

Department of Health and Ageing

# REVIEW OF FUNDING ARRANGEMENTS OF PATHOLOGY SERVICES

Submission – May 2010

## Executive Summary

1. Pathology is an essential specialist medical service which enables accurate diagnosis, management and prevention of disease. Seventy per cent of all medical diagnoses and 100% of all cancer diagnoses rely on a pathology report for diagnosis and care management. On average, every Australian receives approximately four pathology services each year.
2. Australia has accessible, affordable, high quality, low cost, and efficient pathology services achieved through co-operative arrangements between the Government and the private pathology sector over 13 years of hard work. The partnership between the Government and the private Pathology sector has ensured major reductions in cost whilst simultaneously improving quality, unlike the experience in NZ and Canada.
3. The productivity improvements in private pathology in Australia have been spectacular by any measure. Pathology rebates, in real terms, are now about 40% of the rebate level at the start of Medicare in 1984. The productivity improvements are not matched by any other sector in health and have enabled large increases in volume of services to be supplied with greater patient access, both having multiplier effects in terms of overall efficiency and quality in the provision of all health services in Australia. The Government has not recognised these achievements sufficiently.
4. These achievements have been brought about by the private sector response to government limits on growth in MBS outlays and growth in demand. Government policy has driven amalgamation, automation and centralisation which have mainly been achieved by corporatisation and private investment. Corporatisation has enabled reductions in unit costs, and profits have enabled investment in new technology and infrastructure which has increased the range of services offered and further reduced unit costs. Future efficiencies will come from more private sector investment. Profits in the Pathology Sector, as reported in a recent PWC report are in the mid range of health sector profits and are not overly generous. The PWC report was written before the last two budget reductions in pathology rebates.

5. The balance of regulatory measures over time has supported a diversity of pathology providers at the same time as stimulating corporatisation. There are many small specialty laboratories that provide for niche markets and there is a substantial not for profit sector that provides pathology as an essential part of their healthcare mission. This diversity alongside efficiency is a desirable feature of the Australian system.
6. Fee relativities are reasonable in the current schedule. Further improvement should only be through a formal review process, not sectoral opinion. We would support a rigorously designed, expert and informed Relative Value Study in partnership with government and private pathology. However, such a study is unlikely to yield large savings or find that current relativities are significantly distorted.
7. The Pathology Sector is highly competitive now and as such is not opposed to continuing competition in the future. However, the Sector does not favour the use of tendering for the provision of pathology services. Tendering would curtail the rights of Australians to access pathology services through universal rebates available under the MBS which would be politically controversial and jeopardise continuity, access and affordability of pathology services for Australians. Tendering would, on balance, increase concentration in the market and reduce competition. It would discourage investment, impact poorly on the medical and scientific workforce as well as the medical technology industry and restrict Australia's capacity to respond to public health crises. In short we believe tendering would adversely impact on the stability and continuity of service provision.
8. Significant additional efficiency improvements are possible through the formation of partnerships between the public and private sector which would enable the government to extend the productivity gains of the private sector to the remaining 40% of pathology services provided by the public sector.
9. We have identified two broad options open to the Government for funding pathology into the future, a Pathology Reform Agreement with 5 year funding or an Open Competition model. There are pros and cons to each of the options which we examine in this paper. We have not reached a firm conclusion as to these or other options.
10. The propositions advanced in this document and denoted in this Executive Summary require further exploration and discussion. The AAPP welcomes the opportunity to do so within the context of the continuing MBS review.

## Introduction

Pathology is an essential medical service. It provides patients and doctors with 70% of all medical diagnoses and every cancer diagnosis and is essential in the management of most diseases especially chronic diseases such as diabetes, cardiovascular disease, arthritis, hepatitis and HIV. Pathology testing is also required for the majority of preventive health programs designed to avoid the development of chronic disease. As such, it is critical that all Australians have access to high quality affordable pathology services.

The Australian Association of Pathology Practices (AAPP) is the national peak body for private pathology in Australia. Our members include both small specialized laboratories as well as large corporations with laboratories nationwide. AAPP members are committed to the provision of high quality, affordable, safe and accessible pathology service to all Australians. AAPP members provide 85% of all community-based pathology services in Australia. There are approximately 100 million services per year provided through the MBS, almost all undertaken in the private sector. This means, on average, Australians receive four pathology services each year from the private sector. The private sector has an annual turnover of \$2.3 billion approximately and is a substantial employer in the Australian economy.

Australia has one of the best pathology services in the world. Patients have easy access to affordable pathology testing, the results are of very high quality and there have been none of the safety breakdowns that have been seen in other countries such as Canada and New Zealand. The service is very efficient. This has been achieved through consolidation, automation and centralisation in the private sector driven by the constellation of Government regulations that capped expenditures, controlled demand and only enabled profits through productivity gains.

### 1 The purpose of the review

The Government has requested a detailed review of pathology funding arrangements to ensure the Government is paying the right amount to support access for patients to quality pathology services.

The discussion paper identifies three key tasks:

- To establish appropriate fee relativities for MBS items for different pathology disciplines.
- To identify groups of pathology tests that might be appropriate for different funding arrangements; and
- To provide detailed options for implementing tendering for selected pathology services

Pathology testing is used to predict, pre-empt, diagnose and monitor disease, and to determine and monitor appropriate therapies. The dependence upon pathology testing will increase in the era of greater prevention and the development of new technologies for diagnosing and managing disease. It will grow significantly with the ageing of the population and as the focus on prevention of chronic illness increases. It will remain an essential referred medical service which will be increasingly valued, relied upon and utilised in the future.

We believe the current fee-for-service funding system with MBS rebates available to patients who access pathology services remains the best way to sustain the access, affordability and quality of pathology services in Australia.

Of the 18 questions asked in the discussion paper accompanying the review, two relate to quality and sixteen relate to cost.

The review has a concerning focus on cost reduction. Internationally, the results of such focus have been deleterious. Canadian Anatomic Pathology has recently suffered a crisis of serious testing errors and misdiagnosis 'like a crashing wave' with a subsequent review identifying this solution: *'urgent attention to the serious human-resource issues should help alleviate long-standing staffing problems and improve future laboratory performance'*<sup>1</sup>

In 1999, the New Zealand Government conducted a review into the cytology reports emerging from Gisborne Laboratories between 1990 and 1996, following the detection of cervical cancer in women who had undergone cervical screening with no abnormality detected. The samples were rescreened by an Australian private sector laboratory who found clear evidence of high grade precancerous lesions.

In contrast, such problems in the provision of private pathology services in Australia have been rare and relatively insignificant.

In per capita terms, the recent international study commissioned by the MBS Review Task Group has shown that the Canadian system is more costly than Australia's which is achieving substantially higher quality at lower cost.

The MBS Review excludes issues such as the requesting of and demand for services 'except where this is relevant to how services are funded'. However, these issues are highly relevant in determining how services are funded and should not be excluded. The key achievement of the last 15 years has been the management of the increase in demand for pathology services. It is not expected that the demand for pathology services over the next 15 years will be any less. Consideration of demand is inseparable from any examination of pathology funding issues.

The current system has delivered the quality of the services we have today at a progressively lower real unit cost. This is an outcome that if continued, will ensure the sustainability of high quality services for the foreseeable future.

## **2 The Funding System until mid 2009 (under the MOU)**

The funding system that applied in Australia for the past 15 years until the 2009 budget, has delivered easy access, affordable, high quality pathology services to all Australians including those living in rural and remote areas. It has done so at steadily decreasing unit cost to government through productivity gains delivered by private investment in private pathology service provision. Over 90% of outpatient pathology services outside public hospitals are provided by the private and not for profit sectors.

The current system has fostered a diversity of providers, small, medium and large, for profit and not for profit. These segments have emerged to meet the needs of the market and the system overall is functioning well.

