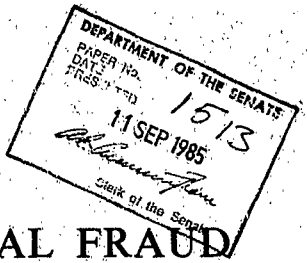

MEDICAL FRAUD AND OVERSERVICING— Pathology

Report

236

Joint Committee of Public Accounts

Parliament of the Commonwealth of Australia 1985

JOINT COMMITTEE OF PUBLIC ACCOUNTS
REPORT 236

INQUIRY INTO MEDICAL FRAUD AND OVERSERVICING : REPORT ON PATHOLOGY

ABBREVIATIONS

AFP	-	Australian Federal Police
AIH	-	Australian Institute of Health
APP	-	Approved Pathology Practitioner
AMA	-	Australian Medical Association
CROMP	-	Central Register of Medical Practitioners
DoH	-	Commonwealth Department of Health
DOP	-	date of processing (see note on statistics)
DOS	-	date of service (see note on statistics)
DPP	-	Director of Public Prosecutions
DRS	-	Doctors Reform Society
DVA	-	Department of Veterans' Affairs
FODS	-	Fraud and Overservicing Detection System
GPS	-	General Practitioners Society of Australia
HIA	-	Health Insurance Act
HIC	-	Health Insurance Commission
HP	-	hospital pathologist (Medicare benefit rate)
LMO	-	Local Medical Officer
MBS	-	Medicare Benefits Schedule
MSCI	-	Medical Services Committee of Inquiry
NATA	-	National Association of Testing Authorities
NPAAC	-	National Pathology Accreditation Advisory Council
NSQAC	-	National Specialist Qualification Advisory Committee
OP	-	other pathologist (Medicare benefit rate)
PAC	-	Public Accounts Committee
RACR	-	Royal Australian College of Radiologists
RCPA	-	Royal College of Pathologists of Australasia
SP	-	specialist pathologist (Medicare benefit rate)

THE PARLIAMENT OF THE COMMONWEALTH OF AUSTRALIA

JOINT COMMITTEE OF PUBLIC ACCOUNTS

236TH REPORT

MEDICAL FRAUD AND OVERSERVICING INQUIRY: REPORT ON PATHOLOGY

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Section 8.(1) of the Public Accounts Committee Act 1951 reads as follows:

> Subject to sub-section (2), the duties of the Committee are:
>
> (a) to examine the accounts of the receipts and expenditure of the Commonwealth including the financial statements transmitted to the Auditor-General under sub-section (4) of section 50 of the Audit Act 1901;
>
> (aa) to examine the financial affairs of authorities of the Commonwealth to which this Act applies and of intergovernmental bodies to which this Act applies;
>
> (ab) to examine all reports of the Auditor-General (including reports of the results of efficiency audits) copies of which have been laid before the Houses of the Parliament;
>
> (b) to report to both Houses of the Parliament, with such comment as it thinks fit, any items or matters in those accounts, statements and reports, or any circumstances connected with them, to which the Committee is of the opinion that the attention of the Parliament should be directed;
>
> (c) to report to both Houses of the Parliament any alteration which the Committee thinks desirable in the form of the public accounts or in the method of keeping them, or in the mode of receipt, control, issue or payment of public moneys; and
>
> (d) to inquire into any question in connexion with the public accounts which is referred to it by either House of the Parliament, and to report to that House upon that question,
>
> and include such other duties as are assigned to the Committee by Joint Standing Orders approved by both Houses of the Parliament.

PREFACE

This report details further findings of the Committee's inquiry into medical fraud and overservicing. In focussing on the accountability for Commonwealth Medicare benefits for pathology services it complements the Committee's earlier Progress Report on Medical Fraud and Overservicing (Report 203) and the Response to Report 203 (Report 212).

Since the commencement of this inquiry in early 1982 evidence has come before the Committee indicating that one particular area of medicine - pathology - has been, and is, growing very rapidly in terms of the services rendered, Commonwealth benefits paid and number of providers. Many serious concerns about pathology have been expressed to the Committee by the major medical associations, senior Commonwealth administrators, the Royal College of Pathologists of Australasia, pathology corporations, specialist pathologists, other practitioners (specialist and general) and patients.

In general these concerns have related to two broad areas:

- the changing nature of the pathology industry in Australia; and
- difficulties with and deficiencies in the Commonwealth's administration of the Approved Pathology Practitioner scheme, the Medicare Benefits Schedule and other associated responsibilities related to the Health Insurance Act.

In preparing this report the Committee has been mindful of discharging not only its traditional duty related to the scrutiny of public monies and the Commonwealth's administration but also of its duty to report to Parliament associated concerns and information.

Hence this report:

- provides some insight into the nature and oligopolistic structure of the pathology industry;
- reviews the administration of the Approved Pathology Practitioner scheme, noting areas where policy changes may need to be considered;
- analyses the issues surrounding the dominance of SP (specialist) benefit payments over OP (other) benefit payments;
- examines the pathology aspect of the Health Insurance Commission's recently acquired responsibility for reviewing Medicare claims;
- recommends the immediate review of all pathology practitioners and their laboratories for accreditation; and

- discusses some implications of 'entrepreneurs' infiltrating the industry.

The Committee is most concerned about the variety of serious problems - in both the Commonwealth's administration and in the pathology industry - that are yet to be overcome.

While the recommendations of this report will go some way towards improving matters Government policy initiatives and action in the pathology area are required. The Committee believes the profession is well aware of most of the problems detailed in this report and is anxious to improve the situation. The continued development of co-operation and consultation between the profession, the Minister and the Commonwealth's administration is essential if improvements are to be made in this area.

This report is intended to cover only those aspects of the Committee's inquiry into medical fraud and overservicing that relate to pathology. Following the Minister's decision in March this year, in concurrence with the Committee's advice, to disband the Surveillance and Investigation Division of the Department of Health and to shift responsibility for review of Medicare claims to the Health Insurance Commission, the Committee believes that many of the significant problems related to the Department of Health's administration being examined in this inquiry may be resolved.

The Committee expresses its sincere thanks to Mrs R J Kelly, MP who chaired the Sectional Committees for this inquiry since 1983. The Committee also thanks the members of its Secretariat for the support given to this reference.

For and on behalf of the Committee.

Senator G Georges
Chairman

M J Talberg
Secretary
Joint Committee of Public Accounts
Parliament House
Canberra
23 August 1985

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ABBREVIATIONS

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RCPA	-	Royal College of Pathologists of Australasia
SP	-	specialist pathologist (Medicare benefit rate)

NOTE ON HIC STATISTICS

The following information has been provided to the Committee by the HIC for clarification of the terms 'date of service' (DOS) and 'date of process' (DOP) as they relate to HIC computer generated data.

'Date of service data' (DOS)

Refers to data collated by the actual date of service which appears on a provider's account or receipt used in support of a claim for Medicare benefits.

'Date of process data' (DOP)

Refers to data collated by the actual date on which a claim is processed through the Medicare on-line system.

In reports based on date of service and date of process, the actual day, month and year are used as the basis for the collation of data. In both cases the day component begins and ends on consecutive midnights.

Reports of services performed by 'date of service' or 'date of processing' for the same period will show different values. The reason for this is the time lag it takes claimants to lodge claims and for those claims to be processed. As there are different lags for different types of claims (17 days for direct bill, 40-67 days for cheque claims and 28 days for cash claims) the amount of difference between reports for a given period will depend upon the billing practice of the doctor and how far back in time you are looking. The further back in time that the analysis is done, the less the difference.

SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

Introduction - statistics (Chapter 1)

The Committee concludes that:

Pathology benefits are a significant and growing segment of Medicare expenditure which should be fully accounted for.

There is legitimate cause for concern about some aspects of the nature of growth in pathology benefits, services and providers pre and post Medicare.

The private pathology industry in Australia appears to exhibit oligopolistic characteristics, i.e. a small number of large pathology groups provide the majority of services.

With the commencement of Medicare, and the Health Insurance Commission's provider claims review function, this Committee's and the Penington Report's concerns about the effective monitoring of medical services such as pathology should be addressed.

The APP scheme (Chapter 2)

The Committee concludes that :

The design and administration of the Department of Health Approved Pathology Practitioner scheme is grossly deficient and requires immediate reform.

The membership of the Approved Pathology Practitioner scheme is 'open-ended' and its potential membership is huge because of inappropriate eligibility criteria.

No regular, effective review of Approved Pathology Practitioners is undertaken or linked to Health Insurance Commission claims review monitoring.

There is no effective stimulus for Approved Pathology Practitioners to abide by the conditions of their Undertaking and its associated Code of Conduct.

The 'once only' $10 Approved Pathology Practitioner license fee is an immaterial amount which appears to engender derision and disrespect of the Commonwealth's administration of the Approved Pathology Practitioner scheme.

There is no requirement for Approved Pathology Practitioners to be accredited and to operate in a laboratory which has been reviewed as part of the Approved Pathology Practitioner's accreditation process, and/or only refer work to other pathology laboratories where work is personally supervised by other resident accredited Approved Pathology Practitioners.

Fee splitting of pathology services is encouraged by current legislative arrangements, these arrangements may foster overservicing and allow poor quality services to be rendered to patients unchecked.

The majority of professional pathologists and those allied to the profession appear to welcome the introduction of a high quality and nationally consistent pathology accreditation programme like that proposed by the National Association of Testing Authorities.

Professional bodies appear very concerned about the current state of the industry and wish to see a significant improvement in both medical practitioner attitudes and the Commonwealth's administration to ensure high standards of performance and to minimise opportunities for the provision of poor quality work.

It is desirable for Approved Pathology Practitioner status to be limited to natural persons such as recognised accredited specialist pathologists, accredited medical practitioners and certain accredited recognised scientists.

Current legal remedies to combat pathology fraud and overservicing based on the Medical Services Committee of Inquiry system are completely unsatisfactory, inefficient and need urgent reform.

The Committee recommends that :

1. Pathology tests for which Medicare benefits are paid must be performed in laboratories personally supervised by resident Approved Pathology Practitioners who are accredited for the Commonwealth by the National Association of Testing Authorities.

2. The Approved Pathology Practitioner eligibility criteria in the Health Insurance Act be amended such that pathology services may not be rendered 'for or on behalf of' an Approved Pathology Practitioner and that only natural persons can be considered for Approved Pathology Practitioner status and accreditation.

3. If a need for pathology services to be rendered 'for or on behalf of' an accredited Approved Pathology Practitioner can be demonstrated because of special conditions, e.g. geographical isolation, then Department of Health approval for the rendering of such services should be specific and appropriately constrained.

4. Approved Pathology Practitioner status be renewable annually after adequate administrative examination and review of the Approved Pathology Practitioner by the Department of Health, in conjunction with the Health Insurance Commission, and after consultation with the National Association of Testing Authorities about the adequacy of the Approved Pathology Practitioner's laboratory standards and organisation.

5. The Approved Pathology Practitioner Undertaking and associated Code of Conduct be immediately revised by the National Pathology Accreditation Advisory Council and thereafter kept under regular review by a sub-committee of the National Pathology Accreditation Advisory Council in consultation with the National Association of Testing Authorities.

6. The Approved Pathology Practitioner license fee be reviewed and made an annual fee of a material amount, linked to the scale of an Approved Pathology Practitioner's practice and sufficient to cover an appropriately apportioned element of the Approved Pathology Practitioner scheme's administrative cost.

7. All pathology laboratories operated by accredited Approved Pathology Practitioners be required to be examined as part of the National Association of Testing Authorities Approved Pathology Practitioner accreditation process under the terms recommended by the National Pathology Accreditation Advisory Council.

8. The National Association of Testing Authorities/Royal College of Pathologists of Australasia scheme be adopted for pathology laboratory inspection and assessment as part of an Approved Pathology Practitioner's accreditation renewal.

9. The Commonwealth ensure that its mandatory Approved Pathology Practitioner accreditation arrangements complement, or be satisfied by, similar existing State Government programs where applicable.

10. Commonwealth pathology accreditation legislation should be designed to introduce a national programme for those State and Territory governments currently lacking legislation.

11. Where States and Territories do not have pathology accreditation implementation programmes, the Commonwealth should offer to provide those programmes.

12. In the absence of State or Territory accrediting machinery, the Commonwealth's National Association of Testing Authorities based accrediting machinery should be employed.

13. Commonwealth inspection reports and recommendations obtained via the National Association of Testing Authorities system should be forwarded to State and Territory accreditation boards where constituted, and pro rata cost sharing arrangements be negotiated.

14. Service companies be permitted to provide premises, equipment and staff to accredited Approved Pathology Practitioners at commercial rates. All documentation specifying the conditions for the provision of such resources be available for inspection at the granting and annual renewal of Approved Pathology Practitioner status by the Department of Health in conjunction with the Health Insurance Commission.

15. The Health Insurance Act be amended specifically to prohibit fee splitting.

16. SP (specialist pathology) Medicare benefits be payable only to accredited specialist pathologists who are recognised by the National Specialist Qualification Advisory Committee.

17. OP (other pathology) Medicare benefits be available to accredited medical practitioners, and certain recognised accredited scientists.

18. OP (other pathology) Medicare benefits remain applicable to tests self determined by accredited recognised specialist pathologists.

19. Appropriate resources be devoted -

to the Health Insurance Commission to ensure continued development of its Medicare claims review systems;

to the Department of Health to permit the administration of the Approved Pathology Practitioner scheme to be significantly upgraded and maintained; and

to the National Association of Testing Authorities to enable it to accredit Approved Pathology Practitioners effectively.

20. As a matter of urgency, the existing Medical Services Committee of Inquiry system be replaced with a Medical Tribunal system along the lines of that originally recommended by the Committee in its 203rd Report.

21. After appropriate consultation with the medical profession, the Health Insurance Act be amended to ensure that the offences, recovery and disqualification provisions of the Act can be effectively and efficiently used to combat medical fraud, and where applicable, medical overservicing.

SP (specialist pathology)/OP (other pathology) Medicare benefits (Chapter 3)

In its examination of SP (specialist pathology)/OP (other pathology) Medicare pathology benefits the Committee has carefully considered the following points made by Professor Herdson, President of the Royal College of Pathologists of Australasia :

(i) 'In the context of the medical scheme operating in New Zealand for about 40 years, the practice of pathology was virtually confined either to hospital laboratories or to a limited number of private laboratories, both headed up by pathologists - on the private laboratory side, the Government paid a fee for service to the pathologists, who could not charge additionally, and no other persons, medical practitioners or otherwise, could be paid for or charge for medical laboratory testing.'

(ii) 'Turning to the Australian scene, the College position is that ideally all medical laboratory tests should be undertaken in accredited laboratories under the direction of medical pathologists and that no others should be allowed to charge for or receive fees for laboratory tests.'

(iii) 'Presently, there are sufficient pathologists in Australia (on a pathologist per population basis) to provide for this recommendation (item ii above) but it is recognised that there are geographic and population density problems in some of the vast 'outback' areas of Australia. However, at least in the large centres, 'pathology services by pathologists' could be achieved forthwith.'

(iv) 'All medical laboratories should be accredited - the present National Association of Testing Authorities/Royal College of Pathologists of Australasia scheme is moving appropriately and should be supported.'

(v) 'There is no place for commercial laboratories providing services.'

(vi) 'Pathologists are the only ones who can provide the vital interpretative and consultative interface between the doctor seeking diagnostic and monitoring help and the laboratory.'

(vii) 'Greater efforts are required in the teaching of senior medical students and junior hospital medical staff in the best use of laboratory (and other diagnostic) procedures.'

