Australian Government

Department of Health and Ageing

REVIEW OF THE FUNDING ARRANGEMENTS FOR PATHOLOGY SERVICES

DISCUSSION PAPER

This paper has been prepared by the Department of Health and Ageing as a basis for consultation with pathology stakeholders. These consultations will inform the development of advice to the Minister for Health and Ageing, the Hon Nicola Roxon MP, regarding options for future funding of pathology services.

This discussion paper has been developed to guide consultation and discussion by providing an overview of some of the issues identified in respect of the current funding arrangements and to help identify possible alternative options for consideration. These options have not been endorsed by the Department of Health and Ageing, the Minister or the Australian Government.

Any queries in relation to the contents of this discussion paper can be directed to the Medical Benefits Reviews Task Group at mbrtg@health.gov.au.

Medical Benefits Reviews Task Group
Department of Health and Ageing
January 2010

REVIEW OF THE FUNDING ARRANGEMENTS FOR PATHOLOGY SERVICES

INTRODUCTION

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

2. This review will take place against the background of the Government's broader agenda to ensure that spending on health is sustainable, affordable and provides maximum benefit to the greatest number of people, which will involve continued emphasis on savings and efficiencies. The Government has decided to move away from price/volume agreements for the management of pathology expenditure. While there will no longer be an artificial cap on pathology expenditure under Medicare, the Government will closely monitor outlays to ensure that they remain consistent with projected expenditure.

3. The pathology review is taking place in the context of reviewing the Medicare Benefits Schedule (MBS). It will align with other review and reform agendas including the MBS Quality Framework, the Review of Health Technology Assessment, the Primary Care Strategy and the National Health and Hospital Reform Commission.

4. The review of pathology has 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.

5. The review will focus on pathology services currently funded through the MBS. The review will not examine issues around the requesting of and demand for pathology services, except where this is relevant in considering how services are funded.

6. The full Terms of Reference are attached.

7. The Department is aware that information about cost structures of providing different types of pathology services, general and specific industry structures, and the clinical requirements of different patient groups, is not captured through existing Medicare data and must be obtained from other sources.

8. The options suggested in this paper are intended to stimulate discussion and to encourage stakeholders to propose additional options for the future.

9. Following consultation with stakeholders and careful analysis, the Department will provide the Minister for Health and Ageing with options for consideration by Government. It is expected that the Government's decisions in response to the review will be reflected in the 2011-12 Budget.

Consultations

10. The Department will undertake an extensive consultation process. These consultations will be largely seeking to gather information about how current arrangements operate in practice and to invite stakeholders to propose options for the future.

11. A Pathology Review Consultation Committee will be established. This Committee will comprise representatives of the following groups:

- Australian Association of Pathology Practices;
- Royal College of Pathologists of Australasia;
- National Coalition of Public Pathology;
- Australasian Society of Anatomical Pathologists;
- Consumers Health Forum;
- Royal Australian College of General Practitioners;
- Australian Medical Association;
- Australasian Association of Clinical Biochemists;
- Australian Institute of Medical Scientists;
- Australian Society of Microbiology;
- Human Genetics Society of Australasia;
- Haematology Society of Australia and New Zealand;
- Australian Society of Cytology;
- Australasian Society of Clinical Immunology and Allergy;
- IVD Australia; and
- Department of Health and Ageing (both the Medical Benefits Reviews Task Group and Diagnostic Services Branch).

The Committee will also include the Chairs of the following advisory bodies:

- National Pathology Accreditation Advisory Council - Prof Leslie Burnett;
- Quality Use of Pathology Committee - Dr Michael Harrison; and
- Pathology Services Table Committee – Mr Scott Jansson.

Written Submissions

12. Stakeholders are invited to provide written submissions addressing all, or selected, issues raised in this discussion paper, by **30 April 2010**. Submissions received will be made publicly available unless confidentiality is specifically requested and justified. Submissions made to the 2008 strategic review of pathology will be taken into consideration as part of this review process. Written submissions should be sent to the following address:

Pathology Review
Medical Benefits Reviews Task Group
Department of Health and Ageing
MDP 153
GPO Box 9848
CANBERRA ACT 2601

13. For further information regarding this discussion paper or to arrange a bilateral meeting to discuss any aspect of the review please contact the Medical Benefits Reviews Task Group at: mbrtg@health.gov.au

Further Consultations

14. A second discussion paper, to be released in mid-2010, will outline the results of this information gathering and analysis phase and will identify a range of possible options. Stakeholders will be provided with an opportunity to comment on these options at that time.