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<sup>1</sup> <http://www.cmaj.ca/cgi/content/full/178/12/1523#R12-3>

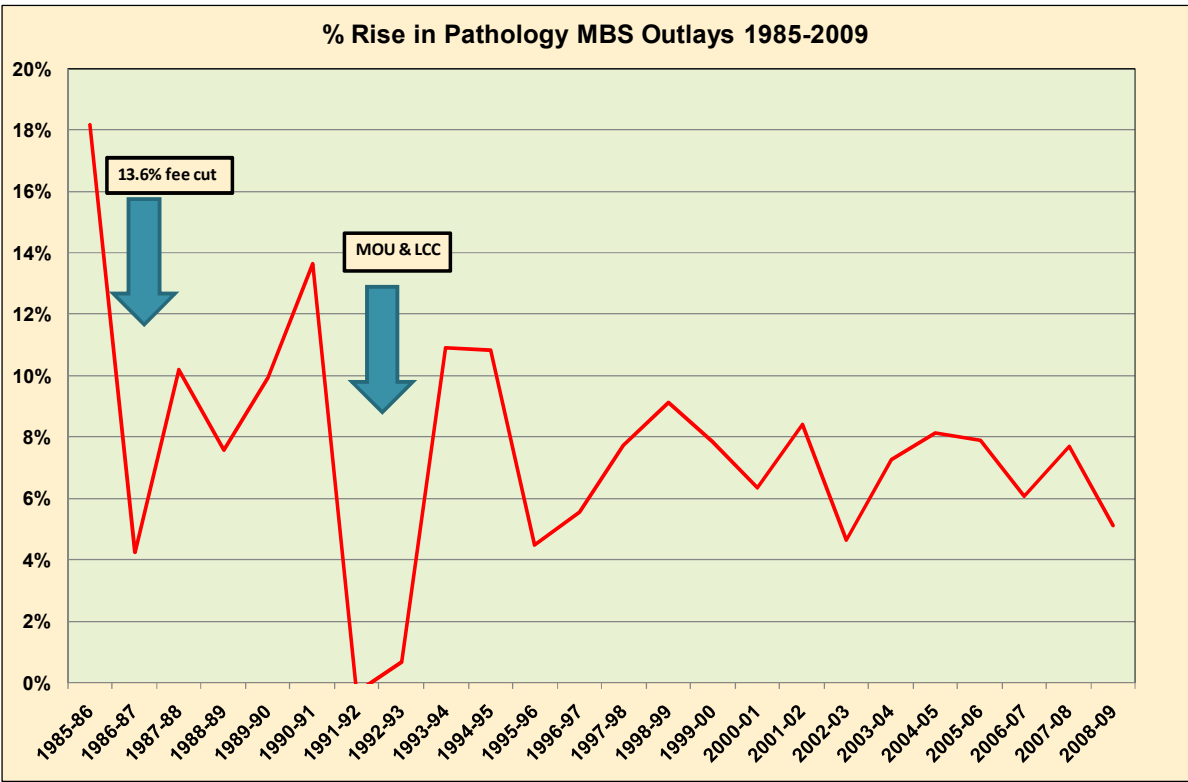
The large corporate providers have emerged because of the government funding system which capped growth and made medium-sized private practices no longer viable. The result was a major process of consolidation, automation and centralisation which has continued up until 2009.

Small providers have survived in this environment. The small providers tend, by and large, to be speciality providers filling niche markets e.g. histopathology, skin pathology, uropathology etc. There are also smaller general providers who service particular regions or groups of referring doctors. These small practices have been able to continue to operate in the MOU era.

The not for profit sector is an especially important sector in the Australian health system. These practices service the patients and doctors from the major teaching and private hospitals run by the major religious denominations. Their pathology service is part of their overall commitment to providing health services to their communities and is seen as an essential feature to continue their mission in the health field. These practices were sustainable under the previous MOU agreement but since the recent changes in the last two budgets are now struggling.

In the 80s and early 1990's, pathology funding was in place through the MBS without any controls on demand such as Licensed Collection Centres, Coning or limits on MBS outlays. The result was very high growth rates in pathology testing resulting in high and unpredictable growth rates in MBS outlays (see Chart 1 below). In response, the Government introduced savage cuts to patient rebates and entered into major disputes with the private sector providers resulting in extensive legal action.

**Chart 1**



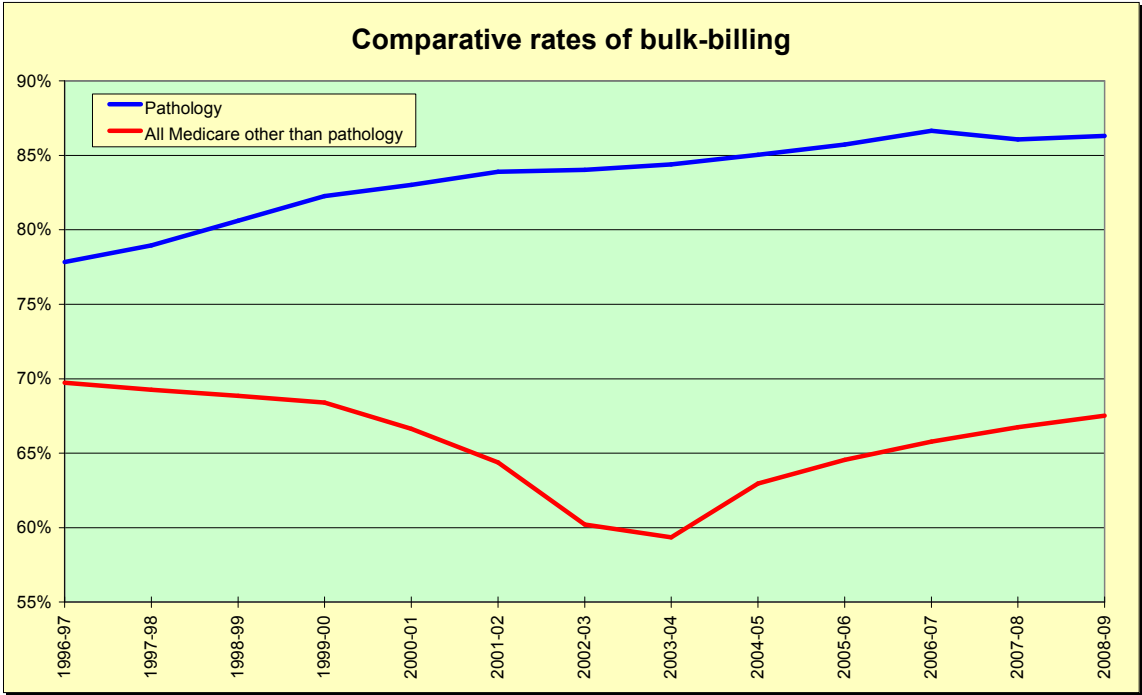
As a result of this situation, both Government and private providers, through the newly formed Australian Association of Pathology Practices (AAPP), developed a methodology to control demand and control costs within an agreement that provided the industry with guaranteed growth and strong

incentives to improve efficiency. In its final form, this was represented as the Memorandum of Understanding (MOU) which had a number of key elements viz: a cap on growth in outlays, a cap on the number of collection centres owned by a single provider, a limit on the number of items that could be charged to Medicare for a single patient episode (Coning).

The result of this agreement has been to:

- tightly constrain the growth in aggregate benefits paid (averaging 7.2% per annum, less than the 7.3% per annum for all other services billed to Medicare); despite very significant growth in the volume of services delivered (averaging 5.9% per annum compared with only 2.2% per annum for all other services billed to Medicare).
- further increase the rate of bulk-billing (remaining as the highest of the major medical peer groups) and in stark contrast to the rest of Medicare (see Chart 2 below).

Chart 2



All the evidence shows that the MOU was a very successful arrangement and partnership, one that delivered significant benefits to patients in terms of access, affordability and high quality services and to government in terms of stability, predictability and controls over outlays. There has not been enough acknowledgment of these achievements that arose from industry and government working collaboratively.

The key to understanding these achievements is to examine the productivity gain within the private sector. The constellation of regulatory measures meant that private providers needed to achieve major improvements in productivity in order to continue to provide a full range of high quality services to patients and still be able to confidently invest for future improvement.

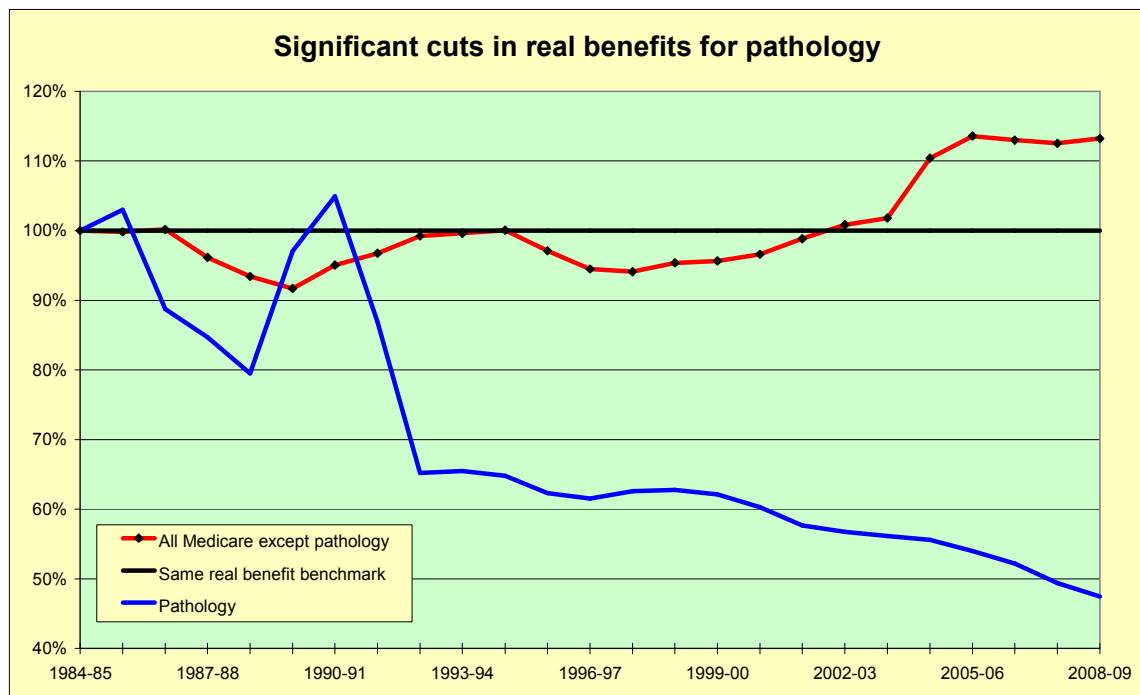
## 2.1 Productivity gains in the sector

The productivity gains achieved within the sector are exceptional. They are the result of consolidation of practices into larger corporate entities, major private investment in automation and purpose-built facilities to maximise the opportunity for automation, and a very significant private sector investment in sophisticated information systems and new technologies that have reduced real costs and improved the quality of the services. Further efficiencies have been made by the private sector centralisation of less common forms of tests into central “hub” laboratories.

