Australian Association Of Pathology Practices Inc.
ABN 41 052 527 634

Productivity Commission Health Workforce Study
AAPP Submission

Table of Contents

1. Summary of Recommendations .... **Error! Bookmark not defined.**

2. AAPP Background 2

3. Introduction 3

4. Promoting effective coordination 3

4.1. Workforce planning, education and training and service delivery 3

4.2. Realignment of roles and responsibilities between governments............ 4

5. Good regulatory practice 5

5.1. Unification of professional registration and accreditation regimes 5

5.2. Medical Services Advisory Committee (MSAC) 6

6. Use of 'market-friendly' mechanisms 6

7. Fiscal gatekeeping 6

8. Meeting core health workforce objectives in new ways 7

PO Box 158 (Unit 6, 2 Phipps Close)
DEAKIN WEST ACT 2600
Tel: (02) 6282 2277 ● Fax: (02) 6282 2953 ● E-mail: aapp@client-solutions.com.au

Productivity Commission Health Workforce Study
AAPP Submission

1. Key Points

- AAPP believes that the particular expertise of doctors as specialist health care professionals, as well as the role of the entire health care team in delivering high quality health outcomes, must be more strongly promoted.
- AAPP agrees that workforce planning must be based on thorough assessment of the needs of the industry as a whole; this would include requirements for specialists, scientists, technicians and other support staff in both the public and private sectors.
- AAPP is seeking an additional $13.75 mil over the final three years (2006/07-2008/09) of the Pathology Quality and Outlays Memorandum of Understanding to increase the number of funded training places in the private sector program from 10 to 50.
- AAPP believes that Government must recognise the negative impacts of condoned cost shifting and other policies on the ongoing sustainability of private pathology.
- AAPP recommends that Government should consider introducing mechanisms to support high quality pathology ordering practice among GPs and specialists, similar to the work of the National Prescribing Service in pharmacy.
- AAPP believes that in the context of a shortage of pathologists and other medical practitioners nationally, it is vital that current efforts to increase transportability and mutual recognition of qualifications among the state medical boards should be finalised as soon as possible.
- AAPP considers that Medicare funding for new testing technologies should be restricted to relevant clinical pre-conditions and that the Pathology Consultative Committee (PCC)/Pathology Services Table Committee (PSTC) should have a role in their evaluation and introduction.
- AAPP believes there needs to be greater recognition by the Government of the effect of its recent policy changes, the increase in defensive medical practice to avoid litigation, and the evolution of health care itself to cope with an ageing population, in putting upward pressure on pathology services.

2. AAPP Background

The Australian Association of Pathology Practices Inc. (AAPP) welcomes the opportunity to provide this submission to the Productivity Commission's inquiry on Health Workforce.

The Australian Association of Pathology Practices (AAPP) is the principal industry body for private pathology practice in Australia, representing over 90% of the private specialist pathology market.

AAPP members provide cost-effective, high quality pathology services to the Australian community.

The AAPP was established in the late 1980s to provide private practice pathology with organised and professional representation during high-level negotiations with the Federal Government.

Our aim is to promote the honourable and ethical practice of pathology and to promote the practice of private pathology within Australia. We seek to help the Government achieve its fiscal objectives, whilst safeguarding professional and economically viable pathology practice.

3. Introduction

AAPP believes the Issues Paper raises a number of valid points, and we are keen to see further development of specific strategies to address these. Whilst international experience in health reform may provide interesting insights, the specific context of health care delivery in Australia, particularly the strong contribution of the private sector, means that any changes to the current system will have impacts that are unique to this country. The negative effect of government-imposed fee controls and increasing red tape on the recruitment and retention of the medical workforce, must be fully considered.

Whilst the document repeats the current mantra on workforce substitution and skill mix redesign, it does not make the link between this and some of the current problems with job satisfaction among the workforce. AAPP believes that the particular expertise of doctors as specialist health care professionals who carry much of the medico-legal responsibility for care, as well as the role of the entire health care team in delivering high quality health outcomes, must be more strongly promoted.