The Committee concludes that :

> In the long run, it would be preferable for Australia to move in the direction New Zealand has as far as limiting the provision of pathology services.
>
> If pathology services were only available at the SP (specialist pathology) rate there may only be a relatively modest but, nonetheless, significant initial increase in overall pathology costs as most pathology is currently supplied at the SP (specialist pathology) fee level.
>
> It could be expected that commercial laboratories will, if they have not done so already, move to 'acquire' specialist pathologists.
>
> Accreditation of Approved Pathology Practitioners and assessment of their laboratories may (if it is robust enough) counteract the 'lending' of specialist pathologists names but, by itself, not necessarily hinder the 'for-profit' attitude of some laboratories.
>
> It is likely that making private pathology available only through specialist pathologists would result in an even stronger concentration of suppliers to the market.
>
> Evidence suggests that there are insufficient specialist pathologists 'supervising' tests effectively enough to warrant SP (specialist pathology) fees being charged for all tests done at laboratories with SP (specialist pathology) status.

> It appears that many of the tests done at SP (specialist pathology) fee levels by large commercial laboratories may not be necessary.
>
> The Medicare fees for many pathology services may be inappropriately high judging by the substantial discounts (eg. 40%) offered by some private laboratories to other Approved Pathology Practitioners.
>
> The widespread application of advanced technology has greatly reduced the cost of many pathology investigations and the Medicare benefits do not appear to have been proportionately reduced.
>
> It is too late, difficult and inefficient to take effective action against pathology screening via ex post legal channels once an abuse has been detected. Preventative action via Medicare Benefits Schedule reform is preferable. Ex post legal action and attempts at restitution and recovery have been shown to be clumsy, inefficient and costly.
>
> There are parts of the Health Insurance Act and its Regulations which need amendment to clarify their meaning, limit their application, and facilitate prompt legal remedies.
>
> In respect of 'self determined' tests ('self determined' by the specialist Approved Pathology Practitioner or non-specialist Approved Pathology Practitioner) the initiating practitioner often has no say in their provision, nor does the patient or the Health Insurance Commission. Yet the initiating practitioner may be held responsible overall for the pathology costs he or she incurs, the patient who was not consulted may have to pay an additional moiety, and Medicare pays most if not all of the additional bill.

While it is ethical, and may be good medical practice in certain circumstances, for specialist pathologists to 'self determine' that additional or different tests to those requested by the originating practitioners should be performed on specimens while they are conveniently to hand, the procedures and controls on 'self determination' should be clarified and such tests better accounted for.

The Committee recommends that :

22. The procedure for revision and monitoring of the Medicare Benefits Schedule be regularly reviewed to ensure that changes to the Medicare Benefits Schedule are timely and responsive to allegations of widespread abuse, and reflect cost reductions which stem from the development of technology which underlies many Medicare Benefits Schedule items.

23. Certain minor procedures, such as collecting blood for pathology testing (Medicare Benefits Schedule items 907, 955) and carrying out certain simple pathology tests (eg. Medicare Benefits Schedule items 987, 989, 2334 to 2342 and 2352 to 2392 inclusive) should not attract Medicare Benefits Schedule benefits when they are performed in association with attendances for which Medicare Benefits Schedule benefits are payable. These procedures should be incorporated in the general attendance items.

24. The Health Insurance Commission continue development of its review systems to ensure that the use of pathology tests for health screening is blocked and no Medicare benefits are paid in these instances.

25. Consideration should be given to the introduction of specific penal provisions in the Health Insurance Act stating that an offence is committed when services have been incorrectly itemised at the SP (specialist pathology) rate instead of the OP (other pathology) rate.

26. Relevant legislative amendments should be introduced to clarify and limit the application of the term 'supervision' in respect of tests billed at the SP (specialist pathology) rate.

27. SP (specialist pathology) Medicare Benefits Schedule fees should only be payable for pathology tests done at branch laboratories of a pathology group (or at central/other laboratories) where a recognised and accredited specialist pathologist is in resident attendance and personally supervising testing.

28. The Health Insurance Act should be amended to prohibit the discounting of Medicare benefits.

29. Both the Medicare bills and relevant test results should be required to state clearly which services were 'self determined', bringing this to the attention of both originating practitioners and their patients, and also facilitating any follow-up enquiries that may be judged necessary by the Health Insurance Commission.

30. A sampling system for routine auditing of 'self determination' should be introduced by the Health Insurance Commission. This could be based upon matching original requests (that are currently required to be held by pathologists) for pathology reviews with the consequent reports of results and bills.

31. 'Self determination' should be restricted to individual case by case decisions or authorisations by the responsible specialist pathologists. This should eliminate the common current arrangements whereby generic instructions are given to technical staff so that whenever a particular investigation is requested by an originating clinical practitioner other (usually additional) tests are performed at extra cost.

'Entrepreneurs' and pathology (Chapter 4)

The Committee concludes that :

Strengthening of the administration of the Approved Pathology Practitioner scheme - in particular regular review of Approved Pathology Practitioners upon re-appointment and the immediate introduction of mandatory accreditation should quickly remove unscrupulous 'entrepreneurs' from the non-Approved Pathology Practitioner market, and to some extent dampen the undesirable side of some Approved Pathology Practitioner and specialist Approved Pathology Practitioner commercial laboratories' 'entrepreneurial spirit'.

The recommendations of this Report should reveal the 'medical entrepreneurs' business practices to the profession, the Commonwealth's administration and the community and thus help generate a greater degree of public accountability. The need for such accountability is indisputable and paramount given the public funding of Medicare pathology benefits.

Further measures are needed in order to strengthen the resolve of both the profession and the Government to check the growth of undesirable 'entrepreneurial' practices in pathology. These measures involve both long and short term commitments to :

- strengthen professional ethics and their application;
- improve co-operation between the profession and the Government;
- enhance the information on 'entrepreneurial' activities available to agencies involved in reviewing Medicare claims; and

- developing a program of independent and objective research into the structure, ownership and economics of the Australian pathology industry.

The growth of the new breed of 'medical entrepreneurs' needs to be checked if the profession is to maintain its effectiveness in society and accountability to society.

Socially undesirable 'entrepreneurial spirit' in the provision of pathology services, or in any other area of medicine, cannot be combatted by any single or simple solution. Rather a combination of techniques need to be applied at a variety of levels - the problem is one for both the Government and the profession.

There are significant problems in the profession taking action to self regulate 'pathology entrepreneurs' via peer review and the application of professional ethics.

Knowledge of many characteristics of the Australian pathology industry is poor in both the Commonwealth's administration and the profession generally.

Technological advances in pathology may assist 'entrepreneurs' to overservice.

Generally, technological change in the field of pathology has led to a reduction in testing time, labour and cost through the increased use of multiple analysis procedures.

The cost effectiveness of the technology which performs a number of pathology tests must be considered in the assessment of the Medicare Benefits Schedule, especially when new pathology tests are being considered for inclusion in the Medicare Benefits Schedule.

Advances in technology have been rapid and have had significant effect on the operations of pathology laboratories, especially the larger commercial laboratories. These developments need to be closely monitored to allow consequential adjustments in remuneration to Approved Pathology Practitioners.

In many cases where pathology abuse has occurred it appears that the patient has not been aware of the general type or extent of pathology tests being ordered.

Better informed patients, interacting with their medical practitioners on the pros and cons of pathology investigations and having increased potential to audit the bills for services provided, could lead to more rational health care and use of pathology services.

Many clinical medical practitioners appear to gradually lose touch with the minutiae of pathology as they work in general practice and the various clinical specialities. Some may rapidly lose competence in the ordering of pathology investigations and instead of ordering the most relevant and useful specific tests may order the most vaguely defined, non-specific or even the wrong tests. It is unlikely that these problems can be significantly ameliorated by any single measure in isolation, such as improved undergraduate preparation for independent clinical practice or peer review.

As all pathology investigations result in reports to the originating medical practitioners, the most simple, effective and inexpensive method of bringing these costs and benefits simultaneously to the attention of all practitioners and their patients would be to record the Medicare fees alongside the results.

It may be desirable for both the patient and the referring practitioner, during a consultation, to be made more aware of the pathology tests and associated Medicare Benefits Schedule costs that were being incurred due to a referral or a request that was about to be forwarded to a pathologist.

The Committee recommends that:

32. Sufficient resources should be made available to the Health Insurance Commission to permit it to complement the Medicare claims information provided by its systems with details derived from field surveys. Such surveys should encompass -

- searches of company records to determine the ownership of pathology companies;
- research to establish the ownership and relationship of relevant subsidiary companies to their main corporate bodies;
- precise identification of those providers, together with their qualifications, in whose names services are being billed; and
- research to establish if a specialist pathologist is actively engaged in the provision or supervision of those services billed under his/her provider number, or has 'lent' his/her name for specialist billing purposes only.

33. The Health Insurance Commission place a special emphasis on reviewing the claims of new (active) Approved Pathology Practitioners.

34. The Australian Institute of Health conduct a detailed industry study of the provision of pathology in Australia to assess and report various industry-wide economic characteristics.

35. The Australian Institute of Health survey and document systems of pathology accreditation and the provision of pathology services in other countries.

36. The Australian Institute of Health develop and undertake a comprehensive research program to analyse specific aspects of current changes in the Australian industry.

37. The National Pathology Accreditation Advisory Council, in conjunction with the Department of Health, Health Insurance Commission, National Association of Testing Authorities and the Director of Public Prosecutions completely revise and strengthen the Approved Pathology Practitioner Code of Conduct in light of recent 'pathology entrepreneurial' moves.

38. The Department of Health, in conjunction with the National Pathology Accreditation Advisory Council, the Health Insurance Commission and the Director of Public Prosecutions research options and implement measures to strengthen the applicability of the Approved Pathology Practitioner Code of Conduct to legal actions concerning 'pathology entrepreneurs'.

39. Where new clinical laboratory test procedures in pathology are advanced to the Medicare Benefits Schedule Review Committee, the developers and manufacturers of such tests should provide the following cost-effectiveness data before consideration is given to granting a Medicare benefit for the test -

- information needed to calculate the costs of performing the test;
- clinical sensitivity and specificity calculations based upon a patient population sufficiently large to enable reliable conclusions to be drawn about the efficacy of the test; and

- cost and efficacy comparisons with existing tests used for the same or similar purpose.

40. A continuous feedback of educative cost/benefit information about pathology be organised for all medical students in their clinical years and all clinical medical practitioners throughout their subsequent professional careers.

41. The introduction of regulations requiring referring practitioners to itemise all pathology requests with Medicare Benefits Schedule benefits, together with an appropriate brief description of the pathology service(s), and to, by law, provide a copy to the patient before the tests are actually formally requested.

CHAPTER 1

INTRODUCTION

- Background
- The Penington Report's Comments on Pre-Medicare Pathology
- Current Medicare and CROMP Pathology Statistics
- Conclusions

Background

1.1 Pathology has stood out as a field of special concern from all points of view during the Committee's second, post 1982, phase of it's Medical Fraud and Overservicing Inquiry.

1.2 Specifically, issues surrounding pathology services provided under the Medicare scheme by private Approved Pathology Practitioners (APP's) at SP (specialist) and OP (other) benefit rates have dominated much of the Committee's oral evidence and written submissions during 1983, 1984 and 1985. Appendices 1 and 2 list this inquiry's hearings, witnesses and submissions to date. In addition the Committee has met regularly throughout this period to privately review evidence and consider Commonwealth administrative changes/reforms implemented in response to the Committee's suggestions made during the conduct of the inquiry.

1.3 The Committee is pleased to note that not only have the recommendations in this inquiry's previous reports (203, 212) led to much needed changes in the Commonwealth's administration but that the inquiry process itself has acted as a catalyst for wider review and greater community awareness of medical fraud and overservicing. Despite these gains it appears that the accountability of the Department of Health's APP scheme is very poor. The Committee is aware of mounting professional and parliamentary concern over the marketing, billing and provision of private SP and OP pathology services.

1.4 Prior to March 1985 there was no system to effectively review Medicare (and pre-Medicare) pathology benefit claims. The following evidence taken during public hearings in the second phase of this inquiry have particular relevance to the issues discussed in this report.

- Royal College of Pathologists of Australasia 21 May 1984 (v.11 of Minutes of Evidence), 3 September 1984 (v.13 of Minutes of Evidence);

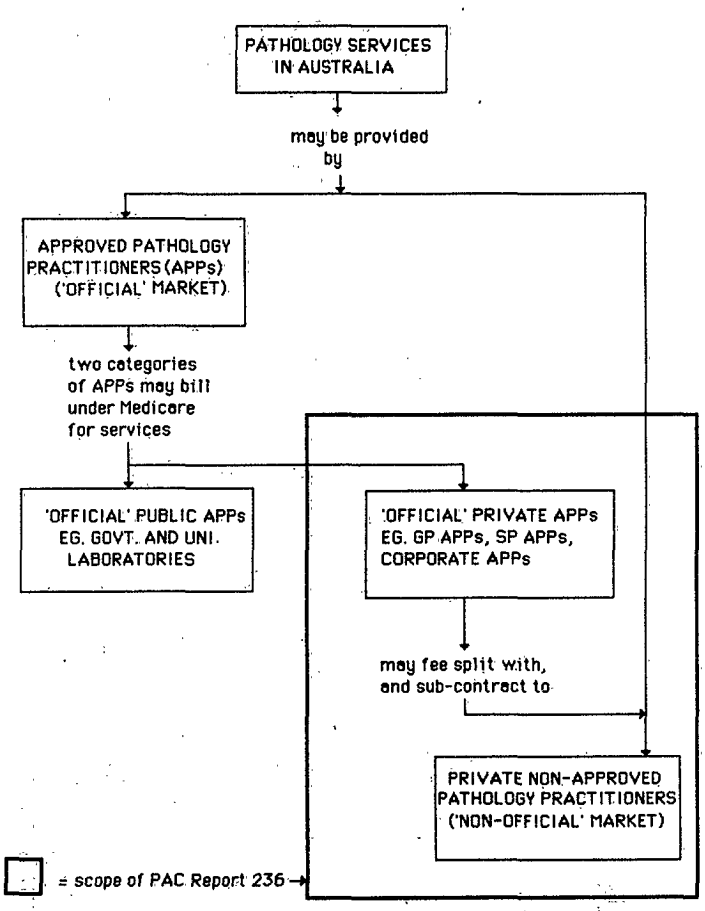
- Macquarie Pathology Services
  4 July 1984 (v.12 of Minutes of Evidence);
- Health Insurance Commission 30 April 1984 (v.11 of Minutes of Evidence), 27 March 1985 (v.15 of Minutes of Evidence);
- Capital Territory Health Commission
  19 April 1984 (v.10 of Minutes of Evidence);
- Commonwealth Department of Health
  5 July 1984 (v.12 of Minutes of Evidence),
  14 October 1984 (v.14 of Minutes of Evidence)
  27 March 1985 (v.15 of Minutes of Evidence);
- *Doctors Reform Society*
  3 September 1984 (v.13 of Minutes of Evidence).

1.5 In addition much evidence has been taken in camera by the Committee and several confidential submissions considered.

1.6 This report addresses issues primarily connected with the private sector of the Australian 'pathology industry'. As discussed in detail in Chapter 2, pathology services in Australia may be thought of as being provided by either non-Approved or Approved Pathology Practitioners (refer to Diagram 1 overleaf). Although the statistics below relate to the 'official' private sector of the industry, i.e. non-government APP's, many of the issues reviewed later (such as laboratory accreditation) apply to both the APP and non-APP segments of the private pathology sector.

