tests. It would seem to me—and it has been done by the whole consumer network—to be a very popular thing. The consumers who are interested in the issue and who bothered to turn up to consultations have said, 'This is something we want; we want to have ownership of which provider we go to,' with the understanding that the provider is fully qualified, of course, and has the accreditation and the standards. They want that. So I want to find out what exactly what could happen legally when you claim that your indemnity insurance could be affected by this change.

Dr Jones—There have been cases where medical practitioners have been held accountable for the failure of one of their clients to follow through with treatment. One in particular that I can think of that caused a fair amount of angst among GPs was where a referral was given to someone to consult a particular specialist. Because the specialist was a couple of country towns away, the client chose not to go to that person, did not follow through in a timely fashion and suffered adverse outcomes as a result, and the GP was held to be responsible. So there are those sorts of situations where—

CHAIR—How could that have been different, in that obviously the GP referred the patient to a specialist that they knew? The doctor in that case would have referred the patient to Dr Bloggs, 'You go to Dr Bloggs,' and it did not happen, and the fault was then put on the first doctor for not following through. In the current system, if a doctor refers a patient to a pathologist and the patient does not turn up, does the pathologist have a right or is there an understanding that the pathologist to which the doctor referred the patient has to tell the doctor that they did not turn up?

Dr Jones—In that situation, the pathologist would never even know of the patient's existence.

CHAIR—No, I am talking about the current system, Doctor. The legal case that you put forward is the basis for your concern—and I have not read it. If you are linking that to this change in the system, the doctor in that case was actually found liable, I understand, because the patient did not go to the specialist that the doctor actually named and referred them to in the same way they would prefer a patient to a pathologist. I want to know how that differs from the current system. If you refer a patient, as doctors do, to a pathology service and they do not turn up and something happens, does the pathology service to which you referred the patient have the right to tell you that the patient has not shown up; and is that different in any way to the case you described where the patient did not go to the specialist?

Dr Jones—The difference between the pathology service provider and the specialist is that the specialist may well have had someone ring them and make an appointment, but the pathology service would not. What I was getting at was my responsibility to follow up on the results. If I know where I have referred the person to, when my software tells me at the end of the day or the end of the week, 'These are the outstanding tests that you've ordered; these are the ones that haven't come back yet'—and the software has the capacity to do that—then I know where to go to chase up the result, because sometimes it is just that the results have not come through.

CHAIR—Why wouldn't you chase up the patient? For example, you might have put it into your system, either manually or on the computer—hopefully, with the new system that is going to happen—that you referred me on to get a series of tests done, but you do not know which pathology service I was going to. When you get to the date you have keyed in as when you expected those tests to come back and they have not, if you had referred me to a specialist pathologist, I take it from the way you describe it that you would get your

office to call the pathologist and say, 'Why haven't I got these back?' If the law changes, why would you not contact the patient directly and say, 'Hey, I referred you for tests last Tuesday and I haven't got the results back; why haven't you done them'? It is one phone call in each case. I am just wondering why that is more difficult.

Dr Jones—It is not a question of it being more difficult. There are two possible breakdowns in the process. One of them is that the test was not actually done at all: the person did not go and have the test done.

CHAIR—Yes.

Dr Jones—The other breakdown in the process is this: for example, in my situation I have a colleague in a neighbouring practice with a very similar name to mine, and often, with drop-down menus on computer screens, those results are sent off to him rather than to me. If I know who the pathology provider is in that particular instance I can ring them and say, 'I think you've sent me one of Paul J's results,' or vice versa. Of course, the next step from my point of view is to ring the patient or to have someone ring the patient and say, 'Have you had that test done?'

CHAIR—Yes. That is what I am trying to get at. In the case that you have brought up where you may have got somebody else's test, which under the current system happens—you get somebody else's test that comes back—on the documentation that goes with the test, which has been raised in a couple of submissions, you actually refer the person to have tests done in your name and everything is supposed to be there. That goes to the pathologist and then they send it back to the doctor who has referred it with all their names on it. So even in the case you have described, you would have got a test back, maybe erroneously, to your surgery, but you would have it from Acme Pathologists, so you would just call them. I just do not see the increased workload, Doctor. I know this is getting into lots of scenarios.

On the responsibility of the doctor, the responsibility of the pathologist and the responsibility of the patient, the professional medical responsibilities of the doctor and the pathologist are quite clearly defined. The difference now is going to be the choice for the patient as to which pathologist they go to. In a perfect world there would be an open discussion between doctor and client at the time of the test—at the time of the hearing—and people would work out what they were going to do. That would be, I think, how everyone thinks it should operate. But in the 'what if' scenarios that have been created in your submission and also a couple of others, it seems to me if the documentation is accurate and people do their job there should not be any further difficulty. The doctor is known and the pathologist is known. They are trained and accredited. The process should not be that difficult. I am trying very hard to see, if people do the right thing, where it would be any more trouble at all.

Dr Jones—There are two things I guess. One is that the situations that we are talking about are a very small minority of the situations. We certainly have not argued that we should, from a doctor's point of view, direct every single patient to a specific place. This is not new in the other areas where we practice. In Canberra we have the luxury of having several orthopaedic surgeons, for example, who do good work with shoulders. I will in general say, 'Who do you want to see?' Sometimes people say, 'I don't care. Whoever you send me to.' Sometimes they will say, 'My brother saw Dr Bloggs,' and so on.

CHAIR—And that is a reason to go or not to go.

Dr Jones—Yes. In our submission we are talking about a very small group of specific circumstances where there is the option of being able to say, 'This is the pathology provider that we believe is in the best interest of that person.' I am not talking about the 90-plus per cent of situations where, quite sensibly, people can choose for themselves—for a whole variety of reasons, as we have talked about earlier today—about where they will go.

CHAIR—In the AMA submission it talks about clinical circumstances. How do you define 'clinical circumstances' in that process—talking about a very small percentage where the doctor would want to have a specific pathologist? What defines a specific clinical circumstance as opposed to familiarity of usage, convenience—all those things? I am taking on board the recommendation you want us to make. How do you then ensure that that is actually quite tightly defined as to clinical? You have given us two examples in your submission. We will be asking the department the same thing. What constitutes clinical in that sense and what will be an accepted clinical process? Will there then have to be a set of guidelines to say, 'These are the acceptable clinical processes in which a doctor can effectively refer to a pathologist'?

Dr Jones—I think most doctors would be horrified if we had yet another set of guidelines. Again, I think we are talking about the situation we talked about earlier. If I can use the analogy of the prescriptions, it is

pretty rare for me to say to somebody, 'I'm ticking the box that says you're not allowed to have generics for this particular drug,' without saying to the patient at the same time, 'These are the reasons why I am doing this.'

CHAIR—Absolutely.

Dr Jones—In some circumstances, the discussion around that particular provider would be the same sort of discussion. The submission really talks about a very small group of circumstances, and we do not have a problem with the vast majority of circumstances, where people are obviously going to be free to choose.

CHAIR—So there would be an even smaller set of circumstances where the person you wanted to do that would not, so we are narrowing it right down.

Mr Sullivan—Isn't the point, though, that this legislation, or what we are proposing to have as an amendment, is based on the fundamental principle in the health system that a clinical judgment and a medical diagnosis are the safety net? We do not say anything more. In, say, public hospital admission, when people are on waiting lists, they are on waiting lists as determined by the urgency of their need; it is not just about when you turned up. That is a clinical judgment; it is a matter of judgment. I think that what Dr Jones is saying is that we just want the facility within this bill that, when a specific referral is required because of a clinical judgment, that capacity still remains, as it does in other parts of the health system. That is all this is about. I understand where you are going on the other parts of the questions—about consumer sovereignty and the like. I do not think anyone is trying to argue that away. All we are trying to put back into this game is the fact that the medical diagnosis and judgment are not undermined to the point where they cannot exist in this process.

CHAIR—It still troubles me that, if you have accredited professional pathology services in a region, there would not be the acknowledgement that any of the accredited professional services in the region would provide the service. It just seems to me to be a subset of judgment, even though all these people have the ability and are around—and I absolutely take Senator Adams's point that in some parts of the world you do not have the luxury; this is a non-event if you are in a place where there is only one. It seems to me that if you have a health system which has professionals accredited then there is an implication that, because you happen to have gone to a GP in your first round of choice—and it is a choice as to which GP you visit, who is there and who is available—the next round of choice is denied you. That is my concern. In terms of the process there, we will ask the department about the interaction and where that came.

There was just one other point I wanted to clarify, in terms of the ongoing discussions that the AMA has with the department. You have made the point that this was not discussed. It came in the budget last year, so I am just wondering about it. At no time in that whole period has this been a matter of discussion?

Mr Sullivan—We say no to that.

CHAIR—I just wanted to clarify that it is not something that just came on the board three months ago or something.