Control on outlays has been further increased through the acceptance by the industry of the coning of tests whereby there is a limit on the number of tests per episode that can be billed to the MBS, even when a greater range of tests is ordered by a requesting GP. One might expect that this would generate gap payments above the rebate, yet bulk billing rates have been rising. The raw data show very large reductions in costs in real terms.

In the diagram below (Chart 3), we established a benchmark benefit (horizontal line) for a scenario where there is no productivity gain at all. This is calculated by indexing the 1984-85 average benefit by an index comprised of wages (60%) and prices (40%). In the absence of productivity gains, the benchmark benefit would have risen from the observed \$15.62 in 1984-85 to \$41.37 in 2008-09. The actual average benefit in 2008-09 was \$19.63. Therefore, the raw data suggests that pathology benefits were cut by **53% in real terms** over the 26 years of Medicare. In fact, these raw data understate the real reduction in pathology benefits for the simple reason that they do not reflect the quality improvements (more reliable, more accurate test results) and the monetary benefits for Government associated with coning of tests.

Chart 3



**In real terms, rebate levels today are 40% of the levels they were set at in 1985, less than all other medical groups. The level of co-operation between the private pathology providers and the**

**Government has yielded huge productivity gains to reduce the average cost per test, a result which is not acknowledged in the Government's discussion paper.**

Over the same period of time, the bulk billing rate has become the highest of all medical groups. Thus the number of services available to patients and the affordability of these services, have increased dramatically.

**All else being equal, without productivity and efficiency gains, the cost to the Federal budget of the 100 million pathology services rendered in 2008-09 would have been \$4.2 billion, \$2.2 billion higher than actually experienced. Cumulatively, the savings to the Government from productivity improvements in Pathology since 1984-85 is in the order of \$16 billion, 88% of which has been achieved in the lives of the MOUs.**

## **2.2 Productivity gains across the general MBS Schedule.**

The productivity gains achieved within the sector are only one aspect of the productivity gains delivered for the health sector more generally. Improvements in the technical quality of investigations significantly assist other clinicians (GPs, physicians and surgeons) to make more accurate diagnoses. Further advances in the use of technology to turn around testing within short time frames and to deliver results directly to doctors, even when they are away from their practices, have added substantial benefits in reduced lengths of stay in hospitals, reduced anxiety for patients and reduced retesting due to lost or misplaced results.

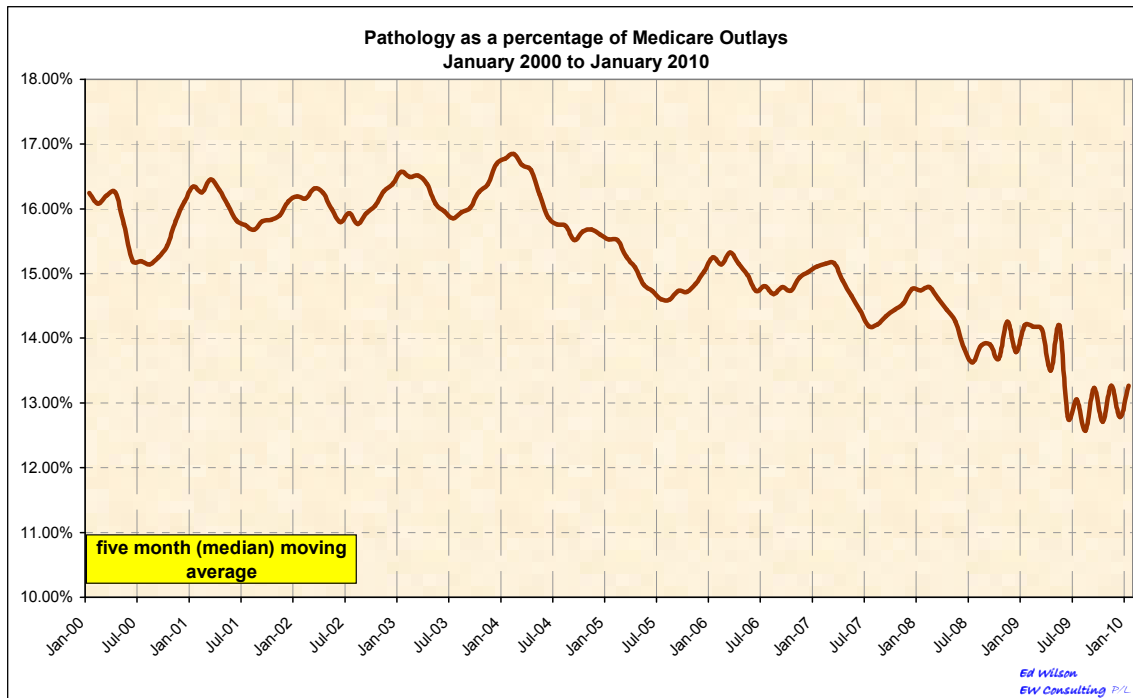
These improvements are a strong feature of the private sector providers. The turn-around times for non urgent tests are not matched in the public sector and nor is the ready availability of results to referring doctors.

These measures improve patient outcomes in a very material way and also reduce costs throughout the health care system (the community sector and the hospital sector). More accurate diagnosis means that better use is made of pharmaceuticals, again helping keep costs down and improving outcomes for patients. It means, in some cases, that costly exploratory surgery is no longer required.

## **2.3 Pathology rebates as a percentage of total MBS outlays.**

By carving out efficiency gains within the sector and reducing the real cost of services, pathology is making services more accessible to patients without breaking the federal budget. Pathology fees as a percentage of MBS outlays are falling (see Chart 4).

**Chart 4**



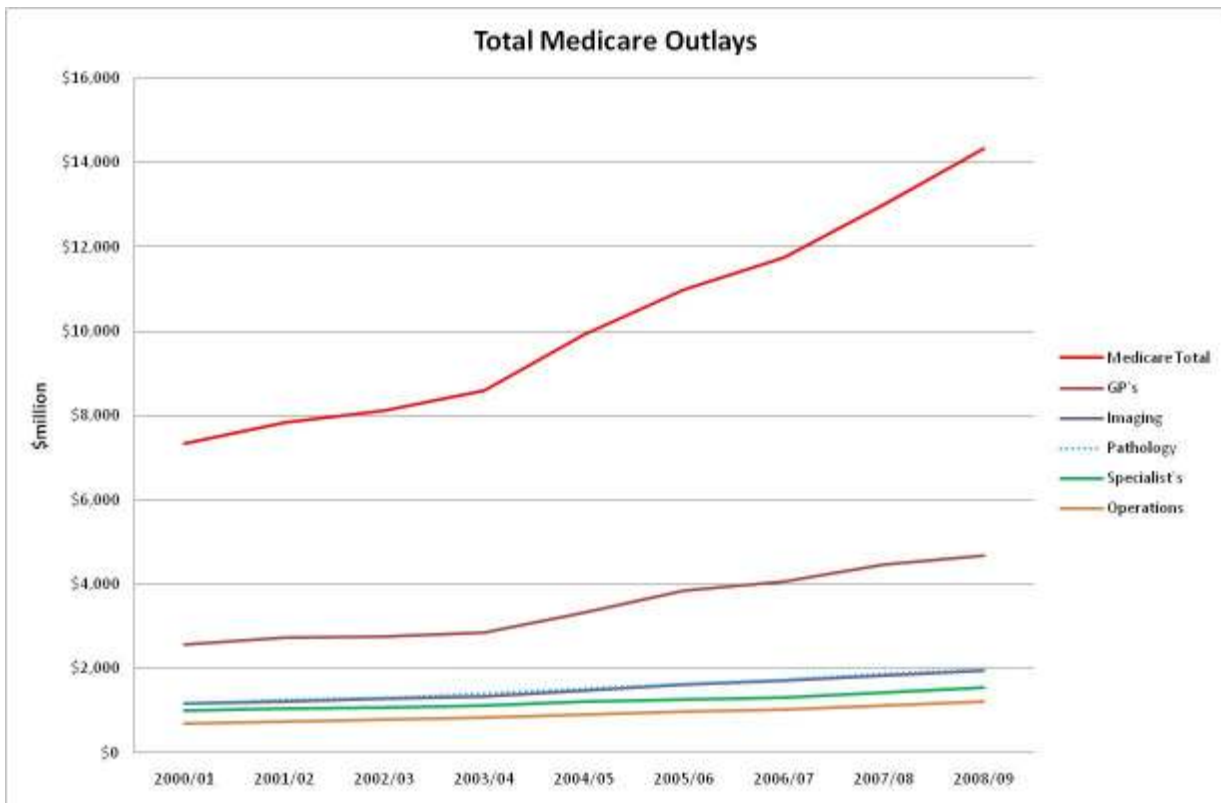
If policy makers fail to appreciate the contribution to better health outcomes from more accurate, cheaper investigations, then they will put at risk one of the important sources of improvement in the overall quality of the health system.