1.7 In this chapter a recent study's findings on pre-Medicare pathology - the Report of the Committee of Inquiry into Rights of Private Practice in Public Hospitals (the Penington Report) - are reviewed and complemented by analyses of current private APP pathology services, benefits and providers derived from the Department of Health's Central Register of Medical Practitioners (CROMP) and the Health Insurance Commission's Medicare data base. Further chapters of this report examine particular pathology issues highlighted by these three sources. Pre-Medicare pathology statistics are often not reliable nor comparable over long periods of time because of the many changes that have occurred in the national health system during the last decade.

DIAGRAM 1 - THE AUSTRALIAN PATHOLOGY 'INDUSTRY'



The Penington Report's Comments on Pre-Medicare Pathology

1.8 The final September 1984 report of the Committee of Inquiry into Rights of Private Practice in Public Hospitals (later referred to as the Penington Report) is a valuable reference document for many topics in the public health field. Although the Report's recommendations focussed on public hospitals, much of its analysis of pathology - and certainly the Commonwealth's evidence on diagnostic services generally - related to the provision of services in the country at large during the seven year period 1975/76 to 1982/83.

1.9 In reviewing the Report's findings on pathology the PAC is mindful of Professor Penington's comment that:

> In a democratic society you have got to accept some controls when people are paid by the public purse.[1]

1.10 In its Summary of Findings the Penington Committee 'recognised that medical practitioners determine utilisation of expensive resources (such as pathology) in the course of patient care'.[2] In its Report the Penington Committee argued that the use of services such as pathology should be monitored if effective controls are to be instituted to allow flexibility in the allocation of future health resources and to ensure that they do not command an unreasonable fraction of the wealth of the community.

1.11 Generally the Penington Committee found that growth in diagnostic services within public hospitals has been substantially less rapid than that outside public hospitals. It stated that:

> In pathology there has been a growth in the number of tests performed and this has arisen through advances in medical knowledge and techniques; such growth has occurred in every other Western industrialised country over the past ten years. However, the rate of growth in Australia is less than that recorded in Britain and North America, with the exception of some specific areas of such growth in Australia where there is clearly a need for surveillance and regulation.[3]

1.12 The Penington Committee recommended ways in which pathology costs could be more effectively regulated through slowing demand for services by providing better information. It also expressed the view that regulation would be more effectively achieved through selective surveillance using systems designed to address 'specific problems'. However, no such 'specific problems' were detailed by that Committee.

1 Reported in the Medical Letter, no. 493, 21 March 1985, p.2.
2 Final Report of the Committee of Inquiry into Rights of Private Practice in Public Hospitals, September, AGPS, Canberra 1984, par. 1.4, pp. 5-8.
3 ibid., pp. 6-7.

1.13 In discussing problems of expenditure on diagnostic services the Penington Committee noted the Commonwealth submission's evidence of apparent rapidly growing expenditure through the medical benefits system on diagnostic services in pathology. Over the period 1975/76 - 1982/83 the submission suggested the number of pathology services provided per patient had increased by 105%, in contrast with figures suggestive of an overall growth of 20% in services per patient for all other items in the Medical Benefits Schedule over these years.[4]

1.14 The Penington Committee did note that changes in insurance coverage, incomplete capture of information on benefit payments, and amalgamation of items of service in some sections of the pathology part of the Schedule led to difficulty in reaching conclusions with respect to pathology utilisation on a population basis.

1.15 However the Penington Committee's own research, designed to overcome these problems, found for the period 1973/74 to 1982/83:

- 'growth in utilisation of pathology services (of all types) per 100 consultations totalling 39.7% over the nine years', and
- 'expenditure on pathology services per $100 spent on consultations with medical practitioners increased from $24.49 to $27.70, an increase of 13.1%'.[5]

1.16 The Penington Report also noted that:

> These figures do not relate directly to total expenditure in the country because of a growth in the number of medical practitioners and with that, a significant overall growth in number of consultations, in excess of population growth.[6]

1.17 Interestingly the Penington Committee found significant (14.1%, 15.4% respectively) reductions in services and costs per consultation associated with radiology during the same period.

1.18 The Penington Committee also reviewed the utilisation of pathology services since the introduction of separate benefit items for hospital pathology providers (HP fees), specialist pathology providers outside public hospitals (SP fees) and for other non-specialist pathology providers (OP fees). It found that over the four year period 1979/80 to 1982/83 the number of pathology tests at the HP (lowest) fee level increased by 22.4%, the OP (middle) fee level increased by 29.1% and the SP (highest) fee level increased by 48.6%. From this the Penington Committee's report stated:

4 Final Report of the Committee of Inquiry into Rights of Private Practice in Public Hospitals, op.cit., par. 4.3, p. 44.
5 ibid., p. 47.
6 ibid.

> There may be more effective regulation in the provision of (pathology) services within the public hospital sector than in the private sector outside, although other factors have influenced growth in the external private sector.[7]

1.19 Two minor matters found in the Penington Committee's analysis of trends in pathology services were that assessment of medical benefits by State showed the growth to be greatest in New South Wales and:

> That the automation introduced in pathology laboratories has lowered the real cost of performing many pathology tests.[8]

1.20 Overall, the Penington Report concluded that the international experience of growth in diagnostic services such as pathology reflects a change in the pattern of health care consequent upon advances in medical science. It found that a significant proportion of the growth in pathology services in the private sector in recent years was attributable to those practitioners who have graduated more recently. It believed these practitioners:

> Will be more conversant with these advances (in pathology and other diagnostic services) and will continue to apply them more readily as they move into independent practice outside public hospitals.[9]

1.21 Importantly for the present situation the Report concluded:

> The introduction of universal health insurance under Medicare will provide the opportunity for the Commonwealth to develop a more comprehensive utilisation of diagnostic services outside public hospitals to be monitored more precisely.[10] ...Detection of fraud and gross overservicing remains a necessary requirement ... Such a system can operate effectively in partnership with the profession.[11]

7 Final Report of the Committee of inquiry into Rights of Private Practice in Public Hospitals, op.cit., p. 49.
8 ibid., p. 50 and All respectively.
9 ibid., p. 52.
10 ibid.
11 ibid. p. 7.

1.22 The Public Accounts Committee supports these findings of the Penington Report. It is noted that the Minister's decision to disband the Department of Health's Surveillance and Investigation Division, dismantle the Fraud and Overservicing Detection System and allocate a provider claims review function to the Health Insurance Commission accords with the Public Accounts Committee's findings and advice to date in this Inquiry. These changes should also meet the Penington Report's conclusions. The Public Accounts Committee understands that the Health Insurance Commission is, as reviewed in a later chapter herein, attempting to ensure that the profession is fully consulted at all levels and disciplines on the operation of the Commission's claims review function.

Current Medicare and CROMP Pathology Statistics

1.23 The commencement of the Medicare universal health insurance scheme on 1 February 1984 has led to more precise analysis of pathology services and benefits via the Health Insurance Commission's Medicare data base systems. This current claims, patient and provider based information can also be complemented by data on Approved Pathology Practitioner registrations derived from the Department of Health's Central Register of Medical Practitioners.

1.24 The following discussion analyses information provided in Tables 1 to 13 at the rear of this chapter. More detailed review of the administrative systems and other associated issues underlying these statistics is contained in subsequent chapters. When read together these tables provide some insight into the private Approved Pathology Practitioner sector of the local pathology 'industry'.

(a) Table 1 - Medicare benefits for part 7 (pathology services) of the Medicare Benefits Schedule.

1.25 To put the discussion in perspective the Committee extracted from the Health Insurance Commission's Medicare system data showing overall Medicare pathology benefits paid up until the end of the March 1985 quarter. The figures in this table relate to all pathology services provided under part 7 of the Medicare Benefits Schedule and thus include services rendered at the SP, OP, HP (hospital) and 'specified simple basic tests' fee levels.[12]

1.26 This table shows that:

- for the 14 month period $350,528,343 of Medicare benefits have been paid for pathology services up until the end of March this year, (interpolated = $300m p.a.);

12 Division 9 of the MBS specifies 13 simple basic pathology tests a practitioner may perform in respect of patients of his own practice, including patients of his partners or other members of a group, if the practitioner is not an APP. The Schedule fees in most cases for these tests correspond to OP rates, although some are lower.

- benefits paid for pathology services are a significant proportion of all Medicare benefits paid;
- during the 14 month period of analysis benefits paid for part 7 (pathology services) as a percentage of all Medicare Benefits Schedule payments have increased from 14% to 15.55%; and
- the ranking of States/Territories according to Medicare pathology benefits has remained fairly stable throughout the 14 month period with New South Wales significantly ahead of Victoria and Queensland, then Western Australia and South Australia close together, then Tasmania and finally the Australian Capital Territory/Northern Territory.

1.27 Although not shown, for all four periods of this fourteen month analysis Part 7 of the Medicare Benefits Schedule has remained fourth in its ranking according to Medicare benefits paid behind Part 10 (Operations - 1st), Part 1 (Attendances - 2nd), and Part 9A (Computerized Axial Tomography - 3rd).

(b) Table 2 - Approved Pathology Practitioners as at 27/6/85

1.28 To appreciate one dimension of the number of people/organisations involved in the industry the Committee extracted from the Department of Health CROMP current figures on APPs, broken down into four classifications and also listed by State/Territory location. Although the CROMP system allows an APP to be listed under multiple classifications, only the designated principal classification and location of the APP is shown here to avoid double counting.

1.29 This table shows that:

- of the 3,061 recognised Approved Pathology Practitioners approximately 44% are registered in NSW and 27% are registered in Victoria;
- the principal classification of most practitioners is that of general practitioner and only approximately 3% of APPs are registered as pathology companies;
- recognised specialist pathologists account for approximately 17% of APP registrations; and
- the relative ranking of States/Territories is the same as for Table 1.

(c) Table 3 - Approved Pathology Practitioners registered each year since 1977

1.30 This retrospective examination of the Department of Health's CROMP registrations of APPs since 1977 gives an idea of the growth and changes in the membership of the APP scheme since its inception.

1.31 This table shows that:

- there has been steady growth in the number of APPs since the inception of the scheme in 1977;
- the relative ranking of States/Territories is the same as for Tables 1 and 2;
- double the number of APPs existed as at 15 July 1985 as compared to the number as at 31 December 1977;
- overall growth rates are not uniformly reflected in each State's growth rates during the period of analysis; and
- projections of the current year's growth of APPs registered show a continuation of decline in APPs being registered since 31 December 1983.

(d) Table 4 - List of Approved Pathology Practitioner classifications as at 27 June 1985

1.32 The Department of Health's CROMP system 'was implemented in 1981 to assist in the correct identification of the providers of medical and pharmaceutical services for the purpose of payment of Commonwealth benefits'.[13] CROMP consists of a group of data bases via which it is possible, amongst other things, to identify the areas of medicine where APP status applies.

1.33 This table shows that:

- there are 45 current classifications of APPs, however when read in conjunction with Table 2 many classifications contain very few APPs; and
- currently APPs are to be found in most areas of medicine.

13 Department of Health submission to the Committee's inquiry into the Auditor-General's Report of April 1985, par.40, p. 8.

(e) Table 5 - Activity analysis of Approved Pathology Practitioners for March quarter 1985 (1/1/85 - 31/3/85)

1.34 Any discussion of the APP scheme (such as that in Chapter 2 below) needs to be supplemented by reliable data indicating the current activity of APPs. This table, constructed by marrying data from both the Health Insurance Commission's Medicare data base and the Department of Health CROMP system, gives a current picture of the number of pathology services rendered by APPs. These levels of activity have been cross classified by APP and other CROMP registrations such as Department of Veterans Affairs' Local Medical Officer status.

1.35 This table shows that:

- of the 3,053 APPs some 31% were either inactive or rendered zero pathology services, while approximately 38% rendered between one and fifty services - thus overall 68.9% of all APPs each rendered little or no pathology services during the quarter;
- only 11% of all APPs provided over 1000 pathology services for the quarter;
- approximately 33% of APPs are registered as only general practitioners, 47% of APPs are registered as both general practitioners and Department of Veterans' Affairs Local Medical Officers (DVA LMOs);
- almost 77% of DVA LMOs who are APPs each rendered little or no pathology services;
- 72.5% of practitioners who are an APP and registered only as a general practitioner each rendered little or no pathology services;
- 41% of practitioners who are an APP and registered as a specialist pathologist each rendered over 1000 services during the quarter;
- 19% of practitioners who are only registered as an APP provided over 1000 services during the quarter; and
- 11.8% of all registered APPs have not made any claims in any period.

(f) Table 6 - Locations of Approved Pathology Practitioners' practices

1.36 A further characteristic of APPs that may be examined is the State/Territory locations of APP practices. Table 6 was prepared using current locations registered with the Health Insurance Commission and CROMP. Two limitations with this analysis are that this breakdown of registered APP locations does not show the number of locations for an APP within a State and/or Territory, nor does it indicate the boundaries of particular APP 'catchment areas'.

1.37 This table shows that:

- although the majority of registered APPs have practices located in one State or Territory, 111 have practices in two or three States/Territories;
- given that Table 5 suggests that the greater majority of APPs are virtually inactive it appears that APPs with multiple State/Territory practice locations may be probably among the more active group of practitioners, in terms of number of services rendered; and
- a small number of APPs have practices in non-adjacent States/Territories.

(g) Table 7 - Number of specialist pathologists professionally associated with the top 25 pathology groups during the March 1985 quarter (1/1/85 - 31/3/85)

1.38 On 27 July this year the Chair of the Committee's Sectional Committee for this inquiry, Mrs R J Kelly, MP, wrote to several pathology groups (including the top 25) seeking information about the number of specialist pathologists professionally associated with them. After consideration of the replies to this letter the Committee has decided to publish some general data on the number of specialist pathologists professionally associated with the top 25 pathology groups during the March 1985 quarter. Though these findings are not readily verifiable, and the integrity of the data rests with the respondents, the Committee believes that the results are a useful supplement to the discussion in Chapter 3 on SP/OP billing.

1.39 It should be noted that the top 25 pathology groups listed employ (as do other APPs) variable but often significant quantities of other classes of staff such as other non-pathology specialists (e.g. specialist physicians), general practitioners, pathology technicians, scientists, administrative and various clerical support personnel.

1.40 This table shows that, based on the responses from pathology groups:

- few of the large (in terms of services rendered) top 25 pathology groups in Australia had many full-time specialist pathologists professionally associated with them during this period;
- 60% of the top 25 pathology groups had part-time specialist pathologists professionally associated with them during this quarter;
- 3 of these top pathology groups (2 groups here are for most purposes the same group, refer discussion Chapter 2) have relatively large teams of full-time specialist pathologists associated with them;
- because the higher SP (specialist) pathology fee can be charged if a test is done by or 'supervised' by a specialist pathologist (refer discussion Chapter 3) for most of these top 25 groups most tests they bill at the SP rate may be done by others under the 'supervision' of a small number of specialist pathologists;
- there are cases where only one or a small number of full-time specialist pathologists appear to 'supervise' many tests billed at the SP rate in different laboratories/locations;
- part-time specialist pathologists may be professionally associated with more than one pathology group;
- after allowing for at least 2 cases where (in each case) it is understood 2 of the top 25 pathology groups may be thought of as one group, 133.4 specialist pathologists are associated full-time with the 21 top pathology groups and 34 specialist pathologists are associated part-time with these groups; and
- the top 25 pathology groups employ full-time approximately 25% of all specialist pathologists.