Mr Sullivan—No. We appreciate that it was part of a budget initiative, but the consultation has been nonexistent.

CHAIR—Thank you very much.

[2.19 pm]

GRAVES, Dr Debra, Chief Executive Officer, Royal College of Pathologists of Australasia

McKENZIE, Associate Professor Paul, President, Royal College of Pathologists of Australasia

CHAIR—Welcome. Do you have any comments to make on the capacity in which you appear?

Prof. McKenzie—I am also a specialist at Royal Prince Alfred Hospital in tissue and anatomical pathology.

CHAIR—Thank you very much. You have information about protection of witnesses and evidence. We have your submission. Thank you very much for that. I invite either or both of you to make some opening comments, after which we will go to questions.

Prof. McKenzie—Thank you for inviting us to appear today before the inquiry. The college sees its primary responsibility as striving to ensure that high-quality pathology services are maintained for the community. We do this by training doctors to become pathologists of the highest standard, supporting them through their professional lives and speaking out when issues arise that could compromise the quality of pathology in Australia. This bill to change pathology requests is one such issue, we believe.

May I start by ensuring that there is no misunderstanding regarding the college's position on patient choice. The college believes strongly that patients should be engaged in choosing the pathologists who will contribute to their care, just as they are for the selection of other medical specialists. Indeed, they have, to an extent, the right to choose this already. To treat pathology as if the choice of provider does not matter, we believe, is to imply that it is just a commodity. We would attest that the pathology request is a specialist referral and, although high-quality standards exist in Australia, particular specialists or practices may offer specific expertise or tests of which a patient themselves may not be aware.

Our view is that patients' choice must be informed, and by this we mean that their decisions should take into account the clinical advice that they are given from their referring doctor as well as other factors of importance to the patient, such as the billing practice and the convenience of collection centres. The patient's episode is only complete after a specimen is collected, tested, the results dispatched and then interpreted and finally acted upon by the requesting doctor.

Pathology as a profession deals with about 50 million patient episodes annually, through Medicare alone, and expands a lot of energy in minimising errors. As I have mentioned to a separate inquiry here, we estimate there may be up to 200,000 identification errors which are detected by laboratories each year. We are concerned that this bill will introduce a new and unqualified risk of misplaced or untransmitted pathology results, which are essentially an error.

The college's concerns go to the heart of patient safety. Foremost of these is the traceability of results. Simply put, if a doctor does not know where a patient has gone to be tested, how can they follow up the results? As I heard you discuss earlier, requesting doctors have a responsibility to follow up on the results of the tests they have requested. The minister, in her speech on 10 February, acknowledged that patients:

> … need to be aware of the potential consequences of not keeping their requesting practitioner informed of their choice, as this may impact on the continuity of their care.

We believe that failure to keep the referring doctor informed could go much further and risk lives or negative clinical impacts.

Pathology tests can yield clinically urgent results in patients who appear otherwise well. An example would be critically high or low serum potassium, which can lead to sudden death by cardiac arrest. Another would be, as mentioned by the previous witness, high or low INR for patients taking the blood-thinning medication warfarin. A high result might mean a serious risk of spontaneous bleeding, possibly into the brain, with fatal results, and a low result could mean insufficient dosage, with a risk that blood clots could occur.

These results need to be transmitted within hours, not days. If a doctor has not received the report and finds the patient has not attended the laboratory to which they were referred, this could mean as many as 90 labs to ring around in Sydney. Delays in transmission of results, or failure to receive the results altogether, could have dire consequences for patient health. We strongly recommend, for this reason, that the changes be deferred until there is a degree of safety provided by a universal e-health record for patients.

Serial tests are another area where the proposal could prove problematic. Comparison of assays over time can be important for monitoring the ever-growing number of patients with chronic conditions. We gave the

example of INR monitoring of warfarin patients in our submission. It is not exactly true to say there is no variation between laboratories because they have different machines and different suppliers of chemicals that go into the machines. There is consistency within laboratories but some variation between laboratories. They give a reference range, but patients are often involved in managing their dose with the latest INR. So changing around in that respect can lead to possible changes in their dosage that are not appropriate.

A further example would be PSA, or prostate specific antigen testing, where serial tests are used for either monitoring what has been discovered to be an abnormal PSA, which might be suspicious for cancer, or testing for cancer recurrence. Methods and result ranges differ between laboratories and a much higher reading based on a different testing method could cause serious alarm to a patient and may even result in inappropriate treatment. Education about pathology results and their interpretation, and standardisation of reporting and methodology, is a process that will need to be gone through in the development of an e-health record. It is really the only way of preventing this problem.

The minister also suggested that the bill will 'encourage pathology providers to compete on price and convenience for patients.' Currently, with most pathology services bulk billed, there has not been much of a need for price competition, so that the main drivers for competition have been the quality and reliability of results and the efficiency of specimen collection and report delivery. This has had the effect of underpinning the major advances that we have made in pathology laboratory quality over the last 2½ decades. While we have an excellent accreditation scheme, like all such schemes it sets minimum standards. If competition becomes based primarily on price, it is likely that no-one will aim higher than the minimum standard. Turnaround of results would be slower, some tests would cease to be offered, introduction of new tests would be inhibited and there would be no incentive to train or conduct research.

We also had some concern about the haste with which the bill was introduced. We were concerned that it showed a lack of understanding about the complexity of pathology referrals. We had raised some concerns before with the Department of Health and Ageing and many of these concerns were actually acknowledged in the department's discussion paper, which was still subject to consultation when the minister gave her second reading speech. We appreciate the Senate committee now giving us this opportunity and considering the issues in more detail.

CHAIR—Thank you. Dr Graves, would you like to add anything at this stage?

Dr Graves—No.

CHAIR—Professor, I am just trying to get the link between patient choice, which this bill offers, and the dire consequences for your industry. It is a really important point and you made it in your submission as well. I put a big cross beside it so I would follow it up.

Prof. McKenzie—It comes a little bit from the comment in the minister's speech, and I believe also in the department's submission relating to bulk billing, that this was conceived as a way of enforcing bulk-billing arrangements. To an extent, we view this as something that might have been more appropriately dealt with during the pathology funding review, which is underway at the moment. So it is something which has been raised by them. We are concerned that the drivers for competition in pathology should be quality and service based, because we feel that that promotes excellence within the profession rather than having the opposite effect, which can occur if the primary concern is cost rather than quality.

CHAIR—And that is because of comments in a speech rather than your belief that patients would be seeking that?

Prof. McKenzie—I do not think that patients are seeking that, because bulk-billing is extensively available to them as it currently exists. This is something not coming from what we can see as a patient focus, but more of a department focus. This came from the minister's comment and particularly a comment in the submission which raises this particular issue, otherwise it would not have been something we might have raised ourselves.

CHAIR—We are looking at the legislation, and the legislation is actually focused on patient choice. So that is an impression you have got from other things; it is not the legislation itself?

Prof. McKenzie—It is not the legislation itself, but what has been thought to be a benefit obtained by the legislation.

CHAIR—Okay. I just could not see it in the legislation.

Senator SIEWERT—Can I get your position really clear: you have obviously raised a whole lot of issues in your submission and also now. You are not opposed to change per se—

Prof. McKenzie—No.

Senator SIEWERT—but you are concerned about the implications of the changes as they currently stand?

Prof. McKenzie—We are concerned particularly, I would say, about the potential for risk coming out of the result traceability issue—

Senator SIEWERT—And that would be the key thing?

Prof. McKenzie—I think that is our primary concern: that there will be an introduction of an extra risk. I know this was gone through in the previous submission. The particular issues may not be particularly common but they occur already. One of our council members gave us an example only a week or two ago, a very recent example. A patient for some reason went to a different pathology company. The normal courtesy would be to contact the doctor and say, 'Do you want us to do the test?' That apparently did not happen. It was processed at another laboratory. The patient was in theatre and the surgeon very angrily rang up from the theatre for some preoperative test results and the patient had not been seen at this particular practice. So it was then a question of finding out where the patient had been.

The difficulties can be multiplied when you are talking about elderly patients, people with a bit of vague dementia perhaps, or who are non-English-speaking. It is not always a simple matter to contact patients. Many elderly patients do not have mobile phones. In an out-of-hours situation the referring doctor's mobile phone will not be on the request form. Most doctors will not give that up easily to patients for privacy reasons. So it can be a real problem for an unknown doctor to be traced out of hours with an urgent result. Sure, the doctor's name and address should be on the form, but then you are relying on somebody either trying to find something on the internet or sending a result by post, which could take a day or two. So it is the urgent out-of-hours, unexpected result we are concerned about. These may be uncommon occurrences but you are multiplying that by 50 million episodes so that a relatively uncommon event multiplied by 50 million episodes can be significant to the individual.

