The Health Insurance Amendment (Pathology Requests) Bill 2010: the risks to patients when the Department of Finance and Deregulation makes health policy

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Patients need to make an informed choice about their pathology referrals

In February 2010, despite representations from the Royal College of Pathologists of Australasia (RCPA) and the Royal Australian College of General Practitioners (conveyed via letters, meetings and discussions), the federal government introduced legislation into Parliament to require all pathology request forms to be marked with the advice to patients that they may be taken to *any* pathology provider.[1] Pathology services underpin modern health care, playing a role in 70% of diagnoses and medical decisions.[2] The key concern of health professionals is that the "non directed" pathology referral will put patient safety at risk and undermine the quality of information that pathologists provide to patient care.

The proposed legislation arose from an interdepartmental review of pathology funding led by the Australian Department of Finance and Deregulation and is touted as creating patient choice.[3] However, from the health professional's perspective, the initiative may seem, at best, disingenuous.

Patients have *always* had the right to take part in choosing their pathology provider — as they do for other medical specialist referrals. Shared decision making between doctor and patient is the strength of the medical specialist referral system, and is of particular importance in making choices about pathology (the "invisible" medical specialty). Amending the request form with a clause advising patients that it may be taken to *any* pathology provider encourages patients to make the decision on their own, after they have left their doctor's surgery — thus making this a "patient choice" initiative that threatens fully informed choice.

Patients may infer from this government directive that it does not matter which pathology provider they use — that they are all the same. In fact, this is not the case. Although all pathology providers are required to meet a national standard of accreditation, they differ in the range of expertise of their pathologists and laboratory teams, their test catalogue and technologies, the content of reports, their second-opinion networks, their access to pathologists for advice, their turnaround times and notification of urgent results, and their after-hours services. Little of this variability may be apparent to patients, who may instead make their "choice" on the convenience of sample collection and price alone, without due regard to the nature of the pathology consultation their doctor sought or whether the important information will be effectively communicated to their doctor.

Patients may choose to shuttle between various pathology providers without understanding the effect this journey may have on the type and usefulness of information provided by pathology testing. For many diseases, a unique diagnostic opportunity arises from testing being carried out in one laboratory over the course of a patient's acute illness. Pathologists can integrate the findings of a range of tests over time to make a diagnosis and can identify disease progression, remission and recurrence earlier, and with more certainty, from a complete and continuous pathology record.

Patients with chronic diseases may understand the importance of serial pathology testing, but may not realise that the tests performed and their reference ranges may vary between laboratories, to the extent that the use of multiple pathology practices could compromise their doctor's efforts to monitor results and could even affect their treatment. Even laboratories that use the same reference ranges may use their own cumulative or graphical reports of test results to highlight changes in the control of common diseases such as diabetes and cancer and in warfarin therapy. Thus, significant changes in a patient's disease status may not be recognised if they are presented by a new pathology provider independently of previous data gathered on the patient.

Lastly, patients may not understand the effect that their independent choices about pathology providers may have on the communication and traceability of their results. The information required for critical decisions may be delayed or lost because the pathology practice cannot deliver reports to an unknown doctor and the doctor cannot pursue them because he or she does not know which practice the patient chose to attend. A large medical indemnity organisation has indicated that it will need to provide risk management advice to its members should this measure be implemented (David Nathan, Chief Executive Officer, Avant Mutual Group Limited, in a letter dated 3 November 2009 referring to an RCPA letter sent to medical indemnity insurers on 17 September 2009 to acquaint them with this measure).

Is this good health policy? Can it be good if it cuts across pre-existing good policy on quality, safety and connectivity (ie, delivery of medical information by information technology systems). The federal government seems intent on proceeding with this legislation, despite the establishment of a Senate inquiry into the risks it poses to patient safety.[4] Why is this? Why is the government seeking to interfere in and weaken the doctor's role in advising patients about their health care? If this is about patient choice, then surely patients would universally choose to be safe?

So, if it is not about patient choice, what *is* it about? By portraying pathology services to the Australian public as being all the same, with no distinction made between the levels of service or expertise offered by different providers, the Department of Finance and Deregulation would be sending a message that pathology is a commodity, to be bought at the lowest price. This premise could be used to justify fee cuts and tendering, both of which are on the federal government's radar.[5]

All Australians (including patients and doctors) need to be aware of the risk to patient care once the case has been made that pathology is a commodity rather than a medical service. This risk is not merely theoretical. In Ireland, after a recent government-led

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tender, all Pap smears from Irish women are now to be reported by a pathology service in the United States — effectively putting an end to training (and the destruction of competency) of Irish pathologists in this area of pathology.[6] In New Zealand over the past decade, tendering of pathology in each of the 21 district health boards has disrupted not only patient care but also the pathology workforce.[7]

There has already been significant government disinvestment in Australian pathology over the past 5 years, with the proportion of the Medicare dollar spent on pathology falling significantly despite a dramatic rise in test numbers over that period (Ed Wilson, Principal, EW Consulting P/L, personal communication). A further government review of pathology funding is underway.[5] It is aimed at saving more money and will bring us closer to the line beyond which funding is no longer sufficient to allow pathology practices to maintain the standard expected by Australian doctors and their patients. In recent years, this line has probably already been crossed in Canada, where chronic underfunding has been identified as a major cause of the widespread failure of diagnosis of breast cancer, with resultant government inquiries being conducted.[8]

The proposed changes to legislation cannot be justified on the spurious grounds that pathology is a commodity and that patients are being offered "choice", when in fact the choice already existed. If the federal government's agenda is to reduce funding for pathology services, it needs to take responsibility for its decision and the consequences of that decision for patient care.

Competing interests

I am an employee of Sullivan Nicolaides Pathology.

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