(h) Tables 8A, 8B, 8C, 8D - March 1985, December 1984, September 1984, June 1984 quarters - services, benefits, patients of the top 25 pathology groups

1.41 Essential background to the discussion in the following Chapters on the provision of pathology services by non-government APPs is current data on services, benefits and patients. In order

to avoid unwieldy analysis the Committee has decided to use data requested from the Health Insurance Commission which focusses on the top 25 pathology groups in each of the following recent quarters. Very few changes occurred in either the overall membership or order of the top 25 pathology groups during this period.

1.42 These four tables show that:

- the top 25 pathology groups rendered the following percentages of all part 7 MBS pathology services -

  March 1985 quarter - 48.69%
  December 1984 quarter - 48.94%
  September 1984 quarter - 48.12%
  June 1984 quarter - 48.58%;

- the top 25 pathology groups received the following percentages of Medicare benefits in respect of pathology items in part 7 of the MBS -

  March 1985 quarter - 50.77%
  December 1984 quarter - 50.97%
  September 1984 quarter - 50.02%
  June 1984 quarter - 50.71%;

- the top 7 pathology groups rendered the following percentages of all part 7 MBS pathology services -

  March 1985 quarter - 25.16%
  December 1984 quarter - 25.20%
  September 1984 quarter - 24.90%
  June 1984 quarter - 24.21%;

- the top 7 pathology groups received the following percentages of Medicare benefits in respect of pathology items in part 7 of the MBS -

  March 1985 quarter - 26.41%
  December 1984 quarter - 26.53%
  September 1984 quarter - 26.18%
  June 1984 quarter - 25.42%;

- within the top 25 pathology groups, for each quarter, the number of pathology services per patient is fairly uniform across all groups though there is less uniformity in Medicare benefits per patient in each quarter;
- there has been very little growth in the number of pathology services rendered, either by the top 25 pathology groups as a whole or in the total for all APPs, during these four quarters,

- there has been positive, though variable, growth in the total Medicare pathology benefits paid; and

- within the top 25 pathology groups each individual group's market share - as measured by either their percentage of total pathology services rendered or percentage of total MBS part 7 pathology benefits - has fluctuated during the four quarters.

(i) Table 9 - Services, benefits, patients of a pathology group aligned with a chain of clinics

1.43 To demonstrate an example of an APP who is of particular concern to both the Government and the profession at present the Committee has decided to publish the data shown in Table 9. While not as significant, in terms of services rendered, as the top 25 pathology groups, this APP is of particular concern because of the very high and apparently unwarranted average Medicare benefit per patient and the number/type of pathology services rendered per patient. This data is of relevance to the discussion in Chapters 2, 3 and 4 that follow.

1.44 This table shows that:

- relative to the figures in Tables 8A, 8B, 8C and 8D this pathology group has a high number of pathology services per patient and large Medicare benefit level per patient; and

- relative to the top 25 pathology groups this group is small in terms of pathology services rendered and total number of patients.

(j) Table 10 - Approved Pathology Practitioners who requested pathology from the top 25 pathology groups during the March 1985 quarter

1.45 To investigate the amount of pathology referral amongst/between APPs the Committee requested the data shown in Table 10 from the Health Insurance Commission. What this does not show (and cannot show because of the dearth of data on non-APPs) is the number of pathology services referred by APPs to non-APPs. Nonetheless the table is useful and its data may be read to support the findings of Table 5 wherein most registered APPs were shown to be inactive or almost inactive.

1.46 This table shows that:

- many current APPs who are registered to provide pathology services have chosen, instead, to request pathology services from the top 25 pathology groups;

- approximately 68% of tests referred on during this period come from APPs who are registered as DVA LMOs but are not specialist pathologists;

- approximately 7% of APPs who are also registered as specialist pathologists have referred pathology on to the top 25 pathology groups during this quarter;

- there is inter-group referral of pathology between the top 25 pathology groups; and

- the total amount of Medicare benefits for tests referred by registered APPs to the top 25 pathology groups is significant ($6m per quarter - or approximately 7% of the total MBS benefits for part 7 services).

(k) Table 11 - Savings if 10% of SP pathology items were claimed at OP rates

1.47 To provide some quantification to the discussion in Chapter 3 on SP/OP billing and to illustrate the general current dominance of SP billing the Committee requested the Health Insurance Commission to provide the analysis summarised in Table 11.

1.48 This table shows that:

- of all the pathology items in part 7 of the MBS, most (206) have at least a two-tiered SP/OP benefit structure (the SP benefit is substantially higher than the OP or HP benefits);

- of MBS pathology items with at least a two-tiered SP/OP benefit structure the greater majority of services are rendered at SP, and over the 4 quarters analysed the dominance of the SP rate is growing as follows:

  June 1984 quarter - 83.3%
  September 1984 quarter - 83.5%
  December 1984 quarter - 85.1%
  March 1985 quarter - 86.8%;

- if there was a uniform 10% shift from SP to OP rates for all MBS part 7 items with at least a two-tiered SP/OP benefit structure, for the 4 quarter period the savings in Medicare benefits would be $7.37m or 2.2% of all Medicare benefits paid, based on (conservative) calculations using MBS rates as at March 1984 for all four quarters (including March 1985).

(l) Table 12 - Locational mix of multi-state Approved Pathology Practitioners

1.49 Several interesting regional characteristics of the 111 multi-state APPs, as shown in Table 6, are given in the locational breakdown in Table 12. It is understood that many of these APPs are not active, as per Table 5.

1.50 This table shows that:

- approximately 37% of multi-state APPs have their principal location registered in NSW;
- the relative State/Territory ranking of the principal multi-state APPs are the same as the State/Territory rankings in Tables 2 and 3; and
- the most popular multi-state APP practice locational mix (regardless of principal location) is NSW/Qld (31.53%) followed by Vic/NSW (26.12%).

(m) Table 13A - SP/OP division of services of top 25 pathology groups for March 1985 quarter,
Table 13B - SP/OP division of benefits of top 25 pathology groups for March 1985 quarter

1.51 To complement the information in tables 7, 8A to D and 11 the Committee has prepared tables 13A and 13B from current Health Insurance Commission data on the top 25 pathology groups.

1.52 These tables show that:

- for each of the top 25 pathology groups almost all of their pathology services are provided at the (higher) SP rate, varying from 99.91% to 94.59%;
- for the top 25 pathology groups as a whole only 1.63% of their services are provided at the OP rate;
- for each of the top 25 pathology groups almost all their pathology benefits have been paid at the SP rate, varying from 99.93% to 95.55%;
- for the top 25 pathology groups as a whole only 1.51% of benefits were paid at the OP rate;
- for the other (i.e. non-top 25) APPs 1,744,723 or 61.39% of their services were billed at the SP rate;

- overall 79.04% of APP rendered pathology services were billed at the SP rate; and
- when the data in these two tables is read in conjunction with the data in table 7 it is clear that, in most of the top 25 pathology groups, specialist pathologists may only be capable of 'supervising' the greater majority of the many tests carried out at the SP rate, even though these tests may be undertaken simultaneously in different branch laboratories at different locations within each pathology group.

Conclusions

1.53 The Committee does not wish to reach detailed conclusions based on the information above prior to discussion in the following chapters of associated administrative systems and other issues.

1.54 It does, however, conclude that:

- pathology benefits are a significant and growing segment of Medicare expenditure which should be fully accounted for;
- there is legitimate cause for concern about some aspects of the nature of growth in pathology benefits, services and providers pre and post Medicare;
- the private pathology industry in Australia appears to exhibit oligopolistic characteristics, i.e. a small number of large pathology groups provide the majority of services; and
- with the commencement of Medicare, and the Health Insurance Commission's provider claims review function, this Committee's and the Penington Report's concerns about the effective monitoring of medical services such as pathology should be addressed.

TABLE 1 – MEDICARE BENEFITS* FOR PART 7 (PATHOLOGY SERVICES) OF THE MEDICARE BENEFITS SCHEDULE

	1/2/84 to 30/6/84 $	1/7/84 to 30/9/84 $	1/10/84 to 31/12/84 $	1/1/85 to 31/3/85 $
ACT	1 048 997	65 841	67 381	66 490
NSW	39 099 542	37 983 057	36 967 736	39 721 480
Vic.	19 617 298	17 750 460	18 572 005	18 657 570
Qld.	19 151 330	14 193 424	12 724 493	15 184 564
SA	6 115 344	5 763 615	5 751 467	6 453 583
WA	7 514 450	6 411 727	6 659 046	6 803 707
Tas.	2 165 798	1 852 884	1 774 670	1 805 857
NT	141 794	124 339	104 035	89 255
Unallocated	-	79 776	39 338	5 990
Total for Part 7 of MBS	94 854 553	84 225 123	82 660 170	88 788 497
Total for all Parts of MBS($)	677 066 609	571 536 025	550 176 153	570 673 126
Part 7 as a % of all MBS	14.00	14.73	15.02	15.55

* based on HIC DOP data as at 10/4/85,

TABLE 2 – APPROVED PATHOLOGY PRACTITIONERS AS AT 27/6/85*

State	General Practitioners	Pathology Company	Specialist Pathologists (including sub-specialities)	All Other Specialists	Total
NSW	726	60	215	341	1 342
Vic.	434	16	155	210	815
Qld.	208	5	38	70	321
SA	82	5	38	66	191
WA	164	5	51	54	274
Tas.	47	5	17	11	80
NT	5	1	1	0	7
ACT	11	2	4	7	24
not specified	6	0	1	0	7
Total	1 683	99	520	759	3 061

*data derived from Department of Health Central Register of Medical Practitioners, only one (principal) classification of the APP is shown.

TABLE 3 - APPROVED PATHOLOGY PRACTITIONERS
REGISTERED EACH YEAR SINCE 1977*

	31 Dec. 1977	31 Dec. 1978	31 Dec. 1979	31 Dec. 1980	31 Dec. 1981	31 Dec. 1982	31 Dec. 1983	31 Dec. 1984	15 July 1985	Total
NSW	758	84	59	62	95	94	93	79	28	1 352
Vic	358	63	80	75	52	61	65	41	23	818
Qld	146	17	21	14	25	24	26	41	10	324
SA	109	9	12	12	8	8	12	11	10	191
WA	116	9	17	14	11	31	24	39	14	275
Tas	37	4	9	3	2	10	8	3	4	80
NT	2	0	1	0	2	1	0	1	0	7
ACT	9	1	3	0	3	2	3	1	1	23
Total	1 535	187	202	180	198	231	231	216	90	3 070
Accum Total	1 535	1 722	1 924	2 104	2 302	2 533	2 764	2 980	3 070	
% growth on previous year	-	12.2	11.7	9.4	9.4	10.0	9.1	7.8	n.a	

* based on Department of Health CROMP data as at 15 July 1985; each practitioner is counted once only at principal location; APP's totals on Table 2 (3 061) and Table 5 (3 053) are comparable.

TABLE 4 - LIST OF APPROVED PATHOLOGY PRACTITIONER CLASSIFICATIONS AS AT 27/6/85*

(* as per Department of Health Central Register of Medical Practitioners)

Anaesthetics
Anatomical Pathology
Cardio-Thoracic Surgery
Clinical Chemistry
Clinical Haematology
Consultant Physician Cardiology
Consultant Physician Haematology
Consultant Physician Pharmacology
Consultant Physician Endocrinology
Consultant Physician Gastroenterology
Consultant Physician General Medicine
Consultant Physician Immunology (including Allergy)
Consultant Physician Internal Medicine
Consultant Physician Neurology
Consultant Physician Nuclear Medicine
Consultant Physician Paediatric Medicine
Consultant Physician Psychiatry
Consultant Physician Renal Medicine
Consultant Physician Rheumatology
Consultant Physician Thoracic Medicine
Cytopathology
Dermatology
Diagnostic Radiology
General Medicine
General Practitioner
General Surgery
Haematology
Immunology
Internal Medicine
Microbiology
Neurosurgery
Obstetrics and Gynaecology
Ophthalmology
Orthopaedic Surgery
Otorhinolaryngology
Paediatric Medicine
Pathology Laboratories
Pathology
Plastic and Reconstructive Surgery
Psychiatry
Radiology
Rehabilitation Medicine
Surgery
Thoracic Medicine
Urology

TABLE 5 - ACTIVITY ANALYSIS OF APPROVED PATHOLOGY PRACTITIONERS FOR MARCH QUARTER 1985* (1/1/85 - 31/3/85)

Number of Pathology Services	Providers who are an APP only	Providers who are an APP and a spec. path.	Providers who are an APP and a GP	Providers who are an APP a spec. path., and a GP	Providers who are an APP a GP and a DVA LMO	Total number of of Providers	% Total	Accum % Total
inactive	44	4	133	146	33	360	11.8	11.8
0	0	0	277	18	301	596	19.5	31.3
1-50	7	2	327	43	770	1 149	37.6	68.9
51-100	3	0	56	20	71	150	4.9	73.8
101-200	1	0	51	17	94	163	5.3	79.1
201-500	1	1	67	32	91	192	6.3	85.4
501-1000	2	1	33	25	47	108	3.6	89.2
over 1000	14	10	72	210	29	335	11.0	100
							100.0	-
Total number of Providers	72	18	1 016	511	1 436	3 053		

inactive = practitioner classified as an APP but has not made any claims in any period
0 = practitioner classified as an APP but has made no pathology claims during the March 1985 quarter
APP = approved pathology practitioner
spec. path. = specialist pathologist (including sub-specialties)
GP = general practitioner
DVA LMO = Department of Veterans' Affairs Local Medical Officer

* based on HIC DOS data as at 1/7/85

TABLE 6 - LOCATIONS OF APPROVED PATHOLOGY PRACTITIONERS PRACTICES

Practice Locations	Number of Approved Pathology Practitioners	%
In one State/Territory only	2 942	96.3
In two States/Territories:		
(a) in non-adjacent States/Territories	25	0.8
(b) in adjacent States/Territories	78	2.6
In three States/Territories	8	0.3
	3 053*	100.00

* number of approved pathology practitioners as at 31 March 1985, based on HIC data as at 1/7/85.

TABLE 7 - NUMBER OF SPECIALIST PATHOLOGISTS PROFESSIONALLY ASSOCIATED WITH THE TOP 25 PATHOLOGY GROUPS DURING THE MARCH 1985 QUARTER (1/1/85-31/3/85)*

Number of Full-Time Specialist Pathologists	Number of Part-Time Specialist Pathologists
8	2
3	0
22	3
3	1
2	2
5	8
6	0
7	1
7	1
4	0
8	2
1	1
17	0
n.a.	n.a.
8	3
n.a.	n.a.
18	1
1	1
1	0
22	3
5	0
1	0
1.4	0
8	3
5	7

* data derived from pathology groups responses to PAC letter of 27 June 1985; note that other (non pathology) specialists, medical practitioners, technicians, scientists, administrators and clerical support personnel are employed by these groups ; n.a = not available (no response received); the relative ranking of these figures does not correspond with the relative ranking of data in Table 8(a)-(d) or 13(a)(b).