#### **2.4 Pathology outlays compared to other medical specialties.**

Between 1998-99 and 2008-09, the raw data show that the volume of pathology services grew by 5.9% per annum. Aggregate benefits grew by 7.2% per annum. The average benefit per service grew by only 0.8% per annum. These raw figures understate the number of services as they exclude coned services. The nominal increase in the average benefit paid is also misleading because it masks the changing composition of pathology services (to a more complex basket of services). For the remainder of the MBS (all other services excluding pathology) the annual growth in services over the period was 2.5% whereas the growth in aggregate benefits was 8.1% per annum. In stark contrast to pathology, but also noting similar changes in complexity, growth in the average benefit per service was a very robust 5.4% per annum.

The graph below (Chart 5) shows that the MBS outlay growth for pathology is similar to other MBS rebateable medical items. The major source of growth in overall MBS outlays is for the recently introduced non-medical items. If the growth rate for pathology is not sustainable, then it is even less sustainable for other specialty medical services funded through the MBS rebate system and so the whole of Medicare would have to be deemed unsustainable. Controls on total outlays should be targeted at the true source of the higher growth rates, i.e. the non medical items.

Chart 5



Since the Pathology MOU was unilaterally abandoned by the Government, the Government has further reduced MBS Pathology rebates further widening the expenditure gap between Pathology and other medical services under Medicare.

## 2.5 Government/Industry Cooperation

The MOU management arrangements established a regular dialogue and joint management process in which Government and the industry worked closely together to ensure the regulatory environment met the needs of Government as well as the needs of the industry.

This process honed the regulations underpinning the MOU and also regularly modified the schedule of fees to ensure an appropriate relativity between schedule items, mostly within disciplines but in more recent times between disciplines as well. These changes were also targeted to ensure best practice in the selection of methodologies to undertake various tests and to exclude tests and methodologies no longer considered essential to disease management.

Since the demise of the MOU, the processes in place for regular dialogue with Government e.g. Pathology Consultative Committee (PCC) and Pathology Services Table Committee (PSTC) are no longer relevant or appropriate. The PCC has been abolished. The PSTC process worked effectively under the MOU. Funding for new tests or to correct inappropriate relativities was found from savings in the pathology section of the MBS. New items or under remunerated items were funded over time by this process. The new MBS Quality Framework destroys the integrity of the PSTC process as savings from the MBS pathology items can now be used elsewhere in health.

In our view, the Government's unilateral action in ceasing the MOU as well as introducing new fee cuts and removing the cap on collection centre numbers is a significant threat to the stability of the sector. This in turn threatens future quality of services to the detriment of the health of patients, it threatens future bulk billing to the detriment of the disposable income of patients and to the detriment of equity in the health financing system and it threatens future co-operation with Government to the overall detriment of patients.

### **3 Funding and relativities**

In the Discussion Paper under this heading the Department asks 10 major questions. These questions are challenging to answer and not always relevant to the three key tasks set for the Review. The answers will differ in different laboratories depending on their clinical profile, location, size, referral patterns and speciality. Most need an independent, formal, and detailed study to answer them. The Review team will receive a mix of views from the industry and the profession. A simple majority is not the way to solve the questions as the answers differ for different environments.

#### **3.1 Common Core Requirements to Maintain High Quality Services**

We think there are highly complex and difficult issues involved here. There is not a simple checklist that can be developed to answer this question. A high quality standard of service exists today. The key elements have been honed over many years of experience, competition based on service, external accreditation and national standards set through the National Pathology Accreditation Advisory Committee. Because of the pressure on costs, these systems in Australia are very sophisticated and in the private sector are carefully scrutinised to ensure any investment or resource is value for money.

Thus it should be noted that all the private providers compete on service and therefore have:

- Highly qualified medical staff
- Highly experienced scientific staff.
- Well-developed internal and external quality control programs.
- Sophisticated information systems with rapid transfer of information between providers and referring doctors and considerable investment in quality systems that ensure results do not go astray.
- Well-developed and highly trained collection and courier services throughout Australia even in rural and remote locations
- Regional laboratories which may not be fully cost effective but make an important contribution to the local medical fraternity.
- Training of pathology registrars as well as applied research
- Strong scientific professional development programs
- Substantial investments in training for front line staff such as collection staff, couriers, data entry clerks etc.
- Purpose-built capital infrastructure to accommodate manual and automated testing and streamline the collection and processing of samples.
- Substantial initial investment, and constant reinvestment, in modern equipment and infrastructure.

- Participation in Government, hospital and professional society and College committees.
- Participation in NATA / RCPA accreditation surveys as volunteer surveyors.
- A commitment to deliver a comprehensive pathology service, for example, the provision of domiciliary visits to patients in remote locations where the costs of providing that service is far in excess of the fee derived for it and after hours services which are critical to patient care.

The relative size and structure of practices varies depending on their location and referral volume and patterns. The relative level of commitment and resourcing in a practice under each of the above headings will vary depending on the size and nature of the practice. There is no “one size fits all” solution. The level will also change over time as technology changes. It is not possible or sensible to try and define the contribution of each of these elements.

### **3.2 Additional Quality requirements for each Discipline**

The key quality elements are the same for each discipline, however they may vary according to the requirements of the discipline. They depend on volume of testing, the nature of the test and the geographic spread of referring doctors.

Some will claim that anatomical pathology is different as it requires a large component of medical input per specimen. However, all the overhead costs apply to these specimens, including collection, couriers, data entry, specimen preparation, staining by machines with scientific supervision, report writing, storage, report communication to the referring doctor, links to public health registers, quality control programs, participation in Government and professional committees etc.

Interpretation of anatomical pathology findings is increasingly linked to results of other testing modalities such as flow cytometry, molecular genetic testing, cytogenetics and cytology. Thus it is difficult both clinically and logistically to separate it out as different from the rest of pathology. Other high volume, more automated tests have a different mix of manual input per specimen but the basic principles are no different.

### **3.3 Do the current MBS fees adequately reflect the costs of providing different kinds of pathology services?**

In a modern pathology practice of substantial size, over 50% of costs are in areas that are common to all disciplines e.g. collection, transport, data entry, sample preparation, information systems, results entry, supply chain logistics, management and corporate overheads etc. Another significant proportion is semi or wholly discipline specific, while less than 25% can be directly ascribed to a particular test.

Thus, in many ways, it is an artificial accounting exercise to allocate costs to individual tests. It is not done as part of the normal financial management of pathology practices. An accounting exercise that requires arbitrary assumptions about cost allocations will have a wide margin of error and is not relevant for effective financial management.

Over the period of the MOU, significant adjustments were made to the current schedule to eliminate waste and try to bring rebates as close as possible to actual direct test costs. This enabled savings in

order to fund underfunded areas. **We believe the current schedule is a relatively good guide to the relative values of tests. There are “swings and roundabouts” but we believe these are within the margin of error that would be seen in any resource based costing exercise for this large a range of services.**

**If the Government wishes to pursue a costing study to reallocate rebates across the pathology schedule, we believe it needs to undertake an exercise similar to the Relative Value Study (RVS) conducted on the remainder of the MBS schedule in the late nineties.** This study posed some challenging questions regarding the correct allocation and calculation of real costs. It considered many of the difficult issues involved in questions such as the development of typical profiles of work, the treatment of various practice costs, non face-to-face time, reasonable annual hours of work, professional relativities, the benchmarking of items across the various specialties from which comparisons could be then reliably based etc. These issues were constantly debated by the profession. This exercise will be just as complex.

It is simply inappropriate to undertake a small study and “guestimate” the appropriate allocation of costs as this will vary considerably between practices based on size, referral patterns, specialty expertise, geographic spread, investment in automation, degree of consolidation and centralisation. It will be different between public and private services. The industry and college undertook a small exercise but it did not include all costs from the public sector, and it was only done across a small sample of private laboratories. It is not accurate and cannot be validated or reconciled.

The private pathology sector would argue for the inclusion of the public sector in a costing exercise to establish relative values. This requires the explicit identification of all costs including the correct proportion of corporate overheads of the host health service. In our experience, costs in the public sector generally run at around 150% of the MBS item fees and even then, this is without all overheads and cross subsidies included. It is therefore scientifically invalid to take the relativities from a public sector laboratory without these costs and apply it to the MBS. In addition, the costs within a private laboratory are very different due to the volumes, mix of work and geographic spread of referring doctors.