1. FEE RELATIVITIES ACROSS PATHOLOGY DISCIPLINES

Background

15. Since 1996, there have been several Memoranda of Understanding (MoU) agreed between the Government and the pathology sector. These price/volume agreements involved seeking to achieve a fixed target rate of expenditure growth by changing rebates where service volumes fell outside agreed thresholds. The last MoU expired at the end of June 2009 and the Government decided that it will no longer use MoUs for managing pathology expenditure.

16. These MoUs were a method for Government to extract a share of efficiencies that it considered were possible in the pathology sector. The need for the sector to manage within the MoU spending caps was a driver in increased efficiency in the sector, achieved through a range of changes including industry consolidation, centralisation and automation to generate economies of scale.

17. It has been suggested that the increased efficiencies and economies of scale associated with high volume tests and centralisation that facilitated increased efficiency through industry consolidation have not impacted evenly across the different disciplines of pathology. Some areas of pathology, such as anatomical pathology, while gaining some benefits from automation of specimen preparation, continue to be largely dependant upon individuals examining specimens and using clinical judgement to diagnose disease.

18. The Department will examine these differences with a view to advising Government about options for funding. This will include looking at areas the pathology sector has raised as particular concerns, such as the "episode cone" described in Rule 18 of the Pathology Services Table.

19. In preparing options for consideration, the following information will be sought.

<u>Common Core Requirements to Maintain High Quality Services</u>

20. The review will be seeking information about what are the common minimum requirements for all disciplines to continue to offer high quality pathology services, in terms of workforce, capital infrastructure, laboratory needs, accreditation, specimen collection and transport services, information technology etc. For example:

- What resources are common to all areas of pathology testing?
- How many pathology services can a single FTE pathologist provide in one discipline compared to each of the other disciplines?
- How many pathologists are needed to run an efficient pathology laboratory service in each discipline?
- How many scientists or other technical staff are needed to run an efficient pathology laboratory service in each discipline?
- To what extent are there economies of scale for different kinds of pathology services and for individual episodes of pathology?

Additional Requirements for each Discipline

21. The review will seek to determine to what extent are the requirements different or the same across the various disciplines of pathology, different pathology tests and different patient groups. For example:

- Where and why are resource needs significantly different between different kinds of pathology testing?

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

22. Previous submissions to the Department have indicated that some tests may be over-remunerated due mainly to improvements in work processes and automation, while others are under-remunerated, and that the MBS needs to be adjusted accordingly. To verify this, the Department will examine each discipline group to determine:

- What is distinctive about each group of services?
- Are there any generalisations that can be made about the way these services are provided, the patients who need them, how the specimens are collected etc?
- Are there any services in the P-Groups that are exceptions, for example because of the way the test is performed, the patient group, the specimen collection or some other reason?
- Do laboratories generally provide these services in the same way, or are there significant differences between laboratories?
- What are the elements that contribute to the cost of providing each service?
- Do services claimed against a particular MBS item generally involve similar costs, or are there circumstances where the costs would vary?
- To what extent are there economies of scale when multiple services are provided in an episode?
- Are there factors that are outside the laboratory's or pathology provider's control that affect the cost of providing these services?
- Are there any aspects of current MBS items or rules that could be improved to better accommodate the specific nature of these services?

23. Does the source of the request have any impact on the complexity or cost of different pathology services? For example:

- Are there particular medical specialties that need or expect a different approach to pathology services for their patients?
- Are there economies where pathology services are requested by doctors working in vertically integrated services that include both primary care and pathology?

What are the consequences if the current relativities are not appropriate?

24. If you consider some current fee relativities are not appropriate, the Department is interested to hear your views. For example:

- What are the consequences of having inappropriate fee relativities?
- Are there aspects of current funding relativities that lead to distorted incentives, unintended consequences or poor outcomes for patients?
- How have the costs of each element changed over the past 5-10 years?

- What evidence is there to support a change to relativities?
- Could any suggested changes be made quickly or would there need to be incremental change over several years?

What factors should be considered in deciding on appropriate MBS fees for pathology services?

25. The Pathology Services Table Committee (PSTC) has developed a formula to assist it to estimate the appropriate MBS fee for some items. The formula takes into account the resources required (staff time, infrastructure/on-costs etc) and consumables and allows for an operating/profit margin. Is there potential to further develop this formula as a tool for determining all pathology MBS fees? For example:

- What factors would need to be included in the formula?
- How would this vary between disciplines?
- How would improved work practices be incorporated into the formula?
- How could increased automation or other efficiencies of a test be factored into the formula?
- How regularly would the formula need to be reviewed to remain relevant?
- Is there scope to regularly review all pathology MBS fees based on an agreed formula?

The "Episode Cone"

26. Any decision on pathology financing arrangements will need to take into account the impact of the "episode cone". The term "episode cone" (described in Rule 18 of the PST) describes an arrangement under which Medicare benefits payable in a patient episode for a set of pathology services, containing more than three items, ordered by a general practitioner for a non-hospitalised patient, will be equivalent to the sum of the benefits for the three items with the highest MBS fees. Coning was introduced in July 1995 with the agreement of pathology stakeholders, to try to address concerns about the inducement of referrals for unnecessary tests. There are some items exempt from this rule and it does not apply to tests ordered by specialists.

27. Stakeholders have consistently argued for the removal of the episode cone on the grounds that they absorb the costs of tests requested by general practitioners. Some providers claim that the episode cone costs providers more than 10% of income.

28. What pathology services are currently affected by the cone that applies to requests from GPs?

- How is this changing over time?
- Are there common combinations of services in a pathology episode that are subject to coning?
- What would be the cost to the Commonwealth if the cone was removed?
- What would the cost be if the MBS paid for the first four (or more) items in an episode instead of three as is the case now?

2. ALTERNATIVE / BETTER TAILORED FUNDING ARRANGEMENTS

Background

29. The MBS is long-established, well-understood, and efficiently administered. Under MBS arrangements for pathology, the Commonwealth is a monopsony purchaser, fixing a floor price for services and assisting some patients to pay prices they might otherwise not be able to afford. The MBS pays fixed rebates to all providers who can meet minimum requirements and there can be little competition on price.

30. As a result of the MoU arrangements, pathology fees have not increased annually based on indexation like most other areas of the MBS. The impact of this and cost consequences of applying indexation-based increases to pathology fees will be considered in the review.

31. The review will consider alternative approaches to funding other than fee-for-service under Medicare and seek to identify any specific areas or disciplines of pathology that might be more appropriately supported through a different financing arrangement. The review will consider international experience with different funding mechanisms, including the New Zealand experience of using a sole provider through the tendering of pathology services.

32. The review will need to consider general issues such as:

- What would be the advantages, disadvantages and risks of adopting different financing arrangements?
- How could alternative approaches to financing be implemented, while maintaining access to high quality pathology services? What transitional arrangements would need to apply?
- What would be the effects of having some segments of pathology subject to fee-for-service arrangements and others subject to different funding arrangements?
- Are there examples of pathology services in Australia that are currently funded through arrangements other than fee-for-service?
- Are there aspects of current funding arrangements that lead to distorted incentives or unintended consequences?
- Are there any implications of the current concentration of the pathology sector? What elements of current funding arrangements have contributed to this concentration?
- What affects might moving to different kinds of funding arrangements have on competition?

OPTIONS FOR DISCUSSION

Tendering

33. Tendering would involve setting out the expected number, kind and quality standards for particular categories of services and inviting competitive bids from providers.

34. There are a number of approaches that could be considered:

1. Single supplier arrangements;
2. Specialised supplier arrangements; and
3. Multiple supplier arrangements.

35. Although cost would be the main consideration in a competitive tender process, aspects of quality, such as predicted turn-around times for providing test results and the level of patient access achieved at that cost could also be used as criteria for selecting one provider over another.

Single supplier arrangements

36. The successful bidder would generally have a monopoly over the supply of the specified services for a fixed period.

37. Detailed requirements would need to be developed, covering the level of service, timeliness of results and quality required for particular services and areas. Developing a tender process would involve complex legal, contractual and economic analysis of particular pathology markets.

38. There are a number of ways tendering could operate. The Commonwealth could contract pathology services directly through pathology providers on the basis of competitive bids. Services could be tendered on a fee-for-service basis or per capita. Providers could tender individually or they could group together to provide a more comprehensive service.