TABLE 8A : MARCH 1985 QUARTER - SERVICES, BENEFITS, PATIENTS OF TOP 25 PATHOLOGY GROUPS*

PATHOLOGY GROUP	NUMBER OF PATHOLOGY SERVICES RENDERED	PATHOLOGY SERVICES % OF TOTAL	PATHOLOGY SERVICES ACCUM. %	MEDICARE BENEFIT PAID $	MEDICARE BENEFIT % OF TOTAL	MEDICARE BENEFIT ACCUM %	MEDICARE BENEFIT PER PATIENT $	NUMBER OF PATHOLOGY SERVICES PER PATIENT	TOTAL NUMBER OF PATIENTS
1	365 705	6.74	6.74	8 288 059.05	7.20	7.20	83.91	4.9	74 631
2	211 456	3.89	10.63	4 641 246.67	4.05	11.25	96.19	5.1	41 097
3	209 291	3.85	14.49	3 413 109.34	3.91	15.16	82.72	5.1	41 282
4	193 221	3.56	18.04	3 237 341.45	3.71	18.87	80.83	4.8	40 061
5	140 765	2.59	20.64	2 563 494.27	2.83	21.80	88.08	3.7	37 854
6	127 531	2.35	22.99	2 039 239.40	2.33	24.14	85.98	5.4	23 724
7	116 128	2.18	25.16	1 983 557.50	2.27	26.41	78.84	4.6	25 915
8	105 405	1.96	27.12	1 947 942.59	2.23	28.64	74.03	4.0	26 312
9	96 173	1.77	28.89	1 559 886.52	1.78	30.42	80.98	3.8	25 481
10	94 284	1.74	30.63	1 488 535.92	1.70	32.12	92.58	5.8	16 078
11	81 537	1.69	32.32	1 553 733.82	1.78	33.90	97.34	5.7	15 982
12	86 866	1.60	33.92	1 533 721.59	1.76	35.66	87.83	5.0	17 445
13	77 868	1.43	35.35	1 278 852.88	1.46	37.12	78.26	4.8	16 788
14	72 841	1.33	36.68	1 250 516.70	1.43	38.55	84.97	4.8	14 717
15	71 576	1.32	38.00	1 248 010.29	1.43	39.98	83.78	4.8	14 966
16	67 704	1.25	39.25	1 095 060.25	1.25	41.24	58.08	3.5	19 526
17	66 199	1.22	40.47	1 085 881.86	1.24	42.48	69.13	4.2	15 707
18	64 400	1.19	41.65	1 101 420.90	1.26	43.74	114.17	6.7	9 647
19	61 555	1.13	42.79	978 187.71	1.12	44.86	91.39	5.1	12 018
20	61 118	1.13	43.91	1 013 145.30	1.16	46.02	73.88	4.5	13 713
21	58 096	1.07	44.98	933 848.83	1.07	47.09	76.55	4.8	12 198
22	52 774	0.97	45.96	840 915.65	0.96	48.05	69.27	4.3	12 317
23	51 114	0.94	46.90	813 062.95	0.93	48.98	104.99	6.8	7 744
24	48 604	0.90	47.79	742 868.00	0.85	49.83	66.38	4.3	11 190
25	48 473	0.89	48.69	817 001.75	0.94	50.77	70.04	4.2	11 664
	2 843 185			44 342 235.80		49.23			
All Others	2 785 838		51.31	43 000 812.28		100.00			
Total	5 429 001		100.00	87 343 048.08					

* based on HIC DOS data as at 2/7/85.

TABLE 8B : DECEMBER 1984 QUARTER - SERVICES, BENEFITS, PATIENTS OF TOP 25 PATHOLOGY GROUPS*

PATHOLOGY GROUP	NUMBER OF PATHOLOGY SERVICES RENDERED	PATHOLOGY SERVICES % OF TOTAL	PATHOLOGY SERVICES ACCUM %	MEDICARE BENEFIT PAID $	MEDICARE BENEFIT % OF TOTAL	MEDICARE BENEFIT ACCUM %	MEDICARE BENEFIT PER PATIENT $	NUMBER OF PATHOLOGY SERVICES PER PATIENT	TOTAL NUMBER OF PATIENTS
1	351 825	6,50	6,50	5 886 328,18	6,98	6,98	59,09	3,5	99 610
2	212 672	3,93	10,43	3 478 680,00	4,11	11,07	51,25	3,1	67 874
3	200 338	3,70	14,14	3 174 902,54	3,75	14,82	53,04	3,3	59 854
4	186 680	3,45	17,59	3 277 301,46	3,87	18,70	60,65	3,5	54 033
5	174 595	3,23	20,81	2 840 234,10	3,38	22,05	64,00	3,9	44 381
6	127 651	2,36	23,17	1 965 472,55	2,32	24,38	71,02	4,8	27 673
7	109 552	2,02	25,20	1 821 781,77	2,15	26,53	55,77	3,4	32 668
8	105 542	1,95	27,15	1 892 057,85	2,24	28,77	51,68	2,9	36 627
9	93 080	1,72	28,87	1 438 856,47	1,70	30,47	50,78	3,3	28 336
10	92 383	1,71	30,58	1 506 754,95	1,78	32,25	54,14	3,3	27 833
11	91 278	1,69	32,26	1 482 026,17	1,75	34,00	63,56	3,9	23 317
12	87 279	1,61	33,88	1 513 839,96	1,78	35,78	56,22	3,2	26 827
13	84 398	1,56	35,44	1 269 163,95	1,50	37,28	69,50	4,6	18 261
14	75 838	1,40	36,84	1 291 598,21	1,53	38,82	54,23	3,2	23 815
15	68 257	1,26	38,10	1 158 606,25	1,37	40,19	51,33	3,0	22 570
16	66 841	1,24	39,34	1 017 290,95	1,20	41,39	52,38	3,4	19 419
17	66 081	1,22	40,56	1 056 289,08	1,25	42,64	48,32	3,0	21 862
18	63 912	1,18	41,74	1 077 558,34	1,27	43,91	75,81	4,5	14 213
19	63 422	1,17	42,91	991 365,09	1,17	45,09	49,11	3,1	20 186
20	62 026	1,15	44,06	973 552,86	1,15	46,24	50,63	3,2	19 227
21	56 926	1,05	45,11	907 822,30	1,07	47,31	46,71	2,9	19 434
22	54 554	1,01	46,12	895 468,95	1,06	48,37	58,59	3,6	15 284
23	52 543	0,97	47,09	817 188,30	0,97	49,33	56,77	3,7	14 394
24	51 929	0,96	48,05	801 378,33	0,95	50,28	82,93	5,4	9 663
25	48 105	0,89	48,94	596 921,90	0,69	50,97	31,92	2,6	18 447
	2 647 747			43 122 398,50					
All Others	2 762 788		51,06	41 473 163,83		49,03			
Total	5 410 485		100,00	84 595 552,33		100,00			

* based on HIC DOS data as at 2/7/85.

TABLE 8C : SEPTEMBER 1984 QUARTER - SERVICES, BENEFITS, PATIENTS OF TOP 25 PATHOLOGY GROUPS*

PATHOLOGY GROUP	NUMBER OF PATHOLOGY SERVICES RENDERED	PATHOLOGY SERVICES % OF TOTAL	PATHOLOGY SERVICES ACCUM %	MEDICARE BENEFIT PAID $	MEDICARE BENEFIT % OF TOTAL	MEDICARE BENEFIT ACCUM.%	MEDICARE BENEFIT PER PATIENT $	NUMBER OF PATHOLOGY SERVICES PER PATIENT	TOTAL NUMBER OF PATIENTS
1	347 758	6,41	6,41	5 610 985,87	6,76	6,76	58,02	3,6	96 713
2	212 245	3,91	10,32	3 219 242,27	3,88	10,64	50,35	3,5	60 344
3	208 212	3,80	14,12	3 381 885,00	4,08	14,72	50,33	3,1	67 185
4	186 529	3,44	17,55	3 180 957,60	3,81	18,53	59,04	3,5	53 535
5	168 484	3,10	20,65	2 843 839,55	3,19	21,72	64,09	4,1	41 258
6	118 779	2,19	22,84	1 792 751,30	2,16	23,88	69,45	4,6	25 813
7	111 456	2,05	24,90	1 909 680,25	2,30	26,18	50,90	3,0	37 594
8	107 838	1,99	26,88	1 745 320,72	2,10	28,29	54,83	3,4	31 834
9	91 488	1,69	28,57	1 370 910,21	1,65	29,94	50,16	3,3	27 328
10	90 274	1,66	30,23	1 407 925,53	1,70	31,64	59,02	3,8	23 856
11	88 774	1,64	31,87	1 425 625,61	1,72	33,36	52,08	3,2	27 374
12	86 188	1,59	33,45	1 448 964,08	1,75	35,10	53,58	3,2	27 044
13	78 415	1,44	34,90	1 283 970,83	1,55	36,65	52,64	3,2	24 391
14	73 032	1,35	36,24	1 168 075,92	1,41	38,08	50,08	3,1	23 325
15	72 422	1,33	37,58	1 111 792,00	1,34	39,40	67,29	4,4	16 522
16	65 192	1,20	38,78	1 008 553,20	1,22	40,61	48,27	3,1	20 883
17	64 426	1,19	39,97	961 767,08	1,16	41,77	48,89	3,3	19 357
18	63 792	1,18	41,14	979 719,05	1,18	42,95	51,55	3,4	19 007
19	61 922	1,14	42,28	976 197,58	1,18	44,13	46,60	3,0	20 949
20	59 708	1,10	43,38	1 003 069,73	1,21	45,34	71,52	4,3	14 024
21	56 909	1,05	44,43	863 733,00	1,04	46,38	58,27	3,8	14 822
22	51 619	0,95	45,38	831 991,55	1,00	47,39	45,95	2,9	18 106
23	50 353	0,93	46,31	614 824,55	0,74	48,13	29,89	2,4	20 565
24	49 394	0,91	47,22	835 188,20	1,01	49,13	55,28	3,3	15 105
25	48 164	0,91	48,12	739 625,35	0,89	50,02	86,51	5,8	8 550
	2 612 314			41 498 075,61					
All Others	2 816 040		51,88	41 455 290,42		49,98			
Total	5 428 354		100,00	82 951 366,03		100,00			

* based on HIC DOS data as at 2/7/85.

TABLE 8D : JUNE 1984 QUARTER - SERVICES, BENEFITS, PATIENTS OF TOP 25 PATHOLOGY GROUPS*

PATHOLOGY GROUP	NUMBER OF PATHOLOGY SERVICES RENDERED	PATHOLOGY SERVICES % OF TOTAL	PATHOLOGY SERVICES ACCUM %	MEDICARE BENEFIT PAID $	MEDICARE BENEFIT % OF TOTAL	MEDICARE BENEFIT ACCUM %	MEDICARE BENEFIT PER PATIENT $	NUMBER OF PATHOLOGY SERVICES PER PATIENT	TOTAL NUMBER OF PATIENTS
1	318 382	6.05	6.05	4 959 098.41	6.50	6.50	53.38	3.4	92 896
2	224 394	4.26	10.31	3 192 129.78	4.19	10.69	54.07	3.8	59 040
3	178 854	3.41	13.73	2 838 283.20	3.86	14.54	55.41	3.4	52 989
4	158 131	3.01	16.73	2 481 606.13	3.27	17.81	63.82	4.1	38 879
5	156 112	2.97	19.70	2 313 640.19	3.03	20.85	59.51	4.0	38 881
6	127 859	2.43	22.13	1 825 867.24	2.40	23.24	67.21	4.7	27 185
7	109 403	2.08	24.21	1 663 803.12	2.18	25.42	62.09	3.4	21 942
8	105 880	2.01	26.22	1 737 023.25	2.28	27.70	47.53	2.8	36 548
9	90 690	1.72	27.95	1 331 568.60	1.75	29.45	54.54	3.7	24 413
10	90 251	1.72	29.66	1 404 255.40	1.84	31.29	38.42	2.5	36 548
11	82 759	1.57	31.23	1 272 325.14	1.67	32.96	48.81	3.2	26 176
12	81 992	1.56	32.79	1 158 372.97	1.52	34.48	48.47	3.3	24 925
13	80 124	1.52	34.31	1 233 208.96	1.62	36.10	41.73	2.7	29 551
14	76 251	1.45	35.76	1 189 259.20	1.56	37.66	82.47	5.3	14 421
15	73 877	1.40	37.17	1 118 186.26	1.47	39.12	84.45	5.6	13 241
16	65 698	1.25	38.42	1 081 489.65	1.42	40.54	52.81	3.2	20 478
17	64 560	1.23	39.64	942 482.15	1.24	41.78	45.16	3.1	20 872
18	64 381	1.22	40.87	926 142.55	1.21	42.99	84.59	5.9	10 948
19	63 048	1.20	42.06	935 403.82	1.23	44.22	35.74	2.4	26 176
20	60 076	1.14	43.21	907 828.55	1.19	45.41	44.30	2.9	20 495
21	59 680	1.13	44.34	834 719.92	1.09	46.51	74.99	5.4	11 131
22	58 740	1.12	45.46	876 834.41	1.15	47.66	47.00	3.2	18 653
23	58 833	1.08	46.53	849 812.40	1.11	48.77	54.50	3.8	15 593
24	55 230	1.05	47.58	629 875.55	0.83	49.60	n.a.	n.a.	n.a.
25	52 819	1.00	48.58	851 078.40	1.12	50.71	64.81	4.0	13 131
	2 556 412			38 662 073.26					
All Others	2 705 597		51.42	37 573 863.67		49.29			
Total	5 262 009		100.00	78 235 736.93		100.00			

* based on HIC DOS data as at 2/7/85.

TABLE 9 - SERVICES, BENEFITS, PATIENTS OF A PATHOLOGY GROUP ALIGNED WITH A CHAIN OF CLINICS*

TIME PERIOD	NUMBER OF PATHOLOGY SERVICES RENDERED	MEDICARE BENEFIT PAID $	MEDICARE BENEFIT PER PATIENT $	NUMBER OF PATHOLOGY SERVICES PER PATIENT	TOTAL NUMBER OF PATIENTS
JUNE 1984 QUARTER 1/4/84 - 30/6/84	12 116	174 253.42	104.09	7.2	1 674
SEPTEMBER 1984 QUARTER 1/7/84 - 30/9/84	38 514	572 895.85	89.90	6.0	6 372
DECEMBER 1984 QUARTER 1/10/84 - 31/12/84	30 175	475 913.15	73.80	4.7	6 449
MARCH 1984 QUARTER 1/1/85 - 31/3/85	29 076	475 874.40	87.22	5.3	5 456

* based on HIC DOS data; because of current Medicare claims action to combat health screening practices by this pathology group the figures for the December 1984 and March 1984 quarters reflect the impact of current HIC administrative action, if disputed/disallowed services were included in these last two quarters it is believed that all figures for both quarters would show significant increases in proportion with previous quarters growth patterns.

TABLE 10 - APPROVED PATHOLOGY PRACTITIONERS* WHO REQUESTED PATHOLOGY FROM THE TOP 25 PATHOLOGY GROUPS DURING THE MARCH 1985 QUARTER

	Practitioners who are an APP only	Practitioners who are an APP and a spec. path.	Practitioners who are an APP and a GP	Pracitioners who are an APP, a spec. path. and a GP	Practitioners who are an APP, a GP and a DVA LMO	Practitioners who are an APP, a spec. path. a GP and a DVA LMO	Total
Number of Practitioners	19	7	1 072	191	2 019	23	3 331*
Number of Pathology Services	3 070	100	99 529	12 270	242 599	1 586	359 154
$ Amount of Medicare Benefit	37 783.10	1 304.50	1 834 550.89	165 320.40	3 945 233.26	27 549.80	6 011 741.95

* based on HIC DOP data as a 5 July 1985; APP = approved pathology practitioner, spec. path. = specialist pathologist, GP = general practitioner, DVA LMO = Department of Veterans' Affairs Local Medical Officer; includes referral by some of top 25 pathology groups to other top 25 pathology groups thus the total number of practitioners is greater than 3,053.