We do not believe that previous benchmarking studies are sufficiently robust to be applied to determining MBS rebate changes. A joint exercise undertaken by the College and the providers illustrates the inadequacy of the methodology and does not reconcile with the MBS. It did not include all the costs relevant to private providers.

A Relative Value Study into the pathology component of the MBS will throw up all the same issues as the original RVS and is likely to be as complex.

However, subject to agreed terms and conditions, if the Government wishes to achieve a true cost based schedule, the AAPP would be willing to participate. The main imperative is for the answers to be derived from an independent study with a rigorous methodology developed in full consultation with the relevant providers. It is not enough for vague and subjective impressions to be the basis of a finding which will have major ramifications for the provision of high quality pathology services for patients into the future.

As such a study would be long term, there would need to be interim arrangements for the inclusion of new items onto the Schedule which were timely and efficient and the adoption of the usual indexation arrangements, applied to all other medical services each year, to Pathology.

### **3.4 Are current relativities in fees between different services appropriate?**

This question cannot be answered by competing clinical groups describing the situation from each one's own perspective or by the claims of the public sector representatives who do not have a good understanding of private provision issues and vice versa. It can only be resolved by independent study, rigorously designed and expertly informed and with the full involvement of the pathology providers.

### **3.5 Are the current arrangements sustainable over the medium to longer term?**

In the view of our members, they are sustainable. The demand for pathology will continue to grow as the population ages and the incidence of chronic diseases increase. The industry believes that by Government and industry working in partnership, there can be a sustainable process to ensure the rate of growth is affordable, productivity gains are encouraged and providers compete on quality.

Because of the sustained growth, the industry is able to participate in such agreements and accept constraints for the greater good of all Australians. In return, it will need a stable environment to continue to encourage future investment and achieve productivity and quality gain. In essence this is a "public/private partnership" of the type that is being increasingly used by Governments to achieve the successful development of capital infrastructure and strong service delivery in many parts of the economy.

This is what has been achieved under the past MOUs and a new form of partnership is the best way to continue to deliver excellent outcomes for patients, Government and the industry.

### **3.6 What factors should be considered in deciding appropriate MBS fees for pathology services?**

A standard approach should be adopted to setting fees for new services. In addition there should be a periodic major review of all items on the schedule to adjust relativities for changes in technology and methodology in the light of best clinical practice. If the Government has established a relationship of trust with the profession/industry through an Agreement for example, adjustment to relativities could occur more or less continuously using the direct knowledge of the parties or for more complex questions, an independent approach developed by the parties. Alternatively, a process of less frequent reviews (five yearly) and with more formality and independence in the method of review and a clearer understanding in advance of how the review findings could also achieve the necessary periodic refresh of the schedule of fees.

### **3.7 The Episode Cone**

This feature was introduced with the agreement of the industry as a means of controlling excessive demand. The industry was able to agree with this control measure because it traded the freedom to charge for all work done in return for a stable environment with a predictable rate of growth and incentives for efficiency gains. The episode cone means that only the three most expensive items in a GP requested outpatient episode are remunerated.

The level of demand has been such that the cone reduces income to pathology practices from GP requests by up to 19% overall and by up to 88% for certain tests. Recent data obtained by the AAPP, shows that over 30% of GP requested Pathology test items are coned out. The level of episode coning for a sample of item numbers from representative laboratories is at Attachment 1

In addition to the episode cone, many tests that are requested and performed do not result in a Medicare payment. This is because the number of tests performed exceeds the number specified in the MBS item. For example in the General Chemistry area only 5 tests are remunerated yet doctors commonly request 20 tests of this kind in every patient episode. Many tests have an item description of “1 or more” and where 2 tests are requested (e.g. high vaginal swab culture & cervical swab culture) and performed there is only payment for one. Similarly clinical restrictors in Items may mean that tests outside these (e.g. more than 4 HbA1c estimations in a year) are not reimbursed. The total impact of this ‘test coning at the item level’ is that up to half the tests that are performed in an average Pathology practice are not remunerated. This is quite different to the circumstance in many overseas Pathology payment systems.

**The incidence of episode coning has increased from 6% of potential income from GP requests for pathology when it was introduced to 19% now. At the time coning was introduced it was not contemplated that it would increase to 19%. The cost, in terms of foregone revenue is very significant.** In addition, because coned out services now represent such a high proportion of GP requests which are not accounted for or recorded by Medicare, there is a significant distortion of Medicare utilisation data.

Additionally, GPs are increasingly being remunerated by Government on the basis of their performance against criteria including whether patients have undergone relevant pathology testing (HbA1c testing for example). This requires the GP to have access to accurate information on this testing which is not available from Medicare Australia as many such tests are coned out and so accurate information is not available.

**This level of coning is only sustainable in a stable funding environment where there is a recognised need to balance the rate of growth with measures to limit excessive demand, as existed under the MOU.** The balance needs to be managed by regular review and adjustment as occurred in the PSTC as part of the MOU and within the context of guaranteed growth in MBS outlays.

Coning is not sustainable under a system of uncapped open competition with rebate reduction as the only means of control on outlays.

## **4 Alternative financing arrangements**

### **4.1 Tendering**

The Government has indicated a desire to identify certain groups of tests which may be suitable for alternative funding mechanisms and to draw up detailed options for tendering for selected pathology services. A further eight questions are posed for consideration in this context, many again about cost.

Pathology is a referred specialist medical service which is intricately linked to the on-going improvement of the health system. Pathologists establish close relationships with requesters, both

GPs and Specialists and a key part of that relationship is the feedback which develops, leading to improved pathology requesting to the benefit of patients. It is not a service which can be commoditized and bundled and treated as if it is outside the mainstream health system.

The current debate over the future roles of the respective levels of Government has demonstrated how importantly Australians regard the health system and how ultimately they will hold the Federal Government responsible for its preservation and improvement and vote accordingly. The availability of access to medical services through universally available rebates for patients accessing these services is a key feature of what Australians value.

**It is doubtful that the Government can introduce tendering in Pathology Services without curtailing the rights of Australians to access these services under the Medicare Benefits Schedule.**

Such a Government decision may be seen as the end of universal access to medical services and the beginning of further erosions to the Schedule to make way for lesser trained health groups.

The paper specifically requests the review to provide detailed options for implementing tendering for selected pathology services

#### ***4.1.1 Tendering – General comments***

Tendering reduces certainty in the pathology sector. This will reduce the willingness of the sector to invest in new technologies and new infrastructure. The focus of the sector will be redirected to the period of the tender rather than a more long term focus. Quality is achieved by continuous improvement. The safety and excellence of the current system has been the result of many years of investment in continuous professional and technological improvements. Tendering will diminish the quality of services available to patients in the longer term.

Another significant point will be the impact of increased demand on the tendering process. We have previously said that the whole story of pathology services for the last 20 years has been the story of major increases in demand for a valued medical service. No tenderer will be comfortable to give an all inclusive price for the provision of some or all pathology services in a region/State etc, in a situation where they assume the risk for rising demand. Pathology is a referred service and tenderers will not have control over demand.

Investment by the sector will be carried out in a more volatile business environment. The rational response to this more volatile environment is to seek higher rates or return to compensate for the greater risk. This may drive up the availability and cost of capital and the cost of service provision for patients in the longer term. If the loss of a tender leads to a write-off of significant current investments and infrastructure, this will cause a lack of confidence in the sector and a lack of future investment. This will also damage access and quality for patients.

Tendering tends to be a complex and costly administrative process. If not handled correctly, it can have seriously disruptive effects on the provision of services and therefore access to vital pathology services. This is particularly true, if in addition to the normal commercial complexities, there is a political overlay of controversy and as we suggest, legislation needing to be passed by the Government.

Tendering may encourage “cherry picking” as providers would only tender for the most profitable areas of work. Conversely, the less profitable or more remote locations may be less attractive for potential tenders and may result in no services being provided.

Any incentive to maintain service quality may be reduced after a tender process as providers currently compete on service standards which would no longer be applicable if the number of providers was reduced. The prevailing culture in the private pathology sector is one of competition based on service and quality. The major scandals over safety issues have occurred in the public sector where this imperative is non-existent. Tendering will radically alter this culture and drive lowest cost at the expense of quality. This is the situation in Auckland, New Zealand.

There would be a major adverse impact on the workforce. Security of employment would be limited to the length of a contract. There would be little incentive for long-term investment in training and education, professional development and succession planning. This is a very serious issue which is already troubling the sector. Medicine, particularly specialist medical services like pathology, are characterised by very long training periods. It is not unusual in specialist medical practice for such training periods to extend for 15 years after departure from secondary schooling. During this time, trainees need stability in their working environment and exposure to the full range of clinical experiences which they need to understand. Similarly, the system depends on the expertise of senior scientists who develop their expertise over many years of experience and professional development. A tendering/contracting environment is hostile to this need and will diminish the quality of training available.