AAPP looks forward to reviewing the Commission's final report and to participating in the implementation of recommendations from the inquiry that contribute to better health care for all Australians.

4. Promoting effective coordination

In achieving a greater clarity of objectives for the health workforce and indeed, the system as a whole, AAPP agrees with the Commission that there is a need "…to condition the expectations of consumers about what levels of service can realistically be provided in what circumstances…" (p. 37). Furthermore, we believe this should be based on broad public debate to define which services are a public good and should be paid for (at least substantially) by the community (either through public or private insurance) and which are discretionary based on a individual's choice and constrained solely by their individual ability to pay.

It is worthwhile reiterating that much of the waste and duplication produced by the current division of responsibility for health services (estimated to cost the system up to $1 billion[1]) is avoidable, and could be used instead to improve the availability and effectiveness of much health care.

The objectives of better integration in the health sector are clear: to improve coordination, prevent patients falling through "cracks" in the system, achieve better communication among and between providers of care and patients, carers and families, reduce adverse events and improve health outcomes.

4.1. Workforce planning, education and training and service delivery

AAPP agrees with the Commission that there needs to be better coordination of workforce planning if the health system is to meet increasing demand over the coming decades. In pathology, planning must be based on thorough assessment of the needs of the industry as a whole; this would include requirements for specialists, scientists, technicians and other support staff, in both public and private sectors.

The Issues Paper notes that pathology is one of the health professions experiencing a mal-distribution of the workforce (p. 14). However, the critical issue for pathology is the severe shortage of pathologists. The 2004 Australian Medical Workforce Advisory Council (AMWAC) review of the pathology workforce recommended that an additional 100 trainees per annum were needed to meet the shortfall.

Lack of access to pathologists has the potential to affect the care provided to patients by other medical specialties that rely on their services. The RCPA has noted that *'if this trend persists, pathology services may even become the capacity-limiting process for many clinical activities: diagnosis and staging of diseases, screening for disorders, quality*

[1] Davis M (2005), Federal system wastes $2.4 bn. Australian Financial Review, 14/3/05.

control of clinical management, education at undergraduate and postgraduate levels, research on clinico-pathological issues, development of cellular and molecular methods and pathogenesis, and patients may face long waits before hearing a final diagnosis, or they will have to endure uncertainty about the diagnosis, as the expertise needed is not available'.[2]

However, it has been suggested that *'the currently decreasing staffing levels in academic departments of pathology and lack of formal rotations into pathology in the immediate postgraduate years are contributing to a difficulty in recruiting Australian graduates into the profession.'*[3]

A recent study on teaching practices in pathology noted that '*Pathology and laboratory medicine is increasingly integrated into [medical school] curricula, rather than included as a stand-alone component… the role of laboratory sessions is declining across all medical schools. The changing role and demands on clinical laboratories have been accompanied by a decline in students' access to laboratories… …Consistent with diminished access to laboratories, there is generally no requirement for students to learn how to perform "laboratory" tests.'*[4]

The report also argued there was a '*…need for expanding the range of clinical environments in which students receive their education, training and experience, so that they are more likely to develop skills appropriate to managing the chronic and sub acute conditions which they will encounter in their subsequent professional practice in the community'*.[5]

AAPP believes this principle should also apply to postgraduate training – we agree with the Commission that there should be a "greater role for clinical training of specialists across public and private hospitals" (p. 38). In the case of pathology, this would extend to private sector laboratories, where an effective training model has already been developed. Private pathology, through the five year Pathology Quality and Outlays Memorandum of Understanding (MoU), has developed an efficient and effective model for pathology training that is partially supported by the federal government as well as by private and public sector pathology providers.

Through the MoU, the profession has allocated $3.75 mil out of its fixed funding cap in years 1 and 2 to fund up to 10 additional training places in the private sector.

Given the initial success of this program, AAPP is seeking an additional $13.75 mil over the final three years of the agreement (2006/07-2008/09) to increase the number of training places from 10 to 50. This relatively small outlay would bolster the number of training places, provide increased exposure for trainees to private sector practice and greatly reduce the current pressure on the workforce (in both public and private sectors) due to insufficient numbers of pathologists.