Senator SIEWERT—In coming up with a way to address that issue you talked about e-health, which is still sometime away. In the meantime you are suggesting that this not proceed until, essentially, e-health is up and running and people can be tracked through the e-health process.

Prof. McKenzie—That is what we would prefer, because we feel that it is a safe way to go. It is not introducing extra risk into the equation.

Senator SIEWERT—Have you consider other ways to make this work besides that option?

Prof. McKenzie—We gave it considerable thought, I must say. We raised our concerns initially with the department, as I mentioned, but apart from trying to find secure ways of doing that, we have not been able to come up with any other way of getting rid of those uncommon but often clinically very important occurrences.

Senator SIEWERT—You talk in your submission on the issues around patients changing their minds after they have agreed to a particular provider with their physician. You say choice could be assured if the legislation included a requirement for requesters to inform patients that they have made a choice. Could you take me through that and explain what you mean? Is this one of the alternatives you have considered if the legislation goes ahead?

Prof. McKenzie—Could you read that to me again?

Senator SIEWERT—On page 3 you talk about the best way to facilitate patient choice without compromising safety is for choice to be made during the consultation with the referring practitioner. In the fourth paragraph down you talk about what happens if the patient changes their mind. Is what you are saying here that if the legislation goes ahead, if it is not delayed, this is a safeguard that you want put into the process?

Prof. McKenzie—I am not sure that I understand the question here. What we were really saying was that we felt the legislation allowed patients to change their minds or do whatever they liked without informing their doctor retrospectively. I think that is a completely believable situation if somebody happens to have the request in their handbag or something and they are out shopping and there is the collection centre for a pathology company; I think that is perfectly reasonable behaviour under these circumstances. We were really trying to cover our agreed position, that it is inappropriate for requesters to recommend particular providers.

Senator SIEWERT—The first part of that paragraph I do not quite understand. I thought you are coming from the position of choice being assured if the legislation required a written requirement for requesters to inform patients that they have a choice.

Prof. McKenzie—What we are meaning there is that the discussion about choice should occur during the consultation so that both parties were fully aware of what was going to happen.

Senator SIEWERT—What I am trying to get to is if the government does not buy or we do not or whatever that the legislation should be halted for the time being, I understood from your submission that you were implying that the legislation should at least include that requirement.

Prof. McKenzie—I think it is reasonable that patients should be aware that this is a discussion they are having with their doctor, just as they would discuss whether or not they want to go to a particular surgeon or obstetrician. They may ask, 'Does this practice bulk-bill? Does it have a convenient collection centre for me?' If the answer is no, they do not bulk-bill, 'Can you find one that does?'

Senator SIEWERT—That is the context of those comments.

Prof. McKenzie—The context really is getting back to our opening statement about informed choice rather than a random choice.

Senator SIEWERT—In other words, that is a suggestion for a requirement in the legislation that that choice can only be made when you are with your doctor and you have that discussion and then the doctor ticks a box once you have agreed.

Prof. McKenzie—That is what we would prefer at this point, with the current record systems.

Senator SIEWERT—You will be aware of the AMA recommendations in terms of having the box. That would complement yours, I would have thought. They are not mutually exclusive, to have a box to say, 'Right, this is the one we want.' Do you support that?

Prof. McKenzie—Our only problem with that is that that is usually when the doctor already knows that there is likely to be a problem. Our concern would be when there is an unknown result—an unexpectedly out of range result; something that comes out of left field, perhaps. There perhaps will not have been any particular reason to have suggested 'ticking the box' but the result might be just as urgent or clinically important. It would be a case, maybe, of an average elderly patient on diuretics. There may not have been any particular clinical reason that was obvious at the consultation to send them to a particular specialist, but they may be just the sort of person who ends up with very low potassium and might drop dead.

Senator SIEWERT—It may have been a presumption on my part that if a particular pathologist's service was being selected by a doctor for a particular reason that that doctor would know that that particular pathology provider—in other words, would understand their processes. I will not go over the reasons that AMA suggested that you should be able—or that you would need, in some cases—to have a particular known provider because of the way they do their results. I was making the assumption that if the doctor was going to the point of saying, 'I want you to go to this pathology provider,' that they would know that pathologist. I was making that assumption. I do not necessarily think that what you have just said, with all due respect, applies to that particular tick-box, if you make that assumption.

Prof. McKenzie—The ticking of the box, I think, comes when there is already, in the doctor's mind, some sort of reason to do that. We are concerned about results where it might be something the doctor had not considered during the consultation.

Senator SIEWERT—That is going back to your original argument.

Prof. McKenzie—It will go part of the way. There will be some times when there are good reasons for sending someone to a particular doctor. It may be that they specialise in that particular area—for instance, if it is an unusual condition. All pathology practices are by no means the same. They have different ranges of tests; they have different areas of interest. Individuals within practices would have specialist areas of interest. So there may be very good clinical reasons for sending someone to a particular practice or a particular specialist. So that covers one set of circumstances but there will still be other circumstances where a sudden unexpected result which is clinically important needs to be got back to the doctor very quickly.

Senator SIEWERT—I do not want to labour the point but I was asking about it not being mutually exclusive. Without saying whether I support it or not, you could have your suggestion and the AMA's suggestion.

Prof. McKenzie—Yes.

Senator SIEWERT—I think they could run together.

Prof. McKenzie—We would agree.

Senator SIEWERT—There are a lot of boxes.

Senator BOYCE—I am not really clear about what you would like done to the legislation. What does the college see as the way of correcting what you perceive to be the problems?

Prof. McKenzie—The legislation has gone a long way. It has an implementation date, I think, of July. We have the concern that there is an increased chance of an adverse clinical event coming out of a lack of communication of results because of the way this is set up. Our position is that we would prefer this to go through and the implementation date be moved to whenever it is that we have an efficiently functional universal health record.

Senator BOYCE—We might all be in our graves by then, Professor McKenzie!

Prof. McKenzie—I hope not.

Senator BOYCE—I hope not too, but—

Prof. McKenzie—I think that makes it a safe way of implementing the legislation. It reduces this risk to something negligible.

Senator BOYCE—You have spoken a little bit about how pathology services specialise in some aspects. Could you give us some examples of that, please.

Prof. McKenzie—Okay. In my own case, I am a tissue pathologist, and I have particular areas of interest. I have specimens sent to me in the area of renal pathology and cytopathology. In other disciplines, such as haematology, some people might specialise in abnormal haemoglobins. A biochemist might have an interest in porphyria or other particular genetic conditions. There may be somebody who is interested particularly in lipid problems. So there are reasons like that to send the material there and get the opinion of a person who has particular expertise rather than somebody who does general biochemistry or haematology in more of a community sort of way. It is a very diverse spectrum of specialties.

Senator BOYCE—I have spoken to a pathologist in Sydney who had some very specific specialties but also was based primarily in a clinical research area.

Prof. McKenzie—But some people would have particular expertise in some common conditions like diabetes or, as I mentioned, lipid disorders. It is not always the absolute rarities, but people do have interests or particular knowledge in some areas of pathology or medicine.

Senator BOYCE—How do GPs know that?

Prof. McKenzie—Mostly they would know from previous referrals and having spoken to and got advice from people. They may have seen publications by these people in medical literature. Often review articles are put out by pathologists in particular areas in papers like *Medical Observer*—the free medical newspapers that come round to GPs. So within medicine there is exposure to get an idea of what people's areas of particular interest are. For instance, biochemists may run lipid clinics. Haematologists work also as clinical doctors.

Senator BOYCE—What would happen at a lipid clinic? Who goes to a lipid clinic?

Prof. McKenzie—People with hyperlipidemia, for instance.

Senator BOYCE—So it is for patients, not for GPs.

Prof. McKenzie—Yes, but they would be referring patients there, so they would understand that.

Senator BOYCE—So at present it relies on the personal exertion of the GP to know these.

Prof. McKenzie—It is very similar to how they would refer to particular surgeons—maybe an orthopaedic surgeon with an interest in hip replacement or a urologist who does kidney cancer or looks at incontinence. It is the same way that people build up knowledge of the profession. Part of a GP's role is to know that they are an advocate for the patient within the rest of the medical system.

Senator BOYCE—In your written submission to us, you have talked about the consequences if an original biopsy result were incorrect. Can you talk us through how that would differ today or on 2 July—making that assumption about the legislation?

Prof. McKenzie—All right. I just need to remind myself of the context.

Senator BOYCE—It is on page 50 of 54 of our material, but it is on your last page. It is your second last paragraph.

Prof. McKenzie—The context of that was related back, again, to the idea that this would lead to an emphasis on price in pathology. Again, that is not part of the direct legislation but part of the conversation that has been had around this legislation. We were concerned because there has been a recent study which is now with the department, looking at the workloads of people in anatomical pathology and the numbers of hours that they are doing. So we feel that pushing price in this area of pathology could lead to people working even longer hours and making devastating errors, basically.