Tenderers will need to amortise their investment over the tender contract period rather than the life of the equipment. This will significantly increase fixed costs for the tenderer. Tendering, due to it being for a fixed period, also acts as a significant disincentive for re-investment in equipment and infrastructure. Tendering would have a major impact on private sector investment in pathology equipment particularly if short term contracts are used. It may increase the potential for major providers to focus investment overseas and leave the Australian market to small local providers, which may drive up costs and reduce benefits of automation and centralisation.

It would be very difficult for new providers to enter the market as all Medicare work would already be contracted out. They would need to wait for a new tender process, and this would be unlikely to happen given the investment required to establish a new laboratory.

There could be a reduced capacity to handle emergency situations like H1N1 testing if laboratory numbers were reduced under a monopoly tendering arrangement.

Most pathology providers have contractual obligations that cannot be unwound in the short to medium term, often for periods of up to seven years. These contracts can relate to leased premises for medical practitioners, collection centres or laboratories and for pieces of testing technologies and other equipment supplies. If the Government is to avoid significant financial damage throughout the health care sector, it would have to give significant notice of its intention to consider tendering and the ultimate decision making to proceed with a tender.

**Our clear advice is that tendering is not desirable for the sector and that there are many political, quality, patient access administrative and commercial risks involved with a decision to implement**

**tendering. We do not think the Government should go ahead with it for all the reasons above and also because it seems to be based on a presumption that there is no competition in the sector at present, which we think is demonstrably not true.**

#### ***4.1.2 Tendering – Single Supplier Arrangements***

If the Government is to award a tender to a specific provider at a given price and volume, it is hard to see how it can if it leaves Australians free to exercise their rights of access to these services under Medicare. They would necessarily need to be curtailed.

If competition was reduced through monopoly tendering, then the price of pathology will rise over the longer term. Pathology providers not successful in gaining a tender, will not survive to compete for the next tender round in five, or more, years' time. The number of providers will decrease further and ultimately there will be no competition. The skills and infrastructure required to operate a pathology service cannot be easily and successfully created to meet a new tender.

The transfer of services from an established provider to a new entrant is fraught with risk. One only has to assess the situation that occurred in Auckland to understand the risks to patient safety and Government reputation.

#### ***4.1.3 Specialised supplier arrangements***

Again, we do not believe this offers Government the best value for money. Tendering for special tests locks in the quantum and price for such tests based on the best methodology at the time.

However, there are often unexpected peaks in demand that require a sudden increase in testing capacity (e.g. swine flu) that are difficult to respond to under a tight contract that specifies a volume and price. It is thus a rigid and restrictive approach.

It is far better to allow market forces to drive centralisation of the more specialised and expensive tests. This is achieved by setting the MBS fee at a level that is only profitable if a large volume is done and by regularly reviewing these fees to keep pace with technology. The market has already driven major centralisation in the private sector through this mechanism. There has been less centralisation in the public sector where direct Government funding has not achieved the maximum volume benefits.

A further benefit of the current approach was seen in the recent swine flu epidemic. It was the private sector that was able to rapidly expand its volume of testing and amount of pathologist advice in interpreting the tests because they were responding to customer demand. This was done at a financial loss as a service to build and grow its customer base. This would not have been possible without additional funding if this testing had been restricted to laboratories contracted to Government departments.

#### ***4.1.4 Tendering - Multiple Supplier Arrangements***

Tendering to establish a price per service is also fraught with difficulty. In order to obtain the best price, the tender would need to specify the volume of work available to the successful tenderer.

If a panel of successful tenderers is the considered approach, respondents will need to bid at a relatively high level in case the volume of work finally available to them is only small. Those who win larger volumes will therefore make more profit than currently. Pathology costs are highly dependent on volume.

In order to obtain the best price under a tender arrangement, the Government would need to specify volumes and therefore direct GPs and specialists as to whom they must refer tests. This is unlikely to be acceptable to referring doctors and patients.

#### **4.2 Separating capital and clinical costs from MBS fees**

Further splitting of the schedule fee based on separate funding for component parts such as clinical or scientific input, performance, capital equipment, etc would be to create an administrative nightmare for Medicare and for the industry.

It would almost certainly result in practice changes to take advantage of every opportunity to increase revenue and so drive practices that were not based on appropriate clinical need and a sensible, management of demand and cost structures.

It would result in a waste of precious resources (funds or time) to maximise the revenue benefits instead of working to increase productivity, control costs and compete on quality of service.

Mostly, it would slow down the adoption of new technology and new practices requiring capital investment to the speed at which the industry can persuade the Government to move on such matters.

#### **4.3 Profitability in the sector**

**In our view, given the Minister's public announcements, one of the main underlying concerns that stimulated the review was a significant concern about pathology industry profits.**

These profits are being made because of the private investment which was necessary to fund the consolidation, automation and centralisation that resulted in the impressive productivity gains already referred to. Private investment only occurs when there is a reasonable return on investment. Government funding would never have built the infrastructure necessary to gain the efficiencies in pathology testing. Therefore, we maintain the profits are necessary to underpin the current system. We also argue by all reasonable standards, these profits are not now excessive.

The AAPP commissioned a study into profitability and returns in the private pathology sector in August 2008. The study was carried out by Price Waterhouse Coopers who has been retained extensively by the Government, including to carry out the costing study for the Relative Value Study into the general MBS conducted in the late 1990s. Thus this company has experience and credibility with Government in this area.

The major findings, which exclude the adverse impact of the rebate reductions imposed in the last two Federal budgets, were:

- Based on PWC's survey evidence, reviews of average performance of the publicly listed pathology providers, and benchmarking against other medical services, pathology sector margins are neither 'unreasonably high', 'extraordinary', nor 'excessive'.
- **Profit performance of the market leaders extrapolated from publicly available annual reports for the three publicly listed pathology services providers shows an average Net Profit after Tax (NPAT) margin of 9% and an average Earnings before Interest and Tax (EBIT) margin of 16%, below the weighted average NPAT and EBIT for the health care sector index.**
- Future cost minimising strategies in the industry are not expected to yield the same level as have been available in the past from amalgamations and automation and given the movements in wage costs and recent Medicare funding cuts may in future lead to a reduction in the level of bulk-billing, firm closures particularly in lower volume locations such as rural, and service level reductions which will reduce access.

More recent analysts' evidence suggest that there is further pressure on the sector following the decision by the Government in the last budget to reduce pathology rebates. A recent analyst report under a heading '**Competition is more intense than expected**' commented that 'we had previously expected that the pathology industry would be able to pass on much of the ~5% Government funding cuts to patients in the form of increased co-payments ... However, it appears that competition is much more intense than we expected, and this will make increasing co-payments over the longer-term difficult. As such, we expect the industry will ultimately end up absorbing most of the funding cuts, rather than passing them on to patients.'

The same report revised down its expectations in pathology for Sonic, Primary and Healthscope on the assumption that intense competition limits the ability of the industry to offset the Government funding cuts. Net profit after tax (NPAT) for the financial year 2010-11 and 2011-12 was revised down for all three of the big companies.

Another recent report concluded that:

- 'Pathology industry (is) entering a period of considerable uncertainty after a favourable past decade.
- 5% fee cut much bigger than any previous fee cuts. 5% represents ~\$100m of lost revenue (which is large compared to industry EBITA of ~\$375m). In isolation, industry margins would fall from 17% to 12%.
- Ability to introduce co-pays is therefore very important but relatively untested.
- Collection centre deregulation also likely to raise costs (but could also drive higher volumes).'