TABLE 11 - SAVINGS IF 10% OF SP PATHOLOGY ITEMS WERE CLAIMED AT OP RATES*

Time Period	Number of multi-tiered Pathology Items Analysed	Number of Services at SP Rates	Number of Services at OP and HP Rates	Total Number of of Services	Total Medicare Benefit $	Savings if 10% Shift from SP To OP $
June 1984 Quarter 1/4/84 to 30/6/84	206	4 385 530	876 479	5 262 009	76 235 737	1 753 956
September 1984 Quarter 1/7/84 to 30/9/84	206	4 532 792	895 562	5 428 354	82 951 366	1 797 168
December 1984 Quarter 1/10/84 to 31/12/84	206	4 607 309	803 176	5 410 485	84 595 552	1 863 158
March 1985 Quarter 1/1/85 to 31/3/85	206	4 712 133	716 868	5 429 001	87 343 048	1 961 894
Total		18 237 764	3 292 085*	21 529 849	331 125 703	7 376 176

* analysis based on HIC DOS data as at 9 July 1985; March 1984 MBS rates used for all four quarters thus no allowance has bee made for increases in SP and OP rates; 206 SP/OP items vary from quarter to quarter with deletions/additions from the MBS; savings estimate based on artificial assumption of a uniform 10% shift from SP to OP, total services same as Table 8.

TABLE 12 - LOCATIONAL MIX OF MULTI-STATE APPROVED PATHOLOGY PRACTITIONERS

Principal Location/ Other Locations	Number of APP's	% of Total Multi-State APP's
Qld/NSW	15	
Qld/WA	1	
Qld/NSW, Tas	2	
Qld/Vic	1	
Qld/SA	1	
	20	18.0
NSW/SA	2	
NSW/Tas	2	
NSW/Qld	18	
NSW/NT	1	
NSW/Vic	11	
NSW/ACT	4	
NSW/ACT, Qld	1	
NSW/WA	2	
	41	36.9
Vic/NSW	18	
Vic/SA	1	
Vic/WA	8	
Vic/Qld	4	
Vic/NSW, SA	1	
	32	28.8
SA/Vic	2	
SA/NSW	1	
SA/Qld, WA	1	
	4	3.6
WA/NT	1	
WA/NSW	2	
WA/Tas	1	
WA/NSW, Vic	1	
	5	4.5
ACT/NSW	4	
ACT/Vic	1	
ACT/SA	1	
ACT/Vic, WA	1	
	7	6.3
Tas/NSW, ACT	1	
Tas/Vic	1	
	2	1.8
Total Multi-State APP's	111	99.9*

* error due to rounding, based on HIC data as at 1/7/85.

TABLE 13A - SP/OP DIVISION OF SERVICES OF TOP 25 PATHOLOGY GROUPS FOR MARCH 1985 QUARTER*

PATHOLOGY GROUP*	OP PATHOLOGY SERVICES	OP PATHOLOGY SERVICES AS % OF TOTAL	SP PATHOLOGY SERVICES	SP PATHOLOGY SERVICES AS % OF TOTAL	OTHER SERVICES*	TOTAL SERVICES
1	8 934	2,70	355 645	96,53	2 866	368 445
2	1 735	0,81	212 490	99,17	50	214 245
3	82	0,04	210 424	99,08	1 875	212 381
4	8 510	4,40	184 720	95,54	103	193 333
5	7 854	5,38	134 560	94,59	44	142 258
6	425	0,33	127 794	99,38	378	128 587
7	1 011	0,84	118 092	98,52	759	119 862
8	3 260	3,03	103 452	96,12	917	107 629
9	74	0,08	95 468	99,15	743	96 285
10	1 284	1,37	92 836	97,91	695	94 815
11	78	0,08	93 485	99,91	5	93 568
12	495	0,56	87 898	99,19	222	88 613
13	444	0,56	77 828	99,61	650	78 920
14	866	1,17	72 867	98,38	336	74 069
15	1 777	2,45	69 565	96,06	1 073	72 415
16	395	0,58	67 288	99,39	20	67 704
17	8	0,01	66 288	99,14	566	66 863
18	1 834	2,85	63 568	98,87	51	65 548
19	1 313	2,09	60 981	97,12	485	62 780
20	80	0,10	60 950	99,57	206	61 216
21	190	0,32	58 116	98,73	555	58 861
22	20	0,04	53 068	99,71	137	53 225
23	28	0,05	50 811	99,17	396	51 235
24	39	0,08	47 971	98,57	555	48 565
25	1 947	3,98	46 285	94,83	536	48 768
All Others	695 744	24,48	1 744 723	61,39	401 832	2 842 059
Total	739 315	13,41	4 356 706	79,04	415 995	5 512 016

* based on HIC DOB data as at 26/7/85, other = HP services.

TABLE 13B - SP/OP DIVISION OF BENEFITS OF TOP 25 PATHOLOGY GROUPS FOR MARCH 1985 QUARTER*

PATHOLOGY GROUP*	OP PATHOLOGY BENEFITS $	OP PATHOLOGY BENEFITS AS % OF TOTAL	SP PATHOLOGY BENEFITS $	SP PATHOLOGY BENEFITS AS % OF TOTAL	OTHER BENEFIT $	TOTAL BENEFITS $
1	168 493,85	2,63	6 139 283,75	96,95	28 896,40	6 332 673,80
2	19 735,05	0,55	3 568 758,47	99,43	542,15	3 587 035,67
3	1 105,55	0,03	3 444 570,17	99,46	17 649,95	3 463 325,67
4	127 819,15	3,96	3 110 600,80	96,02	1 017,85	3 239 437,80
5	114 750,75	4,43	2 472 980,77	95,55	413,05	2 588 134,57
6	5 309,20	0,26	2 047 082,40	99,57	3 577,90	2 055 969,50
7	15 901,10	0,78	1 988 575,20	98,85	7 136,10	2 011 715,40
8	65 448,85	3,32	1 896 119,05	96,24	8 643,90	1 969 211,80
9	568,90	0,04	1 548 143,82	99,51	7 008,25	1 555 719,77
10	13 840,00	0,91	1 474 354,82	96,85	8 477,85	1 494 472,77
11	1 053,40	0,07	1 583 941,77	99,93	58,75	1 584 853,92
12	8 854,50	0,56	1 546 418,88	99,31	2 098,70	1 557 158,09
13	8 865,25	0,53	1 261 095,75	99,00	8 087,80	1 284 068,80
14	24 292,85	1,88	1 253 530,45	97,87	3 085,75	1 280 819,15
15	24 385,05	1,83	1 227 654,06	97,27	10 024,25	1 262 063,36
16	3 428,40	0,31	1 091 398,80	99,67	295,05	1 095 080,25
17	79,80	0,01	1 091 754,15	99,51	5 319,50	1 097 153,25
18	995,10	2,67	1 090 360,30	97,29	488,55	1 120 819,95
19	27 886,05	2,80	964 525,16	96,74	4 843,85	987 068,06
20	1 022,50	0,10	1 012 021,25	99,71	1 951,20	1 014 994,95
21	2 165,75	0,23	937 453,81	99,22	5 191,55	944 811,11
22	196,75	0,02	846 606,80	99,82	1 296,30	848 102,85
23	381,15	0,04	811 119,40	99,50	3 718,00	815 198,55
24	1 254,55	0,17	736 496,90	99,01	6 127,90	743 879,35
25	14 617,75	1,76	802 257,70	97,58	5 407,95	822 283,40
All Others	9 577 690,88	21,88	35 384 980,03	69,40	3 820 075,31	43 782 856,23
Total	10 254 507,84	11,57	74 349 063,17	83,95	3 955 167,51	88 558 738,82

* based on HIC DOS data as at 28/7/85, other = HP benefits.

CHAPTER 2

THE APPROVED PATHOLOGY PRACTITIONER (APP) SCHEME

- Outline of the APP scheme
- Problems
- Evidence and submissions of the RCPA and the NATA
- HIC review of pathology claims
- Conclusions and recommendations

Outline of the APP scheme

2.1 The APP scheme is essentially a national licensing scheme for pathology providers. Administered by the DoH, the scheme was introduced on 1 August 1977 along with a revised Part 7 (pathology) of the MBS which included an SP, OP fee structure (HP rates for MBS Part 7 items were introduced later on 1 November 1977).

2.2 For pathology services in Divisions 1 to 8 of Part 7 of the MBS, Medicare benefits are not payable unless these services are performed by an APP.

2.3 Medical practitioners, or persons employing medical practitioners, seeking to become APPs are required under the scheme to:

(i) complete an Undertaking to comply with a Code of Conduct and the other conditions specified in the Undertaking (refer Appendix 5); and

(ii) pay a fee - $10 (unchanged since 1977).

2.4 Where a medical practitioner, or a person employing a medical practitioner, completes the Undertaking and pays the prescribed fee, the Minister for Health may approve the practitioner, or the person employing a medical practitioner, as an APP. The application fee is not refundable if the Undertaking is not approved.

2.5 Section 16C (1) of the Health Insurance Act (HIA) specifies the categories of 'eligible applicant' for the purposes of giving APP Undertakings as follows:

(a) a medical practitioner;

(b) a person (other than a State or an authority) who employs a medical practitioner or medical practitioners to render pathology services;

(c) a State or authority, being a State or authority specified by the Minister in writing for the purposes of this definition; or

(d) a person (other than a State, an authority or a person referred to in paragraph (a) or (b)) who, immediately before the date of commencement of this section, was carrying on the business of rendering pathology services at the request of medical practitioners; where -

(i) in accordance with an approval granted by the Secretary of the Department of Health, that person issued to the person who incurred the medical expenses in respect of a pathology service so rendered (not being the practitioner who requested the rendering of the service) an account or receipt for his fees in respect of the service; and

(ii) a medical benefit was paid before that date in respect of the service.

2.6 In summary, the common form of APP Undertaking (at Appendix 5) requires that:

(a) there is no sharing of fees or benefits between practitioners ordering tests and an approved practitioner rendering pathology services;

(b) no approved practitioner provides free services, payments or other considerations as incentives to a practitioner ordering tests;

(c) the approved practitioner rendering the service should bill the patient direct; he/she should not bill the practitioner requesting the service;

(d) the approved practitioner may not enter into any arrangement whereby multiple services rules built into the structure of the Schedule are knowingly avoided; or

(e) the approved practitioner will not render or request excessive services.

2.7 The HIA stipulates that Medicare benefits are not payable in respect of a pathology service unless a practitioner has determined that the service is 'reasonably necessary for the adequate medical care' of the patient concerned, whether he/she performs the service or requests another practitioner to perform the pathology tests.

2.8 The Act also prohibits certain practices whereby an APP might induce a medical practitioner to request excessive pathology services. The legislation specifically prohibits:

(a) the making of any payment to the requesting practitioner, either directly or indirectly, or the making of such payment in respect of the staff of the requesting practitioner for the purpose of taking pathology specimens;

(b) the performance of a pathology service at the request of a practitioner with whom he/she has an arrangement for the sharing of the costs of staff or equipment;

(c) the provision of nursing or other staff at the premises of a practitioner for the taking of pathology specimens; and

(d) the performance of a pathology service at the request of a practitioner with whom he/she has an arrangement where space in a building is shared or is provided by one to the other, and the charges payable under that arrangement are not fixed at normal commercial rates.

2.9 Action may be taken under the HIA following the identification of suspected excessive requests for pathology services, the provision of excessive services or breaches of the Act insofar as provision of requesting pathology services.

2.10 The following legislative provisions are available in these circumstances:

- Section 16A of the HIA (refer Appendix 4) requires APPs to retain written requests for pathology services for a period of 18 months (Section 16A (3) (a)), an APP is required to produce these requests for pathology services within 14 days of notification (Section 16 (3) (b)), failure to retain and/or produce the required documentation may attract a fine of up to $1,000;

- Medicare benefits are not payable for pathology services in respect of health screening services, (Section 19(5));

- the Minister for Health may refer to a Medical Services Committee of Inquiry (MSCI) the question as to whether a provider has rendered excessive services or initiated excessive pathology services (Section 82);

- an MSCI shall report to the Minister its opinion on the rendering of excessive services or the initiation of excessive pathology services (Section 104);

- an MSCI may recommend that the Minister revoke acceptance of the undertaking of the APP and the APP repay Medicare benefits (Section 105);

- the Minister may make determinations in accordance with MSCI recommendations (Section 106);

- Section 129 provides penalties of up to $10,000 or five years for making false statements;

- Section 129AA provides penalties of up to $10,000 or five years for offering or accepting bribes etc. in respect of rendering/requesting pathology services;

- Section 129AAA provides penalties of up to $10,000 or 5 years for offering inducements in respect of pathology services; and

- Section 129AB provides penalties of up to $500 or six months for obstructing authorised officers from entering premises for the purpose of exercising the powers of a warrant.

Problems

2.11 All witnesses to this inquiry have expressed grave concern about the many serious problems that currently exist with both the administration and the design of the APP scheme.

2.12 These concerns are encapsulated in the following comments made by a specialist pathologist to the Committee:

> There is nowhere in the schedule that says that only a pathologist should do pathology. Anyone at all can become an Approved Pathology Provider - anybody; all you do is ring the Commonwealth Department of Health and you say: 'I want to be a pathology provider'. They do not say: 'What speciality are you in, doctor ?' or 'Where did you train ?' or 'What did you do ?'. They do not ask you anything. They send you out a form which most sign without even reading and pay $10. When I signed the form back in 1977, I quaked inside before I signed it, it was such an all-consuming, legal thing that I did, and paid off my $10. It is interesting that in 1984 it is still only $10.

So for $10 you can write yourself a cheque to make as much money as you want because now you are an Approved Pathology Provider. That means you are entitled not to do pathology but just to bill for it. There is a very subtle difference. Pathologists do pathology in laboratories but 'ordinary', 'OP', GP providers bill pathology. They do not do it; they send it somewhere. The somewhere can be anywhere, which is not legislated for, which does not meet accreditation requirements, which does not meet quality control. The technician or company, or whoever owns the business charges the fee for doing that pathology, which is about the 50 per cent mark. So in other words, we have a fee split straight away. The GP then bills the patient for something he does not even do, that he does not even know the first thing about.[1]

2.13 A review of the Committee's evidence suggests that there are at least seven major problems with the APP scheme, as follows.

(a) An 'open-ended' membership.

2.14 The APP scheme is 'open-ended' in the sense that its potential membership is huge. Category (b) of Section 16(1) of the HIA permits any person who employs (part or full time) a medical practitioner to render pathology services to be an APP, and any medical practitioner (not just recognised specialist pathologists) to be an APP. As Table 3 shows, APP growth has been strong and continuous since the scheme's commencement, with approximately 206 new APPs being licensed each year.

2.15 One specialist pathologist spoke of the situation as follows :

Specialist pathologist - In the (geographical region), of which I have personal experience, there have been more GP providers 'come on the system', as they call it, in the last six months than have ever passed a pathology exam since the inception of the RCPA. You just ring up the Department and say : 'I want to be a provider'. It sends you a form, you send your $10 and you are in business...

1 PAC 82/9/B(100).

PAC Member - Is this performance of pathology by GPs or APPs conducive to unnecessary tests or overservicing or whatever you like to call it ?