Senator BOYCE—But it is possible for a biopsy result to be incorrect right now, isn't it?

Prof. McKenzie—That is possible, but we are concerned that fatigue and making people do a larger number of biopsies so that the costs to the practice are lower can lead to errors. Admittedly they occur already, but if you have a fatigued person doing twice as much work then they are likely to make significantly more errors, and they can be, for an individual patient, very serious.

Senator BOYCE—So your concern is not so much that the outcome would be more adverse; it is just that there would be more adverse outcomes. Is that correct?

Prof. McKenzie—Yes.

CHAIR—Where is that in this legislation? Where is the argument that people are going to have to work longer and do more consultations in this legislation?

Prof. McKenzie—As I mentioned, it is not in the legislation; it is from the conversation around the legislation—some of the minister's comments about price and the department's submission suggesting that it was a way of forcing cost down and enforcing bulk-billing.

CHAIR—Again, why would bulk-billing mean that people are going to be working longer? I took your argument earlier when you said that you were concerned that there is a general issue around cost, but how does bulk-billing link to pathologists having to work longer hours and do more jobs?

Prof. McKenzie—It depends what the fee is in the bulk-billing thing, whether it is—

CHAIR—That is the point. Can we get it all on record?

Prof. McKenzie—That is what my point was: that this part of the discussion would have been better served through the review of pathology funding. That was our concern with that motive that was expressed. We would be happy to just talk about patient choice. The other things which were mentioned in relation to this legislation caused us some concern. What we are trying to do is to explain the consequences of those motives perhaps.

CHAIR—Sorry, Senator Boyce, but I just want to follow this up, because it is such a core part of your submission, Professor McKenzie.

Prof. McKenzie—I hope that it is not the core part of our submission. The core part of our submission really was the question about traceability of results. This was an addition to our submission, but it was not the core of our submission.

CHAIR—Can we get something from you where you actually can link the concept of workload and cost to bulk-billing?

Senator BOYCE—Isn't it just that more bulk-billing would mean lower profits, so for the service to remain available you would work longer? Is that the rough argument?

Prof. McKenzie—That was the argument, yes.

CHAIR—Okay. I was focusing on the overwork, but it was actually the profitability of the practice which was the issue.

Senator BOYCE—Or even the viability.

Prof. McKenzie—Questions about profitability often result in economies being made and people working longer hours. Labour is the biggest cost in the system.

CHAIR—Got you. Senator Boyce, do you have any more questions?

Senator BOYCE—No. I am happy.

Senator ADAMS—Professor McKenzie, could you tell me what consultation you had with the department over this legislation? Were you involved?

Prof. McKenzie—We did have some discussions with the department before the discussion paper late in 2009, I think.

Dr Graves—We have actually had quite a number of discussions with the department ever since the budget came out last year. We have raised the concerns at various levels and written to various people in relation to our concerns. So we have had consultation. That is for sure.

Senator ADAMS—What results have you had?

Dr Graves—As indicated in Professor McKenzie's statement, a lot of our concerns were reflected in the discussion paper but they have not actually changed the course of the legislation at this stage.

Senator ADAMS—Were you surprised at the legislation coming up so quickly?

Prof. McKenzie—I think we were a little bit surprised that it got to the stage it did before the end of the discussion period, but we recognise that this Senate committee inquiry is also part of the discussion.

CHAIR—As there are no further questions, we thank you very much.

Prof. McKenzie—Thank you.

Proceedings suspended from 2.50 pm to 3.05 pm

BARTLETT, Mr Richard Michael, Acting First Assistant Secretary, Medical Benefits Division, Department of Health and Ageing

GATICA, Ms Georgina, Acting Director, Policy Implementation Section, Diagnostic Services Branch, Department of Health and Ageing

KEANEY, Dr Megan, Medical Adviser, Medical Benefits Division, Department of Health and Ageing

LEARMONTH, Mr David Andrew, Deputy Secretary, Department of Health and Ageing

REID, Mr Chris, General Counsel, Department of Health and Ageing

RICHARDS, Dr Brian, Senior Medical Adviser, Department of Health and Ageing

STUART-SMITH, Ms Jackie, Acting Assistant Secretary, Diagnostic Services Branch, Medical Benefits Division, Department of Health and Ageing

CHAIR—I welcome representatives from the Department of Health and Ageing. You have information on parliamentary privilege and the protection of witnesses. As departmental officers, you know you do not have to discuss issues of policy, but we can ask you questions about how, why and when.

I do want to put on record that I was disappointed that the department's submission was as late as it was. I am making a point of doing that whenever submissions are late.

I invite you to make an opening statement and then we will go to questions. I know you have been listening and basically the questions will be done by issue. We will be raising with you the things that have been in the submission and also in the evidence of this afternoon. That is the format we want to use. Mr Learmonth, do you have an opening statement?

Mr Learmonth—I do not, other than to apologise for the lateness of the submission. I did not realise that. We are sorry for that.

CHAIR—Thank you very much.

Mr Learmonth—There have been a couple of other things on our plate.

CHAIR—Absolutely.

Mr Learmonth—I do not propose to make an opening statement. I am happy to spend the time on senators' questions. We have brought with us a team covering the policy aspect and two of our senior and experienced medical officers, both of whom have had significant private clinical practice experience. They will be able to bring that perspective to bear on your questions.

CHAIR—Okay. I do not think there are any surprises. Can I lead off in terms of the issue that was raised in a couple of the submissions that there was a consultation process that was in place and people were taking part of that and the bill was actually brought into parliament before that was concluded. Whilst I know that the decision about bringing bills into parliament is a ministerial one about when ministers decide to bring things in, in terms of process, were the people who were involved in a consultation process advised—was it drawn to their knowledge—that the bill had gone in? Did you make that kind of personal response to them? In terms of feedback that you have had, have many people raised that issue with you?

Mr Bartlett—Certainly talking to people, there was an awareness of when the bill went into parliament. There was also an awareness that a decision had been made as part of the budget and legislation needed to be introduced by particular time if it was to take effect in the time frame given. The consultation was about issues of implementation and subsequent issues regarding the forms and the format of the forms. People were having a discussion in that context. It was not about whether we revisited the decision.

CHAIR—Okay. It is important to have that on record. Did the consultation continue on the other two things, and has any result come out of the consultation that was started about the whole implementation process and form development?

Mr Bartlett—There were consultations with a range of committees that cover the pathology area. That continued through. As a result of those a discussion paper was developed that went out and comments were sought. Again, there has been some comment about the fact that people's comments were to come in after the legislation was introduced, for the reasons we have just talked about. A workshop has now been scheduled for 28 May. It is intended that all of the interested parties get an opportunity to participate in that.

CHAIR—Thank you.

Senator ADAMS—The AMA have been very critical that the bill does not adequately cover the situation where a doctor has a valid clinical reason for referring a patient to a certain pathologist. Could you respond to that.

Mr Bartlett—I can talk about it in the context of the reasons that they have given.

Senator ADAMS—Yes, that is all right.

Mr Learmonth—Can I just start by saying that part of what this bill does is reflect an acknowledgement that the key decision maker about a patient's treatment is the patient. It gives them some capacity to exercise choice, and we hope will be informed choice. I think what we are talking about is the kind of discussion that might reasonably go on when there is a treatment, accessing that treatment or some other aspect of what the clinician is proposing that deserves full and proper discussion and a clear informed choice on behalf of the patient.

Senator ADAMS—I will give you an example. I am thinking about someone with a chronic disease who has to go regularly for pathology tests which, really, need to be done at the same pathology centre because of the different formulas, different machines and all the rest of it—for example, someone with a cancer tumour line. That is just to give you an idea of where I am coming from. The doctor would want a particular pathologist to do those tests, and it might be every week or every second week.

Dr Keaney—In that particular circumstance, those matters would be part of the discussion between the doctor and the patient. A patient would be guided by their doctor's advice as to the need to have some consistency in that situation, and for that reason a particular pathology provider would be the preferred provider. As I said, I think this measure is about informed choice, and that is only addressed if the discussion addresses all the issues that are relevant to the patient's decision making. So, in the ordinary course of events, we have an expectation that in that circumstance a patient would be guided by their general practitioner or specialist and would in fact follow that advice about the preferred provider.

Senator ADAMS—I would hope they would, anyway. In your evidence, you are saying that a patient is likely to inform their doctor if they change their minds and go to a different pathology provider. What have you based that assumption on? If they decide to go somewhere else, why do you think they would actually tell the doctor, 'I'm going to pathology place A; I'm not going to where you referred me'?