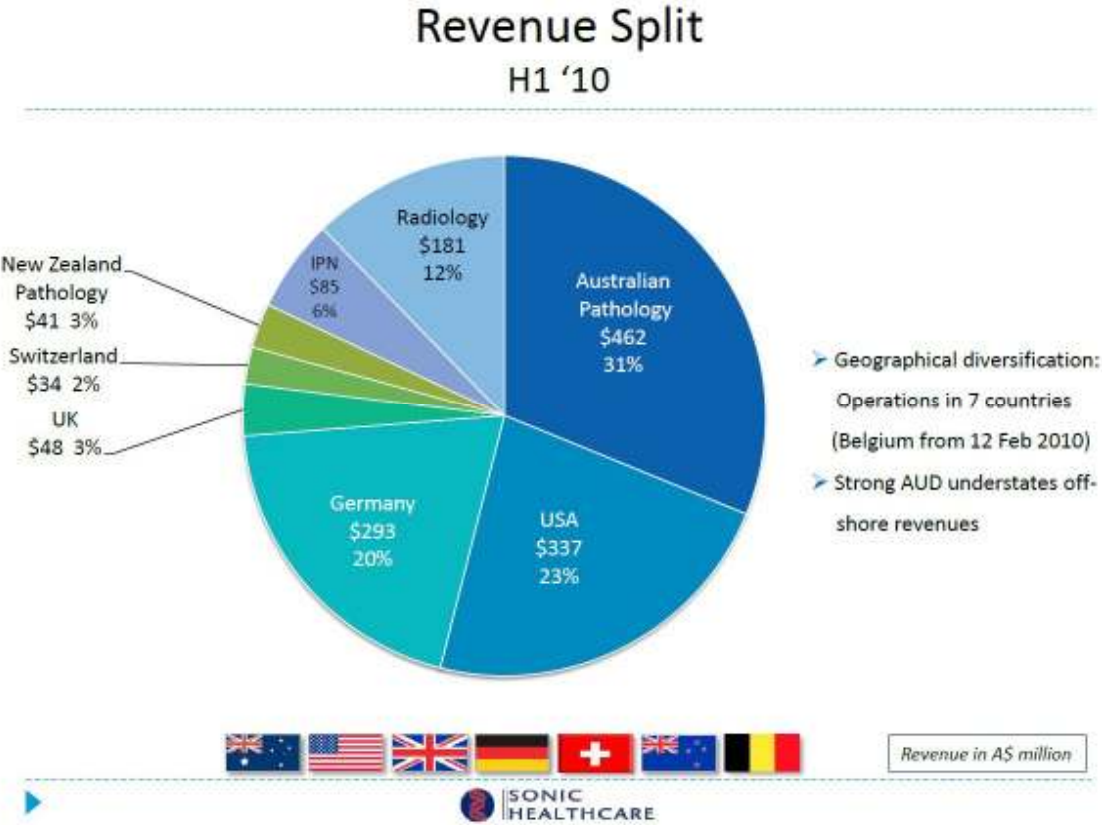
A third report states that in relation to the Pathology sector 'Market share grab is driving up labour/rent cost inflation, especially in NSW/Queensland.' which the report particularly attributes to deregulation of Collection Centres. It goes on to say that in relation to the whole health sector Ramsay Health Care 'remains our only positive view' and that other than that value is hard to find.

The decision in the last budget to remove the cap on the number of collection centres a provider can own is also having a major impact on competition. The response from the industry is not yet fully revealed but is expected to include aggressively chasing market share by seeking to place collection centres in practices that would not have warranted them previously. As reported in the KPMG study on the Approved Collection Centre Scheme in 2006, we believe this will place upward pressure on MBS outlays. KPMG recommended lifting the cap in spite of this pressure because as its report states, there was a cap on MBS outlays to prevent this (upward pressure on MBS outlays) happening. However, the measure is now being introduced at a time when the cap on outlays has been removed. Therefore we believe it will increase costs for the industry and costs for Government. It will not change patient access as this is already very high.

It will create further volatility and uncertainty in the market.

**4.3.1 Is the MBS underwriting profits?**

It is important for Government to understand that the source of profits outlined in company and analyst reports relate to revenue from a range of sources beyond the MBS schedule. Taking as an example, Sonic Healthcare, its revenues are derived from a range of services and in a range of countries. See below:



**AAPP would encourage policymakers to properly consider the extent to which these profits are achieved through service margins on MBS bulk billed work versus overseas profits and profits from non MBS funded activities before forming a negative view on the appropriateness of corporate pathology provider profits.**

Similarly, the return needed to attract private sector investment to build the infrastructure necessary to continue productivity gains into the future must be taken into account. In addition to MBS rebateable services pathology firms also provide services funded through private health insurance, various third party payer schemes, employment health screening, public health programs not funded through the MBS, environmental, food and veterinary services. Together these form a significant share of the pathology revenue stream.

Australia's private pathology sector is a business success story; a sector that generates appropriate profits on which tax is paid in Australia to support a sustainable and high quality service. The overseas success reflects the excellence of the Australian private pathology system in terms of quality and cost. This industry is a substantial employer and is an important industry in the Australian business context. It ought not to be subject to "tall poppy" treatment.

We would argue that to reduce and remove profit as an incentive in the Australian pathology system is to state a preference for Government service provision. It is essential that before determining Government action that will reduce private sector investment, the true costs of service provision in each of those sectors is well understood. The real opportunity for Government in the next 10 years is to develop closer working arrangements between the private and public pathology service providers to enable further cost reductions and service efficiencies to develop.

**We would argue that the private sector service provision is far more cost effective with the profit margins included, given the level of volume testing, automation, consolidation and centralisation that has occurred in that sector.** At the end of the day, the real beneficiaries are patients through better access to affordable high quality services.

Again, a relative value study as discussed above undertaken by a formal study and objective methodology would answer this question.

## **5 Private and public pathology**

The role of the public and private sector in providing pathology services in Australia needs to be revisited in the light of Prime Minister Rudd's health reform agenda.

The private sector has, for many years, undertaken very active programs of teaching registrars in pathology as well as the professional education and development of scientists. Many private sector Pathologists hold formal teaching appointments at University medical schools around Australia and private pathology practices contribute towards the funding of University appointments. It is now actively encouraging research, including the recent appointment of a Chair of Pathology in the private sector and formalising partnerships with new medical schools as a recognised organisation for medical student training. The opportunities in the private sector were recognised by government in its recent announcement of 36 new pathology registrar positions in private pathology practices. This will be in addition to the existing Registrar pool of approximately 20 Registrar positions. These training activities involve formal relationships with many public hospitals. Private Pathologists are significant contributors to relevant peer reviewed journals and at relevant Australian and International Conferences. **The private sector plays a significant role and makes a significant contribution to training, teaching and research in the specialty.**

**The private pathology sector has the same, if not greater, capacity as the public sector in relation to the performance of complex pathology testing and analysis. Claims that the most highly complex work is only performed in the public sector can no longer be supported.**

Currently, the public sector accesses \$200M per annum of MBS outlays for pathology. Much of this is due to the “privatisation” of public outpatient clinics. These services are also funded from direct Government funding of public hospitals at a state level. This is one of the classic examples of cost shifting and it needs to be put onto a proper transparent funding mechanism. The current system is clearly “double dipping”.

There is also the critical question of whether the same productivity gains that have been demonstrated for the private sector have also been achieved in the public sector. The answer is clearly no.

The volume of work in one of the larger private practices on a daily basis would be the equivalent of the pathology from at least 10 major teaching hospitals. Yet in the public sector, there has been little success in consolidating the non urgent work into large automated facilities. We acknowledge that a significant proportion of the work in a major hospital needs to be done on-site for urgent cases which need results within 4 hours. Any tests needed in > 4hours, overnight or longer, which is the majority, could be done in a centralised facility.

There have been many reviews done in all state jurisdictions that recommend consolidation and centralisation. There have been moves in that direction especially in Queensland, Western Australia and NSW. But the gains are much less than has been achieved in the private sector.

In Victoria, there has recently been the ridiculous situation of building a new laboratory and continuing separate management for pathology in the new Royal Women’s Hospital when it relocated to the Royal Melbourne Hospital site. The same situation applies in western Sydney where the Westmead Children’s Hospital has a totally separate service to Westmead Hospital even though they are neighbours. The barriers to consolidation are classic “territory and turf” disputes between competing professional groups and a management by state bureaucracies too weak to overcome the resistance.

Our own experience from working in the public sector, including managing public laboratories and conducting state wide reviews of the opportunities for consolidation, is that public laboratories, on average, run on a budget of approximately 150% of the MBS fee per test.

Given that public pathology is a significant share of total pathology expenditure and the MBS outlays for private pathology are approximately \$2B, the potential savings to the taxpayer if the public sector was to become as efficient as the private sector would be some hundreds of millions per annum, in our view.

We believe it is time that the Government provided a mechanism for “public/private partnerships” between public and private pathology. This would allow the routine work to be put through purpose built private sector facilities to take advantage of the private sector infrastructure. This infrastructure has been funded in significant part by tax based revenue streams, hence such a policy would reflect the Government’s wise stewardship of taxpayer dollars.

Under this model, the public hospitals would retain substantial satellite laboratories for urgent work and staff would be rotated across the hub laboratory as well as the satellites expanding the opportunity for research and teaching while reducing costs.

This would also remove much of the duplication of testing that occurs when a patient is referred from the private GP to the public hospital system.

It is important to note again that the major breakdowns in patient safety in pathology in Australia have occurred in the public sector ( viz Tamworth, Wollongong). These have occurred when individual health service pathology departments have been unable to find suitably competent medical or scientific staff and so have compromised on quality rather than refer samples to external services.

In the private sector, if there is not the relevant expertise at a local laboratory, the sample is quickly referred to a hub laboratory where that expertise exists and so problems due to lack of competent staff are avoided.

**We believe there are major benefits in terms of safety, cost, teaching and research to be gained from the partnering of the public and private sectors.** Pathology performed on public patients could be billed directly to public hospitals at the MBS fee rates, and this would result in major savings to the new, yet to be determined, public hospital networks. Private patients would be billed to the MBS and Private Health Insurance as per current arrangements.

The poorer relative efficiency of the public pathology system is more surprising given that the public sector enjoys significant tax advantages over the private sector in terms of the avoidance of payroll tax and their ability to more comprehensively engage in salary and superannuation packaging compared to the privates.