Specialist pathologist - The figures that I saw in the (geographical region) in 1982-83 honestly would make your hair stand on end.[2]

2.16 It is apparent that the number of APPs in Australia is far in excess of the membership of the dominant specialist pathology professional organisation, the RCPA. The RCPA has stated to the Committee that :

> ... all medical practitioners are potentially capable of registering as APPs. The College's current membership is 1079 Fellows. This includes 117 Fellows in New Zealand and 84 overseas Fellows. Not all of the membership is currently in active pathology practice as the figures include academics, retired pathologists and Fellows who hold other qualifications and practice in various alternate fields of medicine. As we have no knowledge of the number of practising pathologists it is difficult to estimate the percentage of College Fellows. From our manpower studies in 1981 we would venture an educated guess that 85% of practising specialist pathologists (not APPs) are Fellows of the College.[3]

(b) Scheme not reviewed.

2.17 One aspect of the DoH's administration is its lack of regular, effective review of the APP scheme. The Committee understands that once an eligible applicant has paid his/her fee then that is the end of the matter.

2.18 The legal remedy of Ministerial revocation of an APP Undertaking would appear to be an ineffectual device as the HIC's claims review monitoring of APPs is not linked to any DoH administrative function of processing APP applications and regularly reviewing APP scheme membership.

2.19 The DoH's record on administration is not good, as the Committee's 203rd Report detailed. The DoH APP scheme's administration is linked to its Central Register of Medical Practitioners (CROMP). The Committee is concerned to see that the Auditor-General, in his April 1985 Report, in an audit of the operation and update of CROMP through the SA regional office of the Department during 1984 found :

2 PAC 82/9/B(100).
3 RCPA submission 20 June 1984, PAC 82/9/B(84A)Pt.3.

- there was a lack of centrally approved instructions covering regional procedures for the operation and update of CROMP;
- the authenticity of requests for additional provider numbers was not being confirmed with practitioners;
- there were poor communications between central office and the regional office about CROMP changes; and
- certain error reports were not being checked.[4]

2.20 Several of these weaknesses have been included in previous Auditor-General's Reports, e.g. September 1982, May 1983.[5] The Committee notes that the Department is now taking steps to rectify these matters.

2.21 Without effective, visible and regular review of the APP scheme by the DoH there is no stimulus for APPs to abide by the conditions of their Undertaking and its associated Code of Conduct. Similarly, the DoH's generally poor past record of administration needs to be improved if practitioners and others participating in the APP scheme are to be expected to observe their responsibilities.

(c) A $10 fee.

2.22 Since the commencement of the APP scheme the required fee for eligible applicants seeking APP status has been $10. While the Committee is not familiar with the original rationale for setting this particular level of fee, given that it has stayed at this amount since 1977 it seems clear that the basis for its determination was either arbitrary and/or it has not been revised.

2.23 Certainly many witnesses have focussed on the low level and static nature of the fee. Many appear to view it as characteristic of the management of the APP scheme generally, i.e. created many years ago then left alone, not developed nor updated.

2.24 For all APPs it appears that the $10 fee is an immaterial amount.

4 Report of the Auditor-General, April 1985, AGPS, Canberra, p. 70.

5 Refer paragraph 11.1 of September 1982 Auditor-General's Report and paragraph 11.3 of May 1983 Auditor-General's Report.

2.25 Apart from abandoning the fee, possible options for setting an appropriate revised fee in the future might include :

- linking it to the number of pathology services rendered or the amount of Medicare benefits received; or
- an apportionment of an updated DoH administrative on-cost or overhead calculation; or
- a tiered fee structure for solo practitioners, group practices and corporations/commercial laboratories; or
- a fee designed to discourage inactive APPs staying in the industry.

(d) No laboratory accreditation linked to APP status.

2.26 One of the most serious problems with the APP scheme is that there is no requirement for APPs to either :

- operate an accredited laboratory; and/or
- only refer work to other accredited pathology laboratories.

2.27 Mandatory pathology laboratory accreditation is urgently needed to discourage the setting up and operation of 'backyard' pathology laboratories. It is understood that such laboratories may often 'sink test' pathology specimens, i.e. pour the specimen down the sink and return a 'normal' test result to the patient. Accreditation should also ensure that all pathology laboratories provide a high quality of service which is regularly reviewed by a respected, objective, professional agency to ensure maintenance of quality control, appropriate laboratory standards and required levels of clinical supervision.

2.28 APP status should be linked to accreditation such that pathology services billed by the APP can only be provided via a fully accredited laboratory.

2.29 When asked by the Committee about its involvement in long standing proposals for accreditation of pathology laboratories the DoH replied :

> The Department already chairs and services the National Pathology Accreditation Advisory Council (NPAAC) which has responsibility for co-ordinating pathology accreditation in Australia and developing standards and guidelines for pathology services.

When NPAAC was established it was envisaged that each State would establish an accreditation system through passage of legislation and creation of a Board. Because States have been slow to move in this direction (with the exception of NSW and Victoria which have passed legislation but have not as yet established accreditation boards) proposals are now being formulated whereby the Commonwealth, through modification of the present APP scheme, would be able to accredit laboratories directly. Such accreditation could be linked either to an inspection system, established by the Department and professional bodies, or the use of approved private testing organisations.

Such measures would be complementary to State initiatives, and would not be put in place where State accreditation systems were operating. Through a combination of Commonwealth and State schemes, all laboratories in Australia providing pathology services would be subject to accreditation.

The proposal for increased Commonwealth involvement in accreditation has the support of most Australian Health Ministers and it had been expected that legislation would have been introduced in the present session of the Parliament. But because of the need to consult further with States and make detailed administrative arrangements, introduction of the legislation is now expected in 1985.[6]

2.30 Recommendations for the linking of APP status to laboratory accreditation are not new, e.g. the October 1978 Report of the Pathology Services Working Party 'Review of 1977 Changes' recommended such action.[7] Similarly, the RCPA and the NPAAC have for many years now urged the implementation of proposals for Commonwealth accreditation of pathology laboratories. For example, the NPAAC determined at its 8th meeting on 28 February 1985 that:

> In the Council's view the draft proposed Commonwealth legislation should go forward to implementation, the Council also suggested that members of NPAAC could form the basis of the Commonwealth Accreditation Board which should also include a legal expert, a lay person and States' representatives as required;

6 PAC 82/9/B(1)Pt.13.

7 Report of the Pathology Services Working Party, 'Review of 1977 Changes', October 1978, AGPS, Canberra, paragraphs 14 - 22.

> NATA has indicated that it is prepared to act as an agent of governments in respect of pathology laboratory inspections and will accept NPAAC as the standards setting body; and
>
> there is a need to make a clear distinction between NPAAC's standard setting role and any regulatory action by governments.[8]

2.31 At the same meeting the NPAAC noted that:

> Victorian legislation for laboratory accreditation has been passed though not yet fully proclaimed. The establishment of an accreditation board is in progress and the Victorian accreditation system should be in place within a year. Provision exists within the Victorian legislation for the inspection of laboratories to be contracted to an organisation such as the National Association of Testing Authorities (NATA);
>
> selections for the New South Wales Accreditation Board have been made and are to go to Cabinet prior to being gazetted. The NATA/RCPA inspection procedure is a strong alternative to the State establishing its own procedure; and
>
> Western Australia, South Australia and the Northern Territory reported no action in their States/Territories on accreditation although they supported the establishment of the Commonwealth draft accreditation proposal; Tasmania was monitoring the progress made in other States; and the Australian Capital Territory is intending to integrate with the New South Wales scheme.[9]

(e) 'Depersonalised' medicine.

2.32 The Committee is most concerned that the existence of corporate APP status via Section 16C (1) (b) of the HIA can lead to what the past president of the AMA has termed 'depersonalised medicine'.[10] Chapter 4 of this report discusses some serious problems that are now emerging with the infiltration of entrepreneurs and commercial laboratories into the pathology industry.

8 NPAAC 'Report of 8th Meeting', 28 February 1985, p.(iii).

9 ibid.

10 'Medical Practice', Australasian Medical Publishing Co. Ltd.,Glebe, June 1985, No. 30, pp. 18 - 21.

2.33 One specialist pathologist described the situation as follows:

> It was only when the automated machines came on the market that a few very clever, let us not denigrate their intelligence, a few extremely clever medical entrepreneurs saw their opportunity. They had a vision of buying some expensive machine, putting a person in front of it and making a million dollars - and they did. The little people will get squeezed out because they do not have that mentality. You probably know, I do not have to tell you, that all the big commercial laboratories are owned by non-pathologists. There is not a one that is owned by a pathologist. They are owned by medical entrepreneurs and I guess there is a place for them if that is what the public wants. A friend of mine did a locum somewhere and before he hit the place there was a basket on the doorstep with red wine, white wine, champagne, some chocolates and what have you and a request form from the commercial pathology service that he was doing the locum for.[11]

2.34 Even with accreditation it is possible that commercial pathology laboratories - operated by entrepreneurs who rank profit maximisation, market control and accountability to shareholders over and above patient care - may perpetuate and possibly institutionalise overservicing.

2.35 As with calls for pathology laboratory accreditation, the idea of revoking APP status previously granted to natural persons other than medical practitioners, corporate bodies and other legal persons has been recommended by many professional bodies and is not new.[12]

(f) Ineffectual legal remedies.

2.36 Although ex ante measures to control and combat pathology overservicing (e.g. education, changes to the structure of the MBS) are preferable to ex post legal methods following claims review and counselling, there still exists a need for recourse to efficient legal remedies. Such legal remedies may be a 'last resort' and ideally be structured such that, in the most efficient manner, a range of sanctions varying from minor to severe is available.

2.37 If the record is examined as to the success of medical fraud and overservicing legal actions it shows a history of delay, frustration and unsatisfactory outcomes.

11 PAC 82/9/B(100).
12 Report of the Pathology Services Working Party, op. cit., p. 11.

2.38 In particular the MSCI system is now widely acknowledged to be unworkable. The Committee's 203rd Report in December 1982 recognised this and recommended immediate reform via the introduction of a new, efficient Medical Tribunal system to address overservicing. In its 212th Report presented to Parliament in November 1983 the Committee again repeated its belief that a new effective system needs to be urgently introduced to replace MSCIs.

2.39 Now, two and a half years after the 203rd Report's recommendation, the Committee understands that the Government has considered a proposal to replace MSCIs but has not approved any changes pending further research. Similarly, the Committee is aware that an urgent review of offences, recovery and disqualification of practitioners provisions of the HIA (Sections 129 and 19B-E) is currently being undertaken in conjunction with the AMA.

2.40 But it remains that, at present, and for at least the last three years legal remedies for fraud and overservicing in pathology and other areas of medicine have been and are still ineffectual, largely inoperative and wasteful of public resources devoted to their underlying administrative requirements.

(g) Pathology services 'by or on behalf of' an APP.

2.41 Under Section 16A of the HIA pathology services may be rendered by the APP 'or on behalf of' the APP. This has led to two major problems :

- legalised fee splitting whereby an APP effectively 'sub-contracts' tests to another APP, a laboratory or some other establishment in return for splitting the MBS fee with that other organisation/person; and
- major questions surrounding the appropriateness of paying SP fees for all tests done by a pathology group which has one/few specialist pathologists on its staff and/or operates a chain of laboratories where testing is done by technicians and little or no on-site personal 'supervision' provided by specialist pathologists (refer to Chapter 3 for further discussion).

2.42 Legal fee splitting raises several questions. First and foremost, if laboratories are willing to undertake tests for significantly less than the full MBS benefit, then are MBS pathology benefits too high? Secondly, all existing controls tend to address the APP billing for the service and not the laboratory which may actually perform the test in the case of fee splitting. Thus there would appear to be an acute lack of accountability and potentially no quality controls over some laboratories when fee splitting is possible.

2.43 The Committee has examined several office records of one particular (large) pathology group (in the top 25 groups) and found that fee splitting is very active and a means of expanding the corporate network through market capture. For example, a 1984 inter-office memo of the predatory pathology group (referred to below as Z) stated the following :

> I have successfully converted the X practice to full usage of Z. They (X) were previously sending all their bacto, histo and cyto (bacteriology, histopathology, cytology) to a local operation in Y (a regional city). The agreement is that we will bill all histo and cyto in full direct to the patients and that they (X) will now receive a 50% discount on their work instead of the previous 40%.[13]

2.44 A senior DoH officer located in NSW commented to the Committee in 1984, on fee splitting between GP APPs and unregistered laboratories, saying that :

> The proliferation of unregistered laboratories which perform the work for doctors who have registered as APPs is only just beginning. These laboratories perform the work for 60% of the MBS fee, leaving 40% for the doctor who decided the test was necessary. Two leading pathologists have indicated to me that fees should be reduced by 40%. This would help the problem.[14]

Evidence and submissions of the RCPA and the NATA

2.45 Although knowledge of pathology is an integral part of all medical practitioners' training and skills, the provision of pathology services may be viewed as a discrete sector of the market for medical services. Within this sector the RCPA may be said to be, by default of any other suitable organisations, the acknowledged representative of 'pathology interests'. This is so notwithstanding the fact that the College's fellowship coverage only extends to recognised specialist pathologists and does not include all APPs or non-APPs who subcontract to APPs.

13 PAC 82/9/B(1)Pt.11.
14 ibid.

2.46 Founded in 1956, the RCPA has described itself as :

> ... the only body fully representative of specialist pathologists in Australia. It was the first body to undertake an active role in the improvement of all facets of pathology practice. The College initiated nationwide quality control programmes and has advocated the development of a laboratory accreditation scheme since 1972. In 1983 the College approached the NATA in order to establish a jointly administered voluntary laboratory registration scheme.
>
> The College has always taken an active and co-operative role in all matters concerned with the preparation and revision of the pathology section of the MBS. A College Sub-Committee was involved in the drafting and amendment of the original listing, based on the 'most common fee' concept. College Fellows played a major part in the activities of the Pathology Services Working Party. It was a College initiative that led to the formation of the Pathology Sub-Committee of the MBS Revision Committee, and College Fellows have been members of the Sub-Committee since its inception.
>
> The College does not see its major role as being an economic or industrial body for its Fellows.[15]

2.47 From the RCPA's evidence and submissions the Committee observes that the College's position on the APP scheme is essentially a constructive but pragmatic one - the College lives with, and seeks to improve, a scheme it fundamentally objects to.

2.48 In submissions to the Committee the RCPA has advised the following :

> ...the APP scheme has been previously opposed by the College at its Annual General Meeting in Melbourne 1977 and this opposition has never been rescinded. Therefore the Executive has no mandate to endorse the continuation of the APP scheme.[16]
>
> ...the College Annual General Meeting in 1977 carried the following resolution - 'the College opposes the APP scheme because it empowers the Minister for Health, after agreement with his Medical Benefits Advisory Committee, to vary the Code of Conduct from that to which pathologists have given their undertaking to abide'.[17]

15 RCPA 'Submission to the Medicare Benefits Review Committee', 19 September 1984, p. 1, PAC 82/9/B(84A)Pt.3.
16 RCPA submission 25 September 1984, par. 2(a), PAC 82/9/B(84A)Pt.3.
17 RCPA submission 19 September 1984, p. 3, PAC 82/9/B(84A)Pt.3.

2.49 In evidence given before the Committee on 3 September 1984 the RCPA President, Professor P. Herdson, presented 7 key points which represented an 'ideal situation' for the provision of pathology services in Australia.[18] These points are reviewed in the next chapter because of their relevance to SP and OP benefits.