Dr Keaney—The fundamental circumstance we are talking about is one where the selection happens after the patient leaves the doctor's consultation room. It could be that the discussion about what pathology where has occurred, and the patient may have said, 'Based on past experience, I'd rather go here,' so it was a matter that had already been acknowledged within that consultation. Alternatively, the patient may well change their mind afterwards. If they do not choose to tell the doctor about that change of mind, we still think that there are mechanisms in place to ensure that the information returns from the pathologist back to the general practitioner or specialist. As discussed, we have good mechanisms in place. Some of them are legislative: for example, it is a requirement that the doctor's details be on the request form. Of course, pathologists who see their source of work as being principally requesters are very keen to ensure that they provide a good service to both patients and requesters, because that is how they generate business. So we have been informed as part of this consultation that for smaller pathology services, for instance, if they get a referral from a doctor who is not normally a requester they might even take extra effort to ensure they provide good service to attract further business.

Senator ADAMS—To get more business, yes.

Dr Richards—To add to that, as a matter of routine practice, pathology laboratories send the results to the referring practitioner; and, as Dr Keaney has said, the pathology request form, irrespective of to whom it is addressed, has the referring practitioner's details on it. So the issue that you raise is, I think, mainly in relation to when a referring practitioner wants to chase up the results—

Senator ADAMS—That is right. That is where I was coming from.

Dr Richards—prior to them arriving in due course. The practitioner is usually chasing up the results because the patient has re-presented and is sicker or has rung up to inquire about the results. In those circumstances, if the practitioner rings up the pathology company to whom the referral was originally made and the pathology company says, 'We don't know about that,' the practitioner would presumably ring the patient. Or, if the patient was chasing up their results, they would say, 'I went to such and such; can you ring them?' So I think that simple communication between the referring practitioner and the patient would address those concerns. Most patients would not be unaware of the pathology laboratory they attended.

The other relevant factor is the patient who is travelling. A lot of the grey nomads travelling around are on warfarin and they go from place to place. Their referring practitioner is not in a position to know the name of every pathology practitioner in every town they might call into or even when they might be there. One of the advantages of this bill is that a patient with a referral to a pathology laboratory can take it to any pathology laboratory on their travels. So it is not only for patients who are in the one place. Increasingly, patients are on the move, and this allows the patient the choice. Clearly, then, if they are chasing up the results, they will ring up their GP and say, 'I'm in Broome today and I went to this pathology; I need my INR result.'

Senator ADAMS—Moving on from that, on the same issue there have been some witnesses who have suggested that perhaps a patient should sign a form if they have gone to a different place, to take responsibility for the fact that they have changed their mind and not gone to where they were originally going to go. Can you see any sense in that?

Mr Learmonth—The whole question of whether or not the treatment—whether it be a diagnostic test or a treatment test—is accepted, is a matter for the patient. The patient could walk out of that surgery and choose not to have the diagnostic test.

Senator ADAMS—We did have evidence of a court case of a GP, having referred a patient to a certain pathologist, and the results did not come back. The person had a very serious illness. All sorts of problems arose from that. That was the reason it was suggested that perhaps if a patient, after having done the consultation with the doctor about where they are going, decides not to go there but go somewhere else because they feel they should, that the patient should take responsibility by signing the pathology form.

Mr Reid—I would have thought, from a legal perspective that whether they had signed the form or not, would make no difference. If there is a problem and the matter gets to court it will become apparent how the facts have unravelled. If the fact of the matter is that the patient has taken the referral somewhere else and not told the doctor about it and the doctor has been unable to follow up on it, then it is difficult to see how a court could find that the doctor was liable. There is no cast-iron rule that says that doctors are legally obliged to follow up. The whole law of negligence revolves around the principle of reasonableness. They have to take reasonable steps. If the patient has somehow made it impossible to follow up on the referral then it is, in my view, quite unlikely that the doctor would be sheeted home with liability as a result of that.

CHAIR—Is that the advice you have provided?

Mr Reid—I am sorry?

CHAIR—As the AMA and the pathologists have both used that medical indemnity argument in their submissions that is formal legal advice that has been given to the department through you?

Mr Reid—It is not something I have given formal legal advice on. That is just a view I am expressing in this context.

CHAIR—It is a significant part of the AMA's argument—the possible impact on medical indemnity and those sorts of things. I tried to flesh that out with them and they were still very strong on the matter that Senator Adams was raising: the terms of responsibility of practitioners. Your belief is that that is not a blanket rule.

Mr Reid—No. There are a couple of cases that have been cited in the submission.

CHAIR—Yes.

Mr Reid—One is Kite v Malycha and the other is Rogers v Whitaker. Both of those are decisions which have been made in the context of the ordinary law of negligence. As I said, the concept that underlies each of those is 'reasonableness' and whether people have done what was reasonable in the circumstances. If doctors have found that there is a problem because the patient has gone to another pathologist, then provided they have done what is reasonable to follow up on that—that might just consist of getting their secretary to ring up the patient and find out where they have gone so that it could be chased up—they should not have a problem.

Senator ADAMS—In the evidence from the Royal College of Pathologists they commented that GPs commonly do not provide out-of-hours details on their forms so that pathologists can get back to them. They were looking at the extra administrative burden representing that. If a pathology result is a critical one somehow they have to go back and try to get the after-hours service of that particular GP. Do you have any comment on that?

Dr Richards—That is no different from the current situation where an urgent request comes in. If the evidence is that most pathologists do not have the after-hours contact of most of their doctors then that would be no different whether or not the patient went to the provider.

Senator ADAMS—But it were a doctor that continually referred to that pathology centre, I would think that they would have. If a GP has been using them for five years or something, I am sure they would have that. But if the patient goes off somewhere else then the pathologist does not know the referring GP.

Dr Richards—In 17 years I spent in general practice I do not think I ever received an out-of-hours phone call from a pathology provider.

Senator ADAMS—Okay, it was just in their evidence. The AMA were disappointed that they had not had any consultation with the department over this particular legislation. Could you explain that?

Mr Bartlett—We consulted with a range of people involved in the pathology sector. The AMA is represented on a number of the committees that we spoke with. The AMA representatives were there. If they did not report that back to the AMA themselves, that is a matter for them, I think. We certainly made every effort to ensure that they were involved in the discussion.

Senator BOYCE—I think their concern was more centred around the fact that they were asked to consult and the legislation was actually in the House of Representatives before the submission date had closed for that information.

Mr Bartlett—Before you came back, Senator Boyce, we were talking about that. The point that I made was that legislation is necessary and the timing of the legislation was necessary to ensure that it took effect at the date that the budget decision specified. Consultation was about implementation and about changes to request forms. The discussion paper followed up consultation and attempted to look at ways in which issues that had been raised could be addressed. The consultation period went beyond the submission of the legislation because in a sense it is a flow-on from that rather than part of that.

Senator BOYCE—So you were not asking for suggestions around changes to the legislation at all?

Mr Bartlett—We were not asking for submissions about changing the decision that had been made in the budget.

Senator BOYCE—That is all the legislation was asking?

Mr Bartlett—The legislation is there to implement the decision. Yes, there are going to be regulations about things like the forms, and that is part of what the consultation was about.

Senator BOYCE—And that is all the consultations were designed to focus on, the regulations?

Mr Bartlett—It was to do that. It was also to look at potential ways of mitigating any unintended consequences that might flow from the legislation or from the decision that was made.

Senator BOYCE—Wouldn't that normally be something you would have consulted on before the legislation was in the parliament?

Mr Bartlett—Not necessarily. There was a decision that had to be implemented and that follows a certain time frame. As all of the people who put in submissions have acknowledged, in the overwhelming majority of cases this will work smoothly. It was about dealing with the bits on the edges.

Senator BOYCE—And you are somewhat captive to the timeframe that has been set up by the government in this area.

CHAIR—Completely captive, I would imagine.

Mr Learmonth—It is our obligation to administer the decisions made by government.

Senator BOYCE—The other point that has been raised was the view from the pathologists that there are specialist pathologists, people who have more expertise in some areas than an average pathologist, whatever that might be. How do you see this system being affected by that?

Dr Keaney—There are two aspects to that. The first one is what we previously discussed, which is where there are particular circumstances which mean that the doctor would like the patient to see a particular provider then that should be provided in the content of the consultation and we would expect that a patient would generally follow the advice of their doctor in that circumstance. The second one is an ordinary circumstances stage which is covered within the MBS scheme already, which is that pathologists quite often

refer specimens to other providers themselves recognising that other providers might have more expertise. So there is provision within the legislation and within the funding of medical services for that to occur already.

Senator BOYCE—For a test to be reassessed. Is that what you are saying?

Dr Keaney—For a test to be referred on to another pathology provider when the initial pathologist does not have the expertise to do that test, in some very specialised circumstances.

Senator BOYCE—So the actual sample or whatever may be taken to pathologist A but the analysis of that test might lead the GP to refer the sample to another pathologist. Is that correct?

Dr Keaney—No, the first pathologist refers to a second pathologist.