Specialised supplier arrangements

39. Another approach would be to tender for more specialised, complex low volume tests (only) which may provide an opportunity for smaller niche providers to be competitive in the market place. Smaller laboratories would have a greater capacity to compete in these areas where professional input and expertise is more important than access to capital to establish efficient processes for high volume testing.

Multiple supplier arrangements

40. To avoid a monopoly arrangement, open tendering could be undertaken whereby any tenderer who met mandatory criteria, including pricing criteria, could be a successful tenderer. Alternatively, the two or three tenderers with the lowest bids could be awarded the tender, either at the price bid, or at a price set by reference to the other successful tenders (for example, the tender could be awarded to the two lowest bidders, at the price proposed by the second lowest bid). Pricing criteria could consider competitive neutrality in order to level the playing field between public/private providers, as well as large corporations and independent pathologists.

41. The review will consider:

- What segments of pathology services would be more feasible to tender?
- What would be the advantages, disadvantages and risks of tendering different segments?
- How would the transition to new arrangements be handled?
- What problems could be expected in the first stages of any new arrangement? (The New Zealand experience is particularly relevant.)

Component Payment

42. Similar to the MBS relative value guide (RVG) arrangements for anaesthetists, a component payment model could be considered for pathology. Under anaesthesia arrangements, relative payments are made for components of:

- Initiation of management of anaesthesia (fee according to service and category of service);
- Time taken (unit-based element); and
- Modifying units based on complication factors (physical status, emergency, age etc.).

43. Similarly, under pathology arrangements, relative payments could be made for components such as:

- Complexity of service and reporting (higher payment for manual intervention scaling to lower payment for automated testing);
- Capital/equipment; and
- Professional intervention (which could include training and supervision).

Performance-Based Payments

44. In addition to fee-for-service payments, it may be possible for pathology services to attract performance-based incentive payments. While it is recognised that existing quality arrangements for pathology in Australia are world-class, there may be other elements of pathology services that would be appropriate for this type of incentive model, for example, the timeliness of pathology results/reports returned to the requester. Issues that would need further consideration would include:

- How would 'appropriate' turn-around times for pathology results be determined for each test/group of tests?
- What other elements of pathology could be improved with incentive payments?
- How would benchmarks be established?
- How would payments be made and how frequently?
- How would data be collected to measure performance?
- Should clinical indicators be established?
- Would the administrative burden of managing this type of arrangement outweigh benefits?

Different Rates of Medicare Payments based on Professional, Medical or Technical Input

45. Establishing the best use of clinical expertise across all staff directly involved in the provision of pathology services, and then using this as a basis for ensuring staff are used in the most efficient and effective way may provide another avenue upon which fees could be based. Separately remunerating the medical and technical components of pathology testing would recognise the different levels of training and expertise required to supervise and perform different types of testing, interpret results and consult with clinicians.

46. If services performed by pathologists could be separated from those performed by technical and scientific staff, there would be the potential for two forms of payment:

- Continuation of the current benefit arrangement for pathology services subject to detailed input by the pathologist; and
- Where detailed input from the pathologist is only required for outlying results, continuation of benefit arrangements for the pathologist input but a separate direct service payment for the automated test from the Commonwealth to the pathology provider.

47. The review will consider:

- Is it feasible to separate the payments on this basis?
- How would the different rates be determined?

Greater Pathologist Involvement in the Diagnosis Process

48. An additional form of payment could also be considered. To encourage greater involvement by pathologists in the clinical diagnosis of patients, a fee could be included on the MBS to allow the pathologist to be consulted by the referring doctor on the most appropriate test for a particular condition. Alternatively, a request from a medical practitioner could simply ask for the most appropriate tests for a suspected illness/disease, leaving the pathologist to determine what the appropriate tests would be. This would allow the expertise of pathologists to be fully utilised, the correct test(s) to be undertaken with potentially better outcomes for the patient. It should also result in less inappropriate tests being undertaken. Rules and restrictions on tests would need to be in place to ensure over-servicing would not occur.

49. The review will consider:

- If it is feasible to involve pathologists more in the clinical diagnosis process and any cost implications of doing so
- What impact would this approach have on requesting medical practitioners and would it meet their needs in terms of patient care?