4.2. Realignment of roles and responsibilities between governments

The funding agreement between private pathology practices through AAPP, the RCPA and the National Coalition of Pathology Providers (NCOPP) and the federal government, represents an attempt to establish more effective working relationships between the public and private sectors. The agreement includes provision for the workforce arrangements discussed above, in which private pathology is responsible for hosting additional training places that ultimately benefit both sectors as trainees rotate through both private and public placements. This model allows for more efficient and flexible management of medical training funding than is currently undertaken by state health departments.

---

[2] Royal College of Pathologists of Australasia (2003), www.rcpa.edu.au/applications/documentlibrarymanager2/inc_documentlibrarymanager.asp. Accessed 9/05/05.
[3] Weedon D (2003), Whither pathology in medical education? Medical Journal of Australia; 178 (5): 200-202.
[4] Commonwealth Department of Health and Aging (2002), Analysis of Current Teaching Practices in Relation to Pathology (Laboratory Medicine) Final Report. Canberra: DoHA
[5] Ibid.

However, cost shifting between state and federal health budgets continues to plague the efficient delivery of all health services. Cost shifting by pathology laboratories in public hospitals, which depletes the funds available to private patients receiving services from private pathology practices, is creating tension between the sectors because of increasing fiscal pressure being applied through the capped funding arrangements.

AAPP believes that Government must recognise the negative impacts of condoned cost shifting and other policies on the ongoing sustainability of private pathology.

5. Good regulatory practice

There are stringent regulatory mechanisms in place to secure the quality and safety of the testing and diagnostic advice provided by pathology practices in Australia. In fact, private pathology is one of the more highly regulated areas of the profession, through the adoption of quality standards and a practice accreditation process developed by the National Pathology Accreditation Advisory Council (NPAAC) and administered by the NATA/RCPA peer review system. Pathologists undertake five years of postgraduate education to obtain specialist qualification and from next year will be required undertake ongoing continuing professional development in order to meet College fellowship requirements.

Pathology is also in the vanguard of quality assurance through participation in Quality Assurance programs both externally through the RCPA – QAP Pty. Ltd. and other internal QAP programs. As recently noted, *'Pathology laboratories have achieved significant improvements in the timely provision and quality of diagnostic tests. Automation, commercially produced reagents and computing are providing clinicians with an ever-increasing menu of rapid, cost-effective tests. Operational advances in pathology have occurred in consort with analytical developments that measure many types of molecule with specificity and in ever-decreasing amounts, revolutionising the routine assay of many molecules of clinical diagnostic value. Coupled with this progress, pathology services in Australia meet stringent technical, management and quality-assurance standards to hold government accreditation for pathology testing.*[6]

The quality use of pathology is also a key ingredient of the current MoU, with approximately $2 million per annum allocated for studies into the appropriate ordering of this service. As a secondary medical service, pathology providers have little direct control over the volume and frequency of services requested of them. The need for targeting pathology ordering at the point of referral is supported by a systematic review undertaken in 1996, which demonstrated that the provision of education and feedback to general practitioners on their ordering practice (with and without cost information) could improve the appropriateness of diagnostic testing.[7]

AAPP believes that Government should consider introducing mechanisms to support high quality pathology ordering practice among GPs and referring specialists, similar to the work of the National Prescribing Service in pharmacy.

5.1. Unification of professional registration and accreditation regimes

Whilst private pathology has accepted a national accreditation and standards system, the complexity of current provider number and medical registration processes is a barrier to Australian graduates working in Australia. National registration has the potential to promote workforce mobility, enhance career path development and increase flexibility in workforce deployment throughout Australia.

---

[6] White GH (2002), Trusting numbers. Uncertainty and the pathology laboratory. Medical Journal of Australia 2002; 177 (3): 153-155.

[7] Beilby J, Silagy C (1997), Providing costing information to general practitioners—will this intervention change behaviour and create cost savings? *Medical Journal of Australia*, http://www.mja.com.au/public/papers/beilby/beilby.html#refbody20, accessed 9/5/05.

It is worth noting that among practising professionals, pathologists are already among the most mobile. Unfortunately, increasing financial constraints imposed by the capped funding arrangements may force the industry to undertake further rationalisation. AAPP believes it is vital that pathology graduates are able to function in both the public and private sectors; increasing centralisation of private practices into capital and major regional cities may decrease opportunities for training experience to be gained in a range of settings, both urban and rural.

AAPP believes that in the context of a shortage of pathologists and other medical practitioners nationally, it is imperative that current efforts to increase transportability and mutual recognition of qualifications among the state medical boards be finalised as soon as possible.

AAPP also recommends that an analysis of the impact of funding constraints on workforce mobility and on rural distribution be undertaken in the context of future funding decisions.

5.2. Medical Services Advisory Committee (MSAC)

The pathology profession believes that the relationship between the PSTC, responsible for reviewing the appropriateness and relative fee value of pathology items on the Pathology Services Table, and the MSAC, which assesses the efficacy and cost-effectiveness of new tests and services proposed for listing on the schedule, is somewhat ambiguous. In many cases it would be more efficient to have the PSTC review particular technologies rather than the cumbersome process of MSAC.

AAPP considers that Medicare funding for new testing technologies should be restricted to relevant clinical pre-conditions and that the PCC/PSTC should have a role in their evaluation and introduction.

6. Use of ‘market-friendly’ mechanisms

The majority of private sector pathology practices are part of larger corporate entities, which already function to a large extent on competition and market principles, albeit within the confines of a fixed funding cap that limits the ability of individual practices to set their own fees. Private pathology may in fact provide a model for more flexible workforce roles, in that efficient job skill differentiation has already occurred, unconstrained by the rigid industrial demarcations that may be experienced in the public sector. However, the overall shortage of workforce, including senior medical scientists and technicians, lessens the capacity of medical scientists to assist in areas of shortage among pathologists.

7. Fiscal gatekeeping

Through the MoU, pathology is subject to extremely stringent fiscal gatekeeping mechanisms. The effect of the capped funding arrangements has been to deliver significant productivity dividends to the government, at the expense of private pathology profitability. Furthermore, the effect of arrangements such as the pathology MoU is to increase the ‘silo’ mentality plaguing the health system. Such arrangements allow for little flexibility in service provision and hinder better coordination of care.

Pathology is a secondary medical service. That is, a requesting practitioner orders it on behalf of a patient. Consequently, pathology providers have little direct control over the volume and frequency of services requested of them. Recent general practice policies have been designed to boost GP numbers, enhance the role of general practice in the primary care of patients, support the prevention of disease and early intervention, and enable better management of chronic diseases.

Recent policy has also meant an increasing role and greater scope of practice for nurses: specific MBS items have been introduced for cervical screening, immunisations and wound care performed by a practice nurse under the direction of a general practitioner. The potential to substantially increase the number of Pap smears undertaken, whilst having a significant impact on health outcomes, will also clearly have implications for pathology services. While general practitioners have been found to have lower utilisation rates of investigative, outpatient, and specialist services for primary care consultations in emergency departments,[8] there is some evidence that nurse practitioners order tests at a higher rate than GPs.[9] As the role and scope of nursing practice in Australia continues to expand, the flow on effect of this on secondary services must be closely monitored and adjustments made to pathology funding arrangements as necessary.

AAPP believes there needs to be greater recognition by government of the effect of its recent policy changes, the increase in defensive medical practice to avoid litigation, and the evolution of health care itself to cope with an ageing population, in putting upward pressure on pathology services.

8. Meeting core health workforce objectives in new ways

Recent concerns about the declining availability of health workforce, both medical and non-medical, have led governments and health administrators to reconsider skill mix and role differentiation among health care workers. Much of the research in this area has focussed on skill mix and practice redesign involving an expanded role for nurses – to date there is little evidence, particularly in pathology, that the transfer of tasks to non-medical professionals in other roles and areas of health care results in better outcomes or in reduced costs.

In a review of the literature, Buchan and Dal Poz (2002) noted the lack of high quality research demonstrating the benefits of technology or skill transfer, other than for nurses.[10] Furthermore, Richardson et al have suggested that '*increased roles for non-physician personnel may result in service development/enhancement rather than labour substitution.*'[11] In other words, expansion of generic health worker roles may in fact increase demand for services, and thereby increase workload pressures on the existing professional workforce who are required to supervise practice. The apparent belief among policy makers that role substitution will be effective in containing costs and improving access across the spectrum of health care services, not to mention in improving outcomes, may in fact be misguided.

As noted in the National Health Workforce Strategic Framework, it is '*likely that new technologies will initiate more highly complex and specialised tests, requiring skilled, professionals to perform, supervise and interpret results, who in turn will require specific training and knowledge. This tendency runs counter to the prevailing trend to generalisation, or generic health skills and workers.*'[12]

It must be recognised, also, that '*the commoditisation and automation of much of pathology testing contributes to a perception that tests are 100% reliable, and there is also a perhaps related decline in communication between requester and provider. Most tests have limitations, many inconsequential, some important and patient-specific.*'[13] In

---

[8] Dale J, Green J, Reid F, Glucksman E, Higgs R (1995), Primary care in the accident and emergency department: II. Comparison of general practitioners and hospital doctors, *British Medical Journal* 1995; 311: 427-430.
[9] Venning P, Durie A, Roland M, Roberts C, Leese B (2000), Randomised controlled trial comparing cost effectiveness of general practitioners and nurse practitioners in primary care, *British Medical Journal* 2000; 320: 1048-1053.
[10] James Buchan & Mario R. Dal Poz, Skill mix in the health care workforce: reviewing the evidence, Bulletin of the World Health Organization 2002;80:575-580.
[11] Richardson G, Maynard A, Cullum N, Kindig D, Skill mix changes: substitution or service development? Health Policy. 1998 Aug;45(2):119-32.
[12] AHMC (2004), National Health Workforce Strategic Framework, Sydney: AHMC.
[13] White GH, MJA 2003 178 (3): 142.

other words, the role of the professional pathologist in ensuring the delivery of high quality services, both in choosing and interpreting the appropriate test, which has a flow-on effect by improving appropriateness and quality of diagnosis, must not be underestimated.

There is also a potential in the expansion of generic health worker roles to increase demand and thereby workload pressures on the existing professional workforce who are required to "supervise" practice. Achieving an appropriate balance between generalist and specialist services, particularly in technologically based areas of medicine, will be vital. However, given the intractable maldistribution of the workforce between rural and urban areas, and particularly for services that have a substantial technological component, this may also create the potential for governments to apply public subsidies disproportionately to lower-level health workers, which could lead to a differential quality of health care between less and better off patients. It is incumbent on governments seeking to go down this path to consider fully the response of consumers to receiving care from generic vs. specialist health workers.

In contrast, there has been an increasing focus in the health literature on the role of the multidisciplinary teams in improving health care.[14,15,16] Efficiency and productivity concerns, combined with technological advances, have already driven significant rationalisation in private pathology practices, through role differentiation and skill mix redesign. These changes make the most of the complementarity of specialist, technician, nurse, IT and other staff roles in the efficient delivery of laboratory services. There is not much scope for additional workforce substitution in pathology.

AAPP believes that strategies to support the health workforce into the future must recognise the complementary roles of all members of the health care team, and that the particular expertise of doctors as specialist health care professionals who carry much of the medico-legal responsibility for care must be more strongly supported as part of this process.

[14] Wagner EH (2000), The role of patient care teams in chronic disease management, *British Medical Journal* 2000;320;569-572.
[15] Grumbach K, Bodenheimer T (2004), Can Health Care Teams Improve Primary Care Practice? *JAMA.* 2004;291:1246-1251
[16] Casalino LP (2005), Disease Management and the Organization of Physician Practice, *JAMA.* 2005;293:485-488.