Senator BOYCE—Okay. And, as you said, that is currently covered.

Dr Richards—Senator, could I just expand on that slightly. There are and have been for centuries three fundamental tenets of medical ethics, which are, firstly, do no harm; secondly, act in the interests of your patients; and, thirdly, respect your patients' autonomy. I would submit that this measure in fact supports that third tenet of medical ethics—

Senator BOYCE—Absolutely.

Dr Richards—and that where there is a clinical reason to refer to a particular pathologist, whether it is for cytology or histopathology or because of particular expertise, that would form part of the informed consent, as Dr Keaney said, and would be done in a way that respects the patient's autonomy as is required by medical ethics.

Senator BOYCE—I was a little late back, Chair. Have we discussed the report that DoHA currently has?

Senator SIEWERT—Before we go there, though, I have a few more questions in this line of discussion, if that is okay. The comments that you made earlier, as I understand them, were that you do not think we need a tick box as the AMA is suggesting, because a doctor can say to a patient, 'I recommend that for this particular test you go here.' Is that correct? Probably you have heard me make these comments before. At this stage—and I can foresee your answer—I would suggest that there are few doctors that actually have a discussion with their patients about which pathologist to see. They are just given the form; that is it. So—and this is where I am foreseeing your answer—doctors and patients are going to need to start having a discussion that they have not had before about pathologists.

Mr Learmonth—If it matters, Senator.

Senator SIEWERT—If it matters. Isn't the point here that patients are now being given choice and they will need to have a discussion with their doctor about what pathologist they use? That is the whole idea here.

Senator BOYCE—Isn't it similar to the situation of telling the patient not to have a substitute medicine prescribed? Is there something similar there?

Senator SIEWERT—I do not think it is that. When you go to a chemist now for a medicine, the chemist will nearly always say, 'Do you want the generic version?'

Senator BOYCE—Yes, but there is a box that can be ticked by the GP to say—

Senator SIEWERT—Yes, but you get a second choice when you go to the chemist. The doctor can say 'No generic medicine' or not, but, when you go to the chemist, the chemist will ask you anyway whether you want one.

Senator BOYCE—Irrespective of the box?

Senator SIEWERT—If the box is ticked, they might, but besides that they will ask you. But, when you go to a pathologist, the pathologist is not going to say, 'Are you sure you want to come here?' so you are going to have to have that discussion with the physician.

Dr Keaney—I think what was reflected in the discussion with the AMA today was that they recognise that for most patients most of the time it is perfectly appropriate for the patient to choose their own provider, and they were seeking to distinguish what they acknowledged was a rare circumstance.

Senator SIEWERT—Yes.

Dr Keaney—And I think increasingly patients are interested in making a choice about all aspects of their health care. They expect it in relation to specialist referrals, diagnostic imaging, their choice of general practitioner or whatever, and it seems somewhat—I should not say absurd—anomalous, if you like, that it does not exist in this part of practice.

Senator SIEWERT—You do not have to convince me about the issue of choice. I get the argument completely. The issue is that this is now going to be a discussion that people have with their doctors that they have not had in the past. But the specific issue I am after is this tick box. Following up on the thing that the AMA said, if we do not have a tick box, how can we be sure that in fact, in the rare circumstances—as you acknowledged—where a particular procedure is needed or the doctor wants a particular pathologist, the patient does go there? That is my issue. I do not mean to cut you off, but I do not need to be convinced about the argument about choice.

Mr Learmonth—I think you are asking about recording patient choice. It seems to me that patients make all sorts of choices all the time in consultation with their doctors about whether to embark on alternative A or B, whether to follow a line of treatment or not or whether to ignore it and hope it goes away—like I too often do! I guess it is another aspect of a patient choice that is made in consultation about a treatment plan.

Dr Keaney—I think it will be that requesters—doctors—are the ones who will have an awareness of this change, so it will be up to them to recognise that in the particular circumstance they would prefer this patient to go to a particular provider for various reasons. Hence the obligation is upon them to make efforts to ensure that that happens or that the patient has sufficient information around that.

Senator SIEWERT—The point is the obligation goes back to the doctor to have a discussion that they probably have not had in the past. I can tell you they have never had that discussion with me—you have properly heard me say that before. They need to have that and make sure the patient is clear about which pathologist to go to if there is a requirement to go to a specific pathologist.

Dr Richards—Can I perhaps answer that in respect of my own experience and my understanding of how medical practice works in reality. The only tests we are really talking about here is where the referring practitioner has not taken a sample themselves. It is where the patient contains the sample and presents themselves for a pathology test. In most cases where it matters it is on a sample of the patient that the practitioner has removed whether it is a pap smear, a skin lesion or some biopsy.

You will have received submissions saying that there are really two large categories of pathology. One is the highly automated analytical pathology where an actual pathologist does not go anywhere near the sample and the accreditation processes that underpin pathology practices really ensure that it does not matter which pathology laboratory you go to—they are all pretty much the same. Then there is the subjective, manual sort of pathology where a pathologist actually looks at the specimen and that is usually things like the histopathology of cancers and more serious tests. In those cases most of the time the sample is no longer with the patient when it is referred and so the patient does not have an opportunity to take the specimen somewhere else.

In my own practice when I was practising there was one laboratory that was particularly good because it employed a pathologist who was a bit obsessive-compulsive about taking fungal scrapings from toenails. That laboratory got very high levels of positive culture results to confirm a clinical suspicion of a fungal infection of the toenail whereas I found that when I sent patients to other pathology laboratories they were usually negative. I sussed out that there was a particular pathologist somewhere who took great care and cared a lot about it. I would say to my patients, 'Although I normally send my pathology to pathology laboratory X, I would like you to go and get your toenail scraping at pathology company Y because there is a particular pathologist there.' I would name him and say 'I suggest you go there for this reason.' This was years ago. I would give that patient that advice so that they understood the reason that I was referring them to a particular laboratory. I do not think that is a new practice. It is simply respecting the autonomy of the patient and part of the normal patient-doctor relationship. For the majority of patients and pathology samples such a conversation would not be necessary because, in the majority of cases, it would not matter where they went. Where it does matter, I think it is good practice for the referring doctor to explain. I do not see that that is a great imposition on a medical practitioner.

Senator SIEWERT—I am not arguing with you.

Senator BOYCE—The college of pathologists has pointed out to us that there was a report commissioned by them on the workloads in anatomical pathology and that has been sent to you, DoHA in fact funded it. What is intended to happen to that report now?

Mr Bartlett—We have received the report very recently.

Senator BOYCE—What does very recently mean?

Mr Bartlett—In the last month. It will be fed into a range of things that we are doing at the moment including the pathology review that the college of pathologists referred to.

Senator BOYCE—The funding review.

Mr Bartlett—That is right.

Senator BOYCE—This report is mentioned as part of the argument put forward by the pathologists that, if this legislation leads to more bulk-billing, it could lead to pathologists having to work longer hours to make the same profits. What analysis of that case has the department made and what were the results?

Mr Learmonth—I confess I did not quite understand that proposition. But from my perspective there are a couple of things involved in that, so I will do my best to try and unpick it. One of them is a proposition that says, 'If we don't compete so well on things that matter to a patient, like price and convenience, they'll go elsewhere and we'll lose market share.' That happens all the time as companies come and go, as acquisitions happen, as one pathology company is taken over by another. Changes in market share have always happened and will always happen. That is hardly new and there are far bigger influences on changes in market share than what is posited.

The second proposition says, 'If we do lose market share, if the patient decides we're too expensive, inconvenient or otherwise and they go down the road, we're going to have to make up our income.' I wonder how. Pathology exists by request. They cannot self-generate funded work. They cannot decide to do a bunch of pathology to retain their margins and revenue. They rely on people walking through the door with a bit of paper from a requester. So I was not entirely sure how and for what reason that additional work could be generated if they were to lose funded market share.

Senator BOYCE—Isn't that their point: if they were to make less revenue per treatment—

Mr Learmonth—My point is: what are they then going to do? They cannot make up more revenue by doing more treatments. They cannot self-generate work.

Senator BOYCE—No, but I think their argument was that they would make more revenue by working faster—

Mr Learmonth—They do not make more revenue by working faster.

Senator BOYCE—or trying to get a greater market share.

Mr Learmonth—We are talking about a proposition which is in relation to a loss of market share, because people will have voted with their feet and gone elsewhere. If they work faster, they make the same amount of money, because they are paid per unit, not by time. And they cannot self-generate work, so it is completely unclear to us how they might do more work which might earn an income. The proposition is just really unclear to us.

Senator BOYCE—What about in the area of having sufficient spare income or revenue to allow for replacement of equipment et cetera? Is that likely to be affected?