2.50 Notwithstanding the College's basic opposition to the APP scheme, and the College President's 'ideal' views, the College has suggested that several changes be made immediately to the APP scheme. The Committee welcomes this positive approach of the College and is pleased to note that these RCPA proposed changes are :

> ...directed towards suggested modifications to the existing arrangements which could move towards implementing a more ideal state and yet not disrupt the present services or cause too much disturbance to the people who are participating (in the APP scheme).[19]

2.51 First and foremost the RCPA has suggested that the APP scheme be supplemented by :

> ...requiring that laboratories operated by APPs be accredited under the terms recommended by the NPAAC for various types and categories of laboratories. The most satisfactory mechanism for such accreditation would be use of the NATA/RCPA scheme to carry out inspections and assess laboratories. When State Accreditation Schemes are established these could also be accepted by the Commonwealth and ideally would again be based on NATA/RCPA inspections and assessments.[20]

2.52 Second, the RCPA has proposed that :

> ...the APP scheme continues to include a Code of Conduct. This Code of Conduct should be revised and a Working Party of the Department of Health, the AMA and the RCPA may be needed to review it.[21]

2.53 In evidence before the Committee the RCPA Vice-President stated that the reason for such a code of conduct was :

> ...that most of the problems that have occurred in pathology have been in the area of incentives being provided to the ordering doctor in some way. The present APP scheme has failed in that non-approved laboratories have been set up which can legally fee split with the ordering doctor, so that he makes a profit out of ordering the test without actually having to perform it. The test may be medically necessary, but it is still an incentive to run at a high level of testing rather than a low level. From the laboratory's point of view, there is a temptation to cut quality, especially as there is, at the moment, no inspection of quality of service, in order to provide the maximum leeway for furnishing the incentive.[22]

18 RCPA submission 19 September 1984, p. 2, PAC 82/9/B(84A)Pt.3.
19 PAC Transcript of Evidence, p. 1534.
20 RCPA submission 19 September 1984, p. 3.
21 ibid.

2.54 In relation to sub-contracting the College has suggested that :

> Pathology tests for which benefits are paid must be performed in laboratories conducted by APPs and accredited by the Commonwealth. The APP providing the services must bill the patient for services he performs. This means that sub-contracting would not be permitted between APPs. This is to prevent fee splitting arrangements with incentive either for poor quality services or over usage.[23]

2.55 In association with the above, the RCPA has suggested further that :

> ...service companies be permitted to provide premises, equipment and staff to APPs. That these services be provided at commercial rates and under arrangements to be subject to scrutiny at granting of APP status and on annual renewal of APP status by the DoH. In particular service companies be not permitted to provide services to APPs on a fee splitting basis. All charges to be at commercial rates for the services actually provided.
>
> Phase in provisions would be required over say a 12 month period to allow re-arrangements from present sub-contracts (based on fee splitting) to the above type of service contracts.[24]

2.56 On the question of payment of SP benefits the College has recommended the following :

> ... medical benefits at SP rate be paid only to medical practitioners who are specialist

22 PAC Transcript of Evidence, p. 5134.
23 RCPA submission 19 September 1984, p. 2.
24 ibid.

pathologists recognised by the NSQAC, registered as APPs with the Commonwealth and whose laboratories are accredited by the Commonwealth. That all work at the SP rate require a referral by a medical practitioner or dental surgeon with all the present provisions for request forms, ordering requirements and maintenance of records to be continued.[25]

2.57 In relation to eligibility for OP benefits the RCPA has advised that :

> ...the OP rate be available to other medical practitioners for tests performed on their own patients. These medical practitioners would be required to be APPs and to have their laboratory facilities accredited in the appropriate category according to NPAAC recommendations.[26]

2.58 The College's representatives believed this last point is justified and 'necessary in some geographical areas in Australia at present'.[27] In arguing for GP accreditation as per NPAAC recommendations the RCPA Vice-President explained that :

> ...the category for GPs requires that they apply for each individual test that they would do and show that they have the facilities and ability to do the test. This differs greatly from the present arrangements in which the practitioner can be an APP but need not do any of the tests himself. He can send them off on a fee splitting arrangement to a non-approved laboratory over which there is no surveillance as to what sort of staff or equipment are being used.[28]

2.59 The College has also recommended to the Committee that eligibility for OP benefits be broadened to encompass :

> ...other medical specialists and to senior scientists (as defined by NPAAC) subject to registration as APPs and accreditation of their laboratory facilities in the appropriate category under NPAAC recommendations.[29]

2.60 The College viewed NPAAC as reflecting :

> ...a 12 year input by the professional bodies and by the State governments and Commonwealth representatives to try to obtain a workable scheme that would offer quality throughout Australia, freedom to all types of medical practitioners to do work that they are interested in, freedom for referral to university departments and other specialists, but at the same time basic quality and the avoidance of incentives.[30]

25 RCPA submission 19 September 1984, p. 2.
26 ibid.
27 PAC Transcript of Evidence, p. 5136.
28 ibid.
29 RCPA submission 19 September 1984, p. 3.

2.61 In another submission to the Committee the RCPA has argued that, to be effective, peer review of pathologists needs to be complemented by mandatory laboratory accreditation and quality assurance programmes.[31] The RCPA 'position document' on peer review, attached at Appendix 6, refers to the need for peer review to be self regulated but supplemented by mandatory uniform Federal laboratory accreditation standards.

2.62 The submission of the NATA, attached at Appendix 7, complements the RCPA proposals.

2.63 Significantly, the proposal for mandatory pathology laboratory accreditation via the established NATA system is supported by the NPAAC, the RCPA and other professional industry groups. Also, the NSW and Victorian Governments are currently evaluating the NATA system for implementation of their accreditation legislation.[32] The Committee understands that it is likely that a NATA inspection procedure will be adopted by these State Government's accreditation boards.

2.64 The Committee has examined the NPAAC reports for 1983, 1984, and 1985 and notes the Council's continued support for the introduction of a NATA based accreditation system.

2.65 The Committee observes that New Zealand has, for some years now, had a successful pathology laboratory accreditation scheme operating through its Testing Laboratory Registration Council which is affiliated with NATA.

2.66 The Committee has examined NATA's 'Medical Testing : Requirements for Registration' publication and believes it provides a sound guide to pathology laboratory accreditation.

2.67 The Committee observes that NATA is a respected independent authority on laboratory accreditation generally. The Association has proven expertise and widespread industry support for its operation. Most importantly, NATA's governing council has a balanced structure with representatives from government, regulatory, industrial and commercial interests.

30 PAC Transcript of Evidence, p. 5137.
31 RCPA submission 6 September 1984, passim, PAC 82/9/B(84A)Pt.1.
32 Refer NSW Pathology Laboratories Accreditation Act 1981 and Victorian Pathology Services Accreditation Act 1984.

2.68 NATA's assessors and committees of technical advisers are :

- chosen for their own personal expertise and not as representatives of organisations;
- selected on the basis of commercial impartiality and objectivity;
- individuals with recognised knowledge and reputation in a particular area of testing or technology; and
- people with status amongst their peers within the scientific and technical communities.[33]

HIC review of pathology claims

2.69 As a result of information disclosed during the past three years of the Committee's inquiry, and because of the Committee's advice and recommendations, the HIC now has the responsibility of reviewing both patient and provider Medicare claims, including those relating to pathology.

2.70 At the Committee's 27 March 1985 public hearing the Minister for Health announced the Government's 'in-principle' decision to transfer the responsibility for Medicare provider claims review to the HIC.

2.71 The Minister summarised the reasons for this decision as follows :

- the need to limit duplication and waste between the Department and the HIC in such areas as data handling, contact with the medical profession and fraud investigation;
- to give effect to the desirable principle that all operational aspects of Medicare should be brought together in the one organisation;
- to eliminate the need for unnecessary and therefore wasteful transfer of data between the two organisations; and
- to establish the foundation of new approaches to addressing abuses of Medicare Benefits arrangements.[34]

33 'NATA - Its Role and Operation', NATA, Melbourne, 1984, p. 2-3, PAC 82/9/B(105).
34 PAC Transcript of Evidence, p. 5860.

2.72 At the Committee's hearing the Minister also stated that :

> The administration of Medicare attests to this Government's desire to have public authorities conduct their affairs to the highest standards of efficiency and accountability.[35]
>
> No effort will be spared to ensure that those who abuse their position of trust will be punished. The Government wishes, however, to ensure that its efforts are directed at those who deliberately engage in unacceptable behaviour.
>
> It is clearly not in the interests of the Commonwealth or the profession for technical or trivial breaches to be pursued unnecessarily when those breaches may have been made in good faith. The dividing line between these two categories of behaviour will continue to be a matter for exercise of mature, professional judgement and discretion. This decision will go a considerable way to address the legitimate complaints and grievances of the medical profession. It preserves the interests of the Commonwealth and the taxpayer.[36]

2.73 The Committee notes that Statutory Rule No. 70 of 16 May 1985 - Health Insurance Commission Regulations (Amendment) - formalised the HIC's responsibility for reviewing Medicare provider claims in respect of medical fraud and overservicing.

2.74 In this report the Committee does not wish to canvass all issues surrounding the HIC's responsibility for reviewing Medicare claims for fraud and overservicing. Only matters of relevance to pathology claims are reviewed herein. Other, more general, related issues will be addressed in detail in the Committee's Final Report on this inquiry.

2.75 The Committee has closely studied and monitored the structure, development and security of the HIC Medicare data systems and found them most satisfactory. Many of the statistics discussed in this report have been derived from these systems at the Committee's request.

2.76 The Committee has examined the Commission's various control and monitoring systems designed to disclose and monitor medical fraud and overservicing. Generally such systems can be divided into the following categories :

- system wide preventative measures, e.g. controls over the issue of Medicare cards;

35 PAC Transcript of Evidence, p. 5861.
36 ibid., p. 5862.

- pre-payment controls, e.g. assessing rules incorporated in the claims payment system;

- routine post-payment monitoring systems, e.g. high utilization reports; and

- specialised provider/patient specific review systems; e.g. review of a specific provider's patient servicing patterns by billing type.

2.77 The above systems are available both on line and off line and access is strictly controlled via in-built security protocols.

2.78 The Committee observes that the HIC's sophisticated review systems allow it to detect both :

episodic overservicing, where a patient with an illness receives more attendances or other services than are necessary to investigate and treat the illness, (pathology overservicing may lie most commonly in this group); and

generalised diffuse heavy servicing, where there is excessive servicing of the patients of a practice either perhaps through encouragement of doctor dependence in some patients with chronic complaints requiring routine supervision or the active marketing of medical services with no opportunity being missed to generate a fee producing service.

2.79 Overall it appears that the HIC's Medicare systems are most capable of providing relevant, timely and accurate information about pathology claims.

2.80 What is not present, to date, is an adequate structure for acting upon this information when overservicing is detected.

2.81 As noted in the first section of this chapter, the inadequate and inefficient MSCI system is, at present, still the only avenue of formally questioning the provision of excessive services.

2.82 The Committee's 203rd Report and 212th Report clearly demonstrated that the MSCI system in unworkable, inefficient and ineffective.

2.83 The Committee understands that some proposals have been put to the Government to reform the MSCI system along the lines of the Medical Tribunal system proposed by the Committee in its 203rd Report of December 1982. However, as yet, no decision has been taken to implement such a reform, although many options have been considered.

2.84 The Committee is aware that since acquiring its extended role the HIC has been involved in the development of a detailed proposal to amend the offences, recovery and disqualification of practitioners provisions of the HIA. This proposal has been primarily designed by the DoH and is the subject of current discussion with the AMA.

2.85 The Committee believes that these proposed reforms are designed to address cases of overservicing and fraud in an efficient and effective manner via a multi-tiered system involving civil proceedings and, where necessary, criminal prosecution.

2.86 The Committee understands that this proposal is currently being considered by the Government and that discussions with the medical profession are continuing.

Conclusions and Recommendations

2.87 The Committee concludes that :

The design and administration of the Department of Health Approved Pathology Practitioner scheme is grossly deficient and requires immediate reform.

The membership of the Approved Pathology Practitioner scheme is 'open-ended' and its potential membership is huge because of inappropriate eligibility criteria.

No regular, effective review of Approved Pathology Practitioners is undertaken or linked to Health Insurance Commission claims review monitoring.

There is no effective stimulus for Approved Pathology Practitioners to abide by the conditions of their Undertaking and its associated Code of Conduct.

The 'once only' $10 Approved Pathology Practitioner license fee is an immaterial amount which appears to engender derision and disrespect of the Commonwealth's administration of the Approved Pathology Practitioner scheme.

There is no requirement for Approved Pathology Practitioners to be accredited and to operate in a laboratory which has been reviewed as part of the Approved Pathology Practitioner's accreditation process, and/or only refer work to other pathology laboratories where work is personally supervised by other resident accredited Approved Pathology Practitioners.

Fee splitting of pathology services is encouraged by current legislative arrangements; these arrangements may foster overservicing and allow poor quality services to be rendered to patients unchecked.

The majority of professional pathologists and those allied to the profession appear to welcome the introduction of a high quality and nationally consistent pathology accreditation programme like that proposed by the National Association of Testing Authorities.

Professional bodies appear very concerned about the current state of the industry and wish to see a significant improvement in both medical practitioner attitudes and the Commonwealth's administration to ensure high standards of performance and to minimise opportunities for the provision of poor quality work.

It is desirable for Approved Pathology Practitioner status to be limited to natural persons such as recognised accredited specialist pathologists, accredited medical practitioners and certain accredited recognised scientists.

Current legal remedies to combat pathology fraud and overservicing based on the Medical Services Committee of Inquiry system are completely unsatisfactory, inefficient and need urgent reform.

2.88 The Committee recommends that :

1. Pathology tests for which Medicare benefits are paid must be performed in laboratories personally supervised by resident Approved Pathology Practitioners who are accredited for the Commonwealth by the National Association of Testing Authorities.

2. The Approved Pathology Practitioner eligibility criteria in the Health Insurance Act be amended such that pathology services may not be rendered 'for or on behalf of' an Approved Pathology Practitioner and that only natural persons can be considered for Approved Pathology Practitioner status and accreditation.

3. If a need for pathology services to be rendered 'for or on behalf of' an accredited Approved Pathology Practitioner can be demonstrated because of special conditions, e.g. geographical isolation, then Department of Health approval for the rendering of such services should be specific and appropriately constrained.

4. Approved Pathology Practitioner status be renewable annually after adequate administrative examination and review of the Approved Pathology Practitioner by the Department of Health, in conjunction with the Health Insurance Commission, and after consultation with the National Association of Testing Authorities about the adequacy of the Approved Pathology Practitioner's laboratory standards and organisation.

5. The Approved Pathology Practitioner Undertaking and associated Code of Conduct be immediately revised by the National Pathology Accreditation Advisory Council and thereafter kept under regular review by a sub-committee of the National Pathology Accreditation Advisory Council in consultation with the National Association of Testing Authorities.

6. The Approved Pathology Practitioner license fee be reviewed and made an annual fee of a material amount, linked to the scale of an Approved Pathology Practitioner's practice and sufficient to cover an appropriately apportioned element of the Approved Pathology Practitioner scheme's administrative cost.

7. All pathology laboratories operated by accredited Approved Pathology Practitioners be required to be examined as part of the National Association of Testing Authorities Approved Pathology Practitioner accreditation process under the terms recommended by the National Pathology Accreditation Advisory Council.

8. The National Association of Testing Authorities/Royal College of Pathologists of Australasia scheme be adopted for pathology laboratory inspection and assessment as part of an Approved Pathology Practitioner's accreditation renewal.

9. The Commonwealth ensure that its mandatory Approved Pathology Practitioner accreditation arrangements complement, or be satisfied by, similar existing State Government programs where applicable.

10. Commonwealth pathology accreditation legislation should be designed to introduce a national programme for those State and Territory governments currently lacking legislