Ms Rosemary Huxtable PSM & Mr Michael Walsh PSM
Independent Reviewers
National Health Reform Agreement Mid-Term Review
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2 June 2023

Dear Ms Huxtable and Mr Walsh

NHRA Mid-Term Review

Public Pathology Australia (PPA) thanks the Review Team for allowing us to make a submission to the Mid-Term Review of the National Health Reform Agreement Addendum 2020-25 (the NHRA). We provide the following response from the lens of public pathology services which provide services funded under the NHRA and the Medicare Benefits Schedule (MBS).

Key Points

While the objectives of the NHRA are appropriate, there is a lack of specificity as to actions required to be taken and there is still a tendency to cost shift and try to move responsibilities to the other jurisdiction rather than working together on common solutions which could be achieved under the NHRA. Policy and practice could be improved to deliver on NHRA objectives. Funding could also be improved to reflect a more equitable split, eliminate competitive advantages and to cover the full cost of services in rural and regional hospitals to improve equitable access to healthcare for all Australians.

1. High level overview on whether the objectives of the NHRA are being met

It may be said that the objectives of the NHRA are being met, however detailed actions in a schedule to the NHRA must be specified in order to:

- improve equitable access to healthcare for all Australians;
- remove incentives to cost shift;
- ensure the health system will have the required health workforce in place;
- establish a nationally cohesive health technology assessment program;
- detail how a transition to value-based healthcare and outcomes will be achieved;
- enhance health data management and application; and
- ensure appropriate funding for small rural and regional health services (including pathology).

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2. Impact of external factors (such as the COVID-19 pandemic) on the demand for hospital services and the flow-on effects

COVID-19 has had a long lasting impact on the community and health system. In pathology, services quickly upscaled and adopted new technology to meet testing and reporting demands. We have had to de-scale and repurpose equipment and staff as case numbers ebb, but still maintain capacity in the event that we need to upscale to meet a wave of new cases.

The NHRA was not the chosen funding mechanism for the pandemic, rather the Commonwealth and States and Territories entered into National Partnership Agreements (NPAs) which reflected 50/50 cost share arrangements. While a 50/50 cost share agreement is an equitable way of funding, the Commonwealth reduced MBS fees for public pathology testing services despite MBS being the sole responsibility of the Commonwealth. The Commonwealth did not discount services provided by other medical specialties. This led to cost-shifting as outlined in section 5 below.

Consideration should be given as to a 50/50 cost share arrangement between the Commonwealth and the States/Territories for in-patient activity which falls under the auspices of the NHRA.

There also should be standardised Federal Funding Agreements under common terms and funding models agreed to under the auspices of the NHRA. It would boost government confidence if it was mandated that rates were examined with reference to public sector costs. This would have avoided the differing payment rates that occurred during the pandemic as identified in section 5.

The NHRA should be amended to better reflect the Commonwealth's responsibility with respect to the MBS and to ensure it reflects contemporary medical practice. In pathology, the MBS has not been updated to reflect current clinical practice. For example, pathology services have been using PCR based tests to diagnose different conditions for some time but the MBS has not been amended to reflect this.

In areas where there are difficulties in delivering or funding health care, the public health sector meets community need and this is to be funded through the NHRA. However, MBS activity in non-profitable clinical disciplines or geographic regions should not be treated as a state funded Community Service Obligation (CSO). Commonwealth funding arrangements should address this and CSOs should be reviewed to ensure equitable access to health services for all Australians.

3. Performance of small rural and small regional hospitals

Medical pathology services are critical to the functioning of all hospitals. In rural and regional areas, it is imperative to have a laboratory located in the hospital to ensure emergencies and other cases are handled on site. It costs more to perform pathology tests in rural and regional laboratories. However, local laboratories improve turn-around times for results and means clinical decisions can be made faster.

The funding model for rural and regional hospitals need to be amended. Specifically, there needs to be a new funding model for pathology testing in rural and regional areas. Funding should follow the continuity of care; from the community to in-hospital/outpatient and then back to the community. This is not the case currently. Community pathology testing is funded under the MBS, while inpatient testing is funded by the States/Territories via the NHRA.

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Public pathology MBS rates are insufficient to cover the cost of testing patients in the community in rural and regional laboratories. Public pathology providers receive lower episodic fees compared to private pathology providers. This means that where a hospital service has a privatised pathology service (which is funded under the NHRA), the private pathology provider can access higher MBS rates for non-inpatient services than a public pathology provider. Unequal funding arrangements via the MBS distort the market and mean that pathology is not funded in a competitively neutral way.

A solution to the funding issue would be to increase rural and regional hospital block funding arrangements to cover for the cost of pathology testing in the community. Alternatively, a new rural and regional incentive MBS item could be introduced for local testing. This could be modelled from the general practice of diagnostic imaging rural items.