Given the Government's recent pursuit of health reforms and avoidance of blame shifting and cost shifting, we would propose two options for government to consider

- limiting public pathology to public work through block funding under the new Health and Hospitals Network funding mechanisms and that access to MBS rebates be withdrawn.
- allowing partnerships between public and private pathology to overcome duplication and encourage the next steps in sensible consolidation.

## **6 AAPP's proposed solution**

Pathology is a referred specialist medical service like the other specialist medical services that form part of the MBS schedule under Medicare. As such it should continue to be reimbursed in the same way as other medical services. The fee for service MBS schedule is a critical feature of Medicare. Any attempt to change the method of payment risks being seen as an initial assault on the universal nature of the politically popular Medicare rebate system.

**The AAPP believes we already have a Pathology Schedule with appropriate fee relativities. If the Government needs further assurance on this point, this needs to be assessed as part of a formal and rigorous Relative Value Study under agreed terms and conditions.**

**In our view there are two broad options available to the Government. Each of these options contains risks and benefits which need to be carefully assessed and we provide our comments below.**

### **Option 1 – A Pathology Reform Agreement with 5 year funding**

Under this option the AAPP, the RCPA and the Government could re-enter a 5 year funding agreement. There are elements of the previous MOU that were out of date both from the Government and industry perspective. Therefore the parties would negotiate a new “Pathology Reform Agreement” that aligned with the Government’s health reform agenda and continued to deliver predictability in Government outlays to an agreed level, and a stable growth environment for the industry.

Some of the issues which would need to be discussed, as conditions to that agreement, include:

- Agreed level of growth of MBS outlays
- Shared risk of demand rising beyond expectations
- Periodic review of the schedule to maintain relativities based on technology and practice changes using an independent third party to ensure objectivity.
- Appropriate level of coning with data capture of all tests ordered.
- Measures to control demand such as reasonable restrictions on the number of Approved Collection Centres
- Continued Participation in the NPS test ordering education program
- Public / private partnerships to achieve the next step in productivity gains
- Fair value of rebates and outlays recognising demand trends and the need for investment.

These matters have a major impact on the private sector providers of all sizes and specialties. They have less impact on public providers and we believe in any new partnership arrangement there should be a majority of private sector representatives on consultation committees to manage the partnership.

The advantages to the Government and patients would include:

1. A greater level of predictability in Government outlays and the elimination of the need for dramatic interventions to restore budget expectations.
2. High bulk billing rates would be sustainable
3. Competition between providers driving better service for patients, excellent support for referring doctors, and patient safety.
4. A more stable and predictable environment for Government and for the private pathology sector within which improvements to efficiency, productivity, quality, access and affordability can be maximised.

5. A greater level of co-operation between the Government and the private pathology providers with Government decisions benefiting by being supported by good information and advice from the sector.
6. A better environment within which issues such as demand management can be addressed and Government concerns about appropriate fee relativities can be resolved.

The disadvantages to the Government and patients include:

1. Continued resourcing of the work required to negotiate with industry to achieve agreement on the resolution of issues in the private pathology sector.
2. Restrictions on unilateral decision making powers over issues such as Medicare rebates, Collection Centres etc.
3. The assumption of some additional risk by the Government in maintaining the discipline of the Agreement.

Benefits to industry would include:

1. A stable environment to plan service improvements and expansions in response to demand pressures
2. A closer involvement and influence over government decision-making

Risks to industry would include:

1. The assumption of too much future demand growth risk when this should more correctly be borne by the Government and by individual users.
2. Becoming too closely identified with Government objectives leading to a reduction in quality standards over time.

## **Option 2 – No Agreement (Open competition)**

Under this option, there is no agreement between government and the pathology sector as to growth in MBS outlays. The government determines the rebates unilaterally and rebates patients according to its schedule. Pathology practices determine their billing practices and compete on price and service.

Benefits for patients and government

- Increased competition driving costs lower in order to maintain bulk billing in the short term.
- Less administrative load for government

Risks for patients and government

- Demand and therefore costs rising faster than government revenues due to lack of constraint.

- Further reductions in rebates lead to a fall in bulk billing rates and rising patient co-payments.
- Closure of regional laboratories to reduce costs for providers leading to poorer access for rural and remote Australians.
- Episode coning as a means of lowering demand in a capped expenditure environment is no longer appropriate and its removal would be strongly sought by the sector.
- Reduced competition in the longer term as competition favours the larger providers with more access to investment.

#### Benefits to industry

- Less administrative costs.
- Free to promote pathology through new avenues e.g. pharmacies, direct advertising, public health campaigns etc.
- Free to charge copayments and refuse to cone tests
- Increased revenue
- Charge for time in government programs such as NATA / RCPA accreditation and PSTC.

#### Risks to industry

- A more volatile environment reduces certainty and therefore investment
- Increased sovereign risk and ill informed policy decisions
- Smaller providers unable to compete without ability to invest in more marketing and services to attract customers and automation to reduce costs.
- Charitable not for profit sector will also find it difficult to compete in this aggressive environment.
- Diversity of providers will be diminished.

In this scenario, the Government is free to de-regulate the sector and if this ignites higher demand, to control its expenditure by further cuts to rebates. This approach by Government removes the controls on demand. In the preventative category, there is a lot of pathology that clinically should be done but that is not done. Open competition means that doctors and patients would be encouraged to have all appropriate pathology performed as soon as possible. Practices such as advertising and marketing directly to patients may emerge. Episode coning would not be sustainable in this environment. The sector would seek to end episode coning.

These measures are likely to increase revenues, increase collection centre numbers and the rents payable for these centres, all of which will put pressure on outlays. In response the Government will cut rebates and patient gaps will emerge.

This option is likely to favour the larger providers.

Concluding remarks

**The AAPP believes that the achievements of the last 15 years have been impressive and have not been properly acknowledged or appreciated by Government which obviously shares ownership of the achievements. The improvements in productivity and efficiency are very large and have not been achieved elsewhere in the health system.**

There are limits on the ability of any sector to absorb constant budget cuts and yet continue to provide a largely bulk-billed, high quality, low cost service which is a vital service supporting every aspect of the health system. **The Government needs to consider what it can do to ensure the vital role of Pathology is extended and improved for the benefit of the whole health system rather than continue a narrow preoccupation with budget savings.**

In charting its course over the last 15 years the Government has benefited from high quality advice from the private pathology sector. There has not always been agreement but there has been a rigorous approach where proposals are tested strenuously leading to higher quality decisions in the end. The Government should be concerned to continue to receive such advice.

We have seen no evidence to suggest that either the private pathology sector or the fee-for-service arrangements are significantly flawed or in need of major structural review. In our view, the contrary is the case. That is not to imply that a review is unwarranted. Our concern is that the review outcome does not destabilise the sector at the broad level or introduce measures which cumulatively degrade quality and service standards.

The two options identified in this submission for consideration by the Government are put forward in order to promote further discussion on the risks and benefits of these approaches. If other options emerge from the Review process, we would be happy to further discuss those with Government.

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**Attachment 1 – Episode coning**

			Range of foregone rebates
<b>Item number</b>	<b>Description</b>	<b>Low</b>	<b>High</b>
65070	FBE	44.5%	55.5%
65090	B Group	55.8%	73.8%
65120	INR	1.3%	5.7%
66500	chem×1	23.8%	36.8%
66503	chem×2	12.2%	18.9%
66506	chem×3	15.3%	22.9%
66509	chem×4	24.3%	34.2%
66512	chem×5+	22.3%	33.8%
66536	HDL	69.1%	78.8%
66551	HbA1c	38.9%	63.9%
66560	Microalbumin	10.9%	22.4%
66593	Ferritin	26.8%	45.3%
66596	Fe studies	4.8%	11.4%
66599	Either B12 or folate	22.0%	35.4%
66602	Both B12 & folate	0.0%	0.3%
66605	Vitamins	13.3%	71.4%
66608	Vitamin D	0.0%	2.5%
66650	Tumour markers	18.0%	47.7%
66655	PSA	15.5%	26.5%
66656	PSA monitoring	10.3%	16.3%
66695	hormones×1	4.0%	16.1%
66707	hormones×5	0.0%	0.0%
66716	TST quant	8.1%	22.2%
66800	Rx drugs	10.0%	18.9%
66819	Cu,Mn,Se,Xn×1	14.7%	46.1%
69333	Urine M&C	7.4%	17.1%
69384	Microbial antigens×1	4.8%	60.9%
69387	Microbial antigens×2	11.1%	20.1%
69396	Microbial antigens×5	0.0%	0.1%
69475	Hep×1	20.7%	45.7%
69478	Hep×2	6.5%	17.5%
71071	IG×3	10.6%	40.4%
71075	IGE	23.9%	52.7%
71097	ANAs	25.5%	37.9%
71101	ENAs	54.5%	83.1%
71106	Rheumatoid factor	73.8%	87.9%
73527	Pregnancy test	26.4%	58.5%
73529	HCG quant	14.6%	24.4%