Funding for Capital Equipment

50. In general, the MBS includes any relevant capital costs in the rebate for each item, although over time the relative share of capital and other costs has become quite opaque. In any area with significant capital costs, this can create distortions. MBS items are not adjusted to reflect whether capital investment has recently occurred or whether equipment is fully depreciated. As a result, the cost of capital may be over-compensated, if fully depreciated equipment remains in service generating the same level of income. Conversely, if over time equipment prices fall or new technology enables services to be provided more efficiently, then newer equipment may be over-compensated by fixed MBS rebates.

51. The review will consider the following questions in relation to capital equipment:

- How significant is capital expenditure for different kinds of pathology?
- What alternative means could the Government use to assist the funding of capital equipment?
- If capital equipment were funded through different mechanisms, what implications would this have for current funding arrangements?

Public/Private Laboratory Mix

52. What roles should the public and private sectors be playing in providing pathology services?

- Is the current balance about right, or is there a need for change?
- Does the public sector provide a high proportion of the less profitable, complex services?
  - If so, is this appropriate?
  - Is there evidence to support this?

3. PATIENT ACCESS TO PATHOLOGY SERVICES

Background

53. Any proposed changes to pathology arrangements must, at a minimum, ensure that the existing level of access for patients is maintained. The Department will, as part of the review, examine whether there are ways to improve access to pathology services, particularly in rural and remote areas.

54. The review will seek to determine:

- How effectively are current arrangements contributing to patient access to appropriate pathology services and to better health outcomes?
- Is there an appropriate role for patient co-payments in funding pathology services?
- Pathology services are eligible for Medicare rebates only when requested by a medical practitioner. How much influence do/should patients have over pathology requesting?
- Are there patient groups whose needs are not being met by current arrangements? For example, patients with particular chronic diseases, in geographical areas, or Indigenous patients? Would point of care testing be beneficial for particular groups of patients?
- Are there patient groups that currently do not have sufficient access to pathology services? Why?
- Are there patient groups that are currently over-serviced? Why?

55. There are two recent Government initiatives that are relevant here.

<u>Restrictions on Pathology Collection Centres</u>

56. The placement of pathology collection centres obviously impacts on patient access. Currently, the government restricts the maximum number of collection centres that each pathology provider can operate. From 1 July 2010 these restrictions will be removed. This means that in future, the operation of collection centres will be a business decision for each provider and will not be restricted by a government imposed quota. The review will seek to determine whether this change is likely to improve access for patients.

<u>Point of Care Testing</u>

57. Point of Care Testing (PoCT) is the term used to describe pathology testing undertaken outside a laboratory environment as part of a health care consultation. It usually involves the use of small (sometimes hand-held) automated testing machines that contain the appropriate reagents and measuring devices. These procedures produce a test result “on the spot” after the insertion of a specimen (eg. blood or urine). This type of testing is increasingly being used in health care settings and in other community settings, particularly for the monitoring of chronic health care conditions such as diabetes and cardiovascular disease. PoCT is currently used for a limited, but increasing, range of tests.

58. PoCT is not currently funded under the MBS unless the provider and the laboratory are covered under national pathology accreditation arrangements, including the Category M laboratory arrangement for the provision of pathology testing by general practitioners in their surgeries.

59. The Department funded a trial of PoCT to determine its safety and effectiveness in the GP setting. Whilst the results are still being considered by the Government, PoCT potentially offers improved access to pathology services as the patient is no longer dependant on having access to a collection centre or laboratory for a limited range of tests. The potential impact on patient access of publicly funding GP PoCT will be considered as part of the review. For example:

- What would be the likely take-up of PoCT by GPs if it were to be listed on the MBS?
- How would this impact on patients in terms of reduced visits to collection centres or laboratories?

4. OTHER OPTIONS

Background

60. There may be a number of other alternative options that could be considered for the funding of pathology services. While these options need further development, views of stakeholders are invited.

Episodic Payments

61. Episodic payment can be an appropriate method of payment for a number of different treatment types, including some hospital in-patient episodes:

- Should episodic payments be considered for pathology?
  - If so, for which types of services?

Rewards for Innovation

62. A rewards-based payment framework could be established for non-clinical achievements. Examples of this could be: servicing under-serviced locations; participation in clinical training placement programs; and other areas of innovation.

- How would this type of program be measured/developed/remunerated?
- Who would assess the achievements?
- What impact would this have on other programs?

The Department welcomes comment on any of the suggestions included in this paper. In addition, stakeholders are encouraged to provide additional information or options for consideration.

Medical Benefits Reviews Task Group
Department of Health and Ageing
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