4. Implementation of the long term reform and other governance and funding arrangements (and whether practice and policy delivers on the NHRA objectives)

The NHRA refers to teaching and training but the NHRA is bereft of how this should be delivered and respective Commonwealth/State responsibilities. PPA, together with Royal College of Pathologists of Australasia, has made a separate submission to the NHRA Mid-Term Review on the matter of workforce and specialist training.

There remains a need to establish a nationally cohesive Health Technology Assessment (HTA) program. While referenced in the NHRA, comprehensive overhaul of the HTA program has not been achieved. We note there is a HTA Review process on foot as negotiated with Medicines Australia but this may not be holistic and cover all HTAs / Medical Services Advisory Committee processes as it is focused on processes associated with the Pharmaceutical Benefits Advisory Committee.

The NHRA needs to mandate that all jurisdictions must disinvest in low or no value based care. In pathology, while the MBS Pathology Services Table has been added to over the last two decades, there has been no substantial changes in the Pathology Services Table and it has not kept pace with modern clinical practice. Unlike other medical specialities, the Pathology MBS Review recommendations have not been implemented and the full Pathology Clinical Committee recommendations have not been put on public record. While public inpatient activity in pathology falls under the NHRA, inpatient test menus and charging structures in some jurisdictions are based on the MBS and so the MBS does influence inpatient services under the NHRA.

There should be mandated reforms in enhanced health data management and application rather than a vague reference to the same. The NHRA could enshrine interaction between the Australian Digital Health Agency (AHDA), the Commonwealth and the States and Territory Health Departments to enact the National Digital Health Strategy. Enhanced health data is recognised as an enabler in the NHRA (C42) but the ADHA is not recognised as a national body (in Schedule B – National Bodies).

In pathology there could be a National Digital Pathology Strategy which could include targets to increase uploading of medical reports to the My Health Record, strategies to improve data collection (including for MBS activity), establishment of a national electronic requesting repository, increased interoperability of health IT systems and adoption of Artificial Intelligence Guidelines.

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5. Unintended consequences such as cost-shifting, perverse incentives or other inefficiencies that impact on patient outcomes

Commonwealth and State/Territory funding to test for COVID-19 was essential during the pandemic. However, funding arrangements from 2020 until 31 December 2023 have perverse incentives to cost shift to the private pathology sector; with the private pathology sector receiving double the amount of MBS rebates for COVID-19 tests compared to the public pathology sector.

The arrangements negotiated between private pathology providers for non-MBS COVID testing and claimed under the NPA may not have reflected the cost of the tests. Contract pricing may have also varied between jurisdictions. Public pathology providers tested for COVID-19 at cost under the NPA.

There must be equitable payment to all pathology providers to reduce incentives to cost shift to the MBS and private sector. Pathology providers should receive the same fee for the same test and this fee should reflect the cost of the test. This will reduce incentives to cost shift and ensure governments receive the best value for money for pathology.

6. Whether NHRA remains for-for-purpose given shared priorities for better integrated care and more seamless interfaces between the health, disability, and aged care sectors

Funding does not follow the patient journey and is fragmented between NHRA, MBS and the NPA during the pandemic. This provides avenues to cost shift as mentioned above.

Private pathology providers receive significantly more per pathology episode to service residents in aged care facilities (RACFs) compared to public pathology providers. In addition, the Commonwealth contracted one private pathology provider to conduct COVID-19 testing in all RACFs which effectively monopolised this service. This had catastrophic consequences during the pandemic when the private pathology provider could not manage the volume of testing required (e.g. St Basils COVID outbreak). Fortunately, the public pathology sector stepped in to test for COVID-19 at some RACFs (e.g. Dorothy Henderson and Newmarch House outbreaks). Had this been under usual funding arrangements (i.e. the MBS), the State would have had to subsidise this testing as the public sector receives inadequate MBS funding for every RACF pathology episode compared to the private pathology sector.

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7. What would make it easier for Australians to access healthcare and relieve pressure on our public hospitals?

The following would make it easier for Australians to access healthcare, relieve pressure on our public hospitals, improve sustainability of service provision and value for money:

a) Changes to the MBS Pathology Services Table so that it is competitively neutral. Public pathology is the only medical speciality sector penalised under the MBS with lower fees. Adjustments need to be made to Respiratory (COVID) Nucleic Acid Amplification PCR MBS fees, Patient Episode Initiation fees (for all collection types including those in residential aged care facilities) and pathology Bulk Billing Incentives fees.

b) A new funding model for remote/rural/regional pathology service provision by increasing the amount of block funding to rural/regional hospitals for community testing or an incentive payment for providers who collect and test in certain Modified Monash Model areas under the MBS.

We invite you to reach out to PPA CEO Jenny Sikorski (0466 576 221, ceo@publicpathology.org.au) to discuss this submission further.

Yours faithfully

Dr Petra Derrington
President

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