Mr Learmonth—You are talking about business viability, and there are a whole bunch of things which impact on business viability. Market share is certainly one of them but, as I have said, there have always been and will always be very significant drivers of market share that go to corporate merger and acquisition, vertical integration and a whole range of things. It seems to me that this is no different at all in that sense. It is one more factor that is going to potentially influence a pathology company's market share. There are a bunch of other factors that go to companies' revenue as well, because what we are talking about essentially is profitability and viability and a capacity to reinvest capital. Market share is clearly one of them. Cost structure—how much they are actually spending per test versus making protest—is independent. There is the question of how they are financed. We have all seen enough companies in trouble because they have paid too much for an acquisition. I can think of a few in our space recently. All this means is that there will be a clear incentive for pathology companies to conduct themselves in a way that is attractive to consumers—to be price competitive and convenient—and that is underpinned by a strong quality assurance process, and on balance that is probably not a bad thing.

Dr Richards—Could I just add that the bill, as I understand it, seeks to give patients a choice in pathology provider. The implication is that that should be an informed choice, and that has been the subject of a good deal of the discussion in submissions. That argument acknowledges that that choice might be exercised, which is the desired effect of the bill—that patients be given a choice. Where it does not matter clinically and it is a matter of price and convenience then the patient can make that choice on those grounds. Where it does matter clinically then the patient should be advised by their referring practitioner in relation to that.

Senator BOYCE—I think the concern that the college was putting was based more around the fact that the minister had talked of this leading to cheaper unit cost in the area.

Mr Learmonth—Not unit cost, but perhaps unit price if there is not price competition and there is an incentive to compete on price between patients.

Senator BOYCE—Sorry; I was talking about unit cost for the consumer.

Mr Learmonth—I am sorry.

Senator BOYCE—Is that not the case?

Mr Learmonth—Sorry; I am lost.

Senator BOYCE—The minister said prices—let us use 'prices'—would be cheaper for consumers.

Mr Learmonth—We would expect that as a consequence of consumers being enabled to exercise choice in a competitive market. Now there will be pressure on suppliers to compete based on cost and convenience.

Senator BOYCE—How do costs come down without profit being affected?

Mr Learmonth—Profit is a complex mixture of revenue, unit cost, cost of borrowing and all sorts of other things. People make choices in all sorts of markets, including in health, about how they might best maximise their responsibility to their shareholders, and they make decisions about trade-offs between price, market share and volume.

Senator BOYCE—But, as you have pointed out, there is no way that the providers can affect the volume except at the margins, so how do you have lower prices without an effect on net revenues?

Mr Learmonth—What this does not do is to try to protect the profits of the big pathology companies. What it tries to do is to empower consumers within a quality framework.

Senator BOYCE—Let us do this one at a time. The question was: won't net revenues be affected if prices go down?

Mr Learmonth—If prices go down, I would expect they will.

Mr Reid—There are also other variables, such as economies of scale and the surplus capacity in the provider. There are a whole lot of variables, which—

Senator BOYCE—Surplus capacity?

Mr Reid—Yes. If a lab is operating at 70 per cent capacity, it can often do more work for a lower unit cost, for example, because you are getting—

Mr Learmonth—There is scale economy, as with other industries, so the cost variables—

Senator BOYCE—Yes, but could it not also decide that, if because of this the net revenues on that 70 per cent fell, it was feasible to close down a service that might be equidistant between two other services?

Mr Learmonth—I am not sure that is the case in relation to the lab. We are talking about the work for the labs, which tend to be central, not the collection centres. This is labs. They draw work in from a variety of places.

Senator BOYCE—But the collection centre is surely a business cost of the pathology services, isn't it?

Mr Learmonth—If they are experiencing some pressure on their revenue, that must be because someone else is not and the patient is choosing to use someone else who is doing better because they are offering a better service to the patient, which includes price, convenience and everything else that the patient might value. So the fact that someone else, whom the patient is not using, may have their revenue affected—

Senator BOYCE—No—

Mr Learmonth—I am not sure what the consequence is.

Senator BOYCE—We are simply saying that you could have exactly the same market share but have lower net revenue because prices have fallen. Couldn't you?

Mr Learmonth—That would be a choice you would make. Pathology companies can make their own choices about how they chase revenue and market share. They price their product like anyone else.

Senator BOYCE—Absolutely, and that might include rationalising their services or their points of delivery.

Mr Learmonth—It would be up to them. If what you are talking about is one contracting in some way, that will be because the consumer—the patient—has chosen to go somewhere else.

Senator BOYCE—You are quite right: that could be why.

Mr Learmonth—I am coming from the perspective of the consumer. Pathology company X might have experienced a contraction because more patients are walking through the door of pathology company Y. What I am focusing on is: is the patient getting access to quality pathology at a price and a level of amenity that suits them? The answer is, 'Yes, if they can choose.'

Senator BOYCE—That is absolutely exactly what I am concerned about as well, but that requires that the pathology services remain viable businesses, doesn't it? I am not entirely convinced that that viability has been assessed.

Mr Learmonth—It requires that there be a viable pathology industry.

Senator BOYCE—Which would include viable services.

Mr Learmonth—Whether that means everybody stays in exactly the same—

Senator BOYCE—I do not think I suggested that, Mr Learmonth. To have a viable industry we must have viable services. What analysis of the viability of the industry did the department do as part of looking at this legislation?

Mr Learmonth—This measure does not involve us unilaterally changing prices, revenues or anything else in relation to a company. Pathology companies will make their own choices, and that will include choices they think will keep them viable in cost structure, revenue, market share and every other aspect. It is not for us to second-guess that.

Senator BOYCE—No.

Mr Learmonth—They will do what best suits them in the market place.

Senator BOYCE—Exactly. Could it not lead to a change in the sorts of services or sorts of pathology practices that some pathology services may offer?

Mr Learmonth—It is possible. As I said, what we are talking about are shifts in market share. That happens all the time.

Senator BOYCE—No, I am not talking about shifts in market share—that is the point. I thought we had clarified the point that you could keep the same market share, but if prices went down, even with the same market share, you would have lower net revenues.

Mr Learmonth—If you are a company that wants to keep market share and you find yourself under competitive pressure and your response is to reduce your prices so the same number of people keep walking through the doors as used to, as opposed to going down the road, that is your choice and you will do so in such a way you believe is to maintain the best proposition for viability for your company.

Senator BOYCE—Yes, but this is not simply about the best pathologists, for want of a better term, having the highest market share. There could be no change in market share and yet revenues would fall.

Mr Learmonth—And the patient gets a quality pathology service at the place of their choice.

Senator BOYCE—As long as we continue to have viable pathology services, yes. That is the point.

Mr Learmonth—There is nothing in any of this that leads us to conclude that the industry is in any way an issue here.

Senator BOYCE—What is your reaction, then, to comments like those from the College of Pathology, that '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 and research'?

Mr Learmonth—There has always been a profit motive and they have always had a fiduciary duty to maximise the profit to the shareholders. They have, I think rightly, embarked on improvements in quality and efficiency in the industry over the years. There is a quality pathology assurance program that guarantees and underpins quality in all operating pathologists and, within that construct, they are all right now trying as best they can to get market share and to take costs out of their business. That is what companies do. I don't think this changes that equation one iota.

Senator BOYCE—I am just interested in why you think that, given that we have agreed that prices would fall.

Mr Learmonth—Because they currently operate in market place, they currently are obviously subject to a profit incentive, they have an obligation under company law to pursue that and I am sure they will be making all sorts of decisions in the best interests of their company and their shareholders, whether it be about market share, revenue, pricing, cost structures already of those things that determine shareholder value. They have those imperatives now. The context or the landscape in which those imperatives apply changes all the time whether because we change the MBS funding in relation to pathology or company X is swallowed by company Y or whatever it might be. Those same imperatives apply in a changing landscape. Nothing changes here, I think.

Senator BOYCE—Thanks, Mr Learmonth.

CHAIR—The pathology industry continues to talk with the government about pricing, doesn't it? Consistently the College of Pathologists kept saying that discussions of this type would be better suited for the discussion on pricing.

Mr Learmonth—Yes, that is correct, Senator. That is ongoing and there is regular dialogue, and many of Mr Bartlett's hours have been taken with that. But this is not about pricing.

CHAIR—So that continues—

Mr Learmonth—Absolutely.

CHAIR—and the sensitivity which they have expressed in their submission and their evidence is that they feel, as Senator Boyce has been pointing out, that somehow this discussion about choice and market share is linked to costing. So those discussions will continue anyway. This particular piece of legislation—

Mr Learmonth—Yes. They are completely separate.

CHAIR—is separate and it is looking at patient choice.

Mr Learmonth—Completely separate.

CHAIR—But in terms of the debate, it was very real to the College of Pathologists and they continue it—and I just want to get that on the record.

Mr Learmonth—The college did not mind in the previous budget where, at the same time that this measure was announced what was also done was a rebalancing of pathology rebates towards anatomical and away from highly automated. These are separate and independent things.

CHAIR—Separate and independent discussions.

Mr Learmonth—Completely.

CHAIR—Dr Richards, were you wanting to put something on record?

Dr Richards—I am admitting that I am not a health economist; I am just a humble medical practitioner. Having run my own private practice for quite a long time, I would see no reason why a medical practitioner would reduce their price if—

Senator BOYCE—We are talking about a pathologist reducing their price, not the doctor.

Dr Richards—A pathologist is a medical practitioner.

Senator BOYCE—Okay. I was talking in the context of a GP.

Dr Richards—I do not understand why any business would reduce its price if there were no pressure on its market share. If there were pressure on the market share you would seek to understand where the pressure was coming from, and my observation would be that consumers would want to choose on quality, which relates to the advice they would need to get from their referring practitioner in that respect, plus convenience and price.

Senator BOYCE—But Mr Reid has already talked to us about pathologists who had a 70 per cent utilisation rate, for want of a better term, so clearly there is market share out there to try to attract in different areas.

Dr Richards—It is not an equilibrium market—

Senator BOYCE—No, of course it is not.

Dr Richards—and it is not a perfect market. There is market failure because of lack of information.

Mr Learmonth—And lack of choice.

Senator BOYCE—But it is also a growing market, and investment in that market is something that we hope continues—

Mr Learmonth—There is recent substantial investment in that market.

Dr Richards—And what this bill seeks to do is add information to that market to make it operates more successfully as a market to give better benefits for consumers and for their society as a whole.

CHAIR—I have some questions about the informed choice. We have on record from the consumers and also from the different medical practitioners the need for informed choice, if choice is going to go to consumers. I am interested in how that informed choice should be handled. The bill is silent on that. The bill just says that there should be the choice.

The AMA has been quite direct. It says that if the government insists on putting through the legislation they would have to look at some support for practitioners to have systems that would reflect that. I am at a loss as to what those systems would be, but in terms of process, Mr Bartlett, you have been involved in the discussions around this. Have there been any recommendations made in the various discussions about implementation, which is basically what we are talking about? How do you maintain informed choice at the time of discussion which, we will agree, should happen—discussion between the medical practitioner and the customer about what they should do with their pathology test? How could you ensure at that point that it is informed choice? Would it be imposing more workload on doctors? Would they have to be quasi information sources for all the pathologists in the area? It was pointed out to us by the College of Pathologists that there were several hundred, I think, in the Sydney region—I think that was part of their statement. I am just trying to get some idea about how you in your discussions have looked at the issue of informed choice.

I am a consumer. I am at the doctor. I have got to have tests. The doctor will probably say that he usually uses Acme, but I am thinking of the various things that would inform me—location, opening hours—if I am working—cost and so on. What is the onus? What is the extra workload going to be? It is very easy at the moment. You go to the doctor. They fill out the form with the name of the company on it and you go. But if we are changing the dynamic, how do you inform? I am interested to hear from any of you about that issue.

Mr Bartlett—Senator, significant parts of what you are describing already occur. One of the key things that people complain about to their GP is if they have gone and seen a pathologist and they have not been bulk-billed.

CHAIR—Right.

Mr Bartlett—Similarly, if somebody needs a particular sort of test, there will be a discussion that will get you to the point of saying, 'You need a pathology test.' At the moment, it is filling out a form, but equally there can be a discussion about, 'This is the pathologist that is nearer and this is the pathologist that bulk-bills or does not bulk-bill.' Again, these are discussions that in some cases happen now.

CHAIR—Is it expected that the GP has that knowledge?

Mr Bartlett—The GP generally does have that knowledge. Certainly, we are seeing at the moment that 60 per cent of GPs are referring to two or more pathology companies for similar tests, so clearly there is a choice happening now. One assumes that there is a degree of collaboration between the doctor and the patient in terms of making that choice. Rather than the GP saying, 'I'll send this person to this one; I'll send that person to that one,' we have to assume that these conversations are happening now. Similarly, if you are telling someone to go and get pathology, you need to convince them that they need the pathology. They do have a very clear choice at the moment between either getting it or not getting it, and there are clearly cases where people do not. Again, if you want them to use a particular pathologist, it is a logical step in that conversation, and, again, I think it is happening now.

CHAIR—Is there any preclusion in medical offices to having advertising? Is there anything that stops them from in their foyer having advertisements from 'Acme Pathology' so that even if the doctor does not say, 'Go to this one,' you know about it. Is there anything that says you cannot have that? I do not know.

Mr Learmonth—No.

Dr Keaney—There is not. There is a general notion within requirements under health registration that advertising should be of a professional nature, so it should not be comparative of that doctor's service versus the other person down the road, and it should advertise ordinary things like opening hours, what kinds of services there are and prices. But it should not be the kind of thing that you might see and—

Mr Learmonth—It is about the difference between advertising versus awareness.

Dr Keaney—Yes.

CHAIR—I am worried about informed choice. Everyone agrees that there should be, and I am wondering how you get that knowledge. One of the points that I was trying to follow up on—and I got quite confused at times—was around what happens when people do not go to their service. Both the AMA and the pathologists seem to think that this legislation would create some problems if a GP said to a patient that they needed to have these tests and the patient did not go. I am still a little bit unsure about what happens now.

Mr Learmonth—If they did not got at all?

CHAIR—If they did not go at all. Both of them made this point.

Mr Learmonth—Nothing changes.

Dr Keaney—That is the same circumstance as now. I cannot see clinically what the difference is between going to a pathologist you do not know and a pathologist you do know. The person who has the information as to whether they did or did not go and the reasons is the patient themselves. It would then seem to me that the appropriate contact would be between the requestor, the doctor, and the patient.

CHAIR—The doctor and the patient. That is the point that I was trying to get from the AMA. The *Hansard* will be helpful, I would hope, in terms of exactly what was said, but the inference was that under the current situation if the GP actually refers a patient to a pathologist and no results come back, it is a simple task for the GP's office to call the known pathology service and say, 'Hey, I have not got any results for Mrs Jones'—that kind of thing.

Mr Bartlett—There was some information provided at the last Consumers Health Forum of Australia. They had some anecdotes which suggested that people who at the moment go to pathology providers and are unhappy with them, for price or other reasons, may well choose to go to places like public hospital emergency departments to get their pathology done. So there are already things of this sort happening, and I am not sure that it gets either simpler or more complex as a result of these changes.

CHAIR—That is what I wanted to get on record: that it was not just me thinking that that was difficult and that in the health system there will always be a percentage of people for whom crises happen. The pathologists raised the case of someone who was in surgery at the time of this requirement. I am sure that could happen but I am not quite sure how often it would. Because the pathologist and the GP did not know each other, they would not have been able to get the right tests for this person who was in the middle of some kind of surgery.

Dr Keaney—It would seem to me, with respect, that if the results were important for the conduct of the operation and the patient was already anaesthetised, somebody should have perhaps followed that this up before the patient was put to sleep, and if the patient was not already asleep then the patient could still be asked where they went for their pathology in that pathologist run.

CHAIR—Just before they go under!

Senator SIEWERT—Don't let it worry you, but!

Dr Keaney—I know that circumstance was raised as one of the examples in the AAPP's submission and I thought to myself, 'Well, when would you put the patient to sleep and not know what the results of the tests were?'

CHAIR—Yes, I was a bit lost on that one. There were two issues. About the other one, the AMA said that if the box tick arrangement happened, that would affray some of their concerns, and the pathologists said that should the health identifiers bill go through and the e-system was up and running effective, that would allay their concerns. In terms of e-health, is that something that the department would say would be an advantage? Should the e-health system be activated the pathologists thought that some of the concerns about communication which have been put and that are failing in the current system—and the pathologists were quite open about the fact that there are already quite significant errors in the exchange of information happening in the current system—would be allayed. Is that a position that the department agrees with?

Mr Bartlett—The e-health record, given it is up and running, should mean that you get a more consistent and more accurate exchange of information between treating doctors.

CHAIR—And treating pathologists.

Mr Bartlett—All treating doctors, be they pathologists, radiologists, whatever.

CHAIR—So if the e-system were working, this lost record business about whether the patient did or did not go and which pathologist they went to should be overcome—

Mr Bartlett—It should be.

CHAIR—Say a doctor puts a person down to go to a pathologist, regardless of who or where they are—and there is the point you made about travellers—the pathologist would be able to automatically confirm through the e-health system that this patient received this service.

Mr Learmonth—There is a baseline area of communication issues right now. The e-health system will address a lot of those issues around safety and quality in transmission of information. The question is whether this change, in terms of its marginal effect, adds materially to those problems and enough to offset the clear advantage to the patient.

CHAIR—There being no further questions, is there anything else that anyone would like to put on record? There being nothing, that concludes our hearing today.

Committee adjourned at 4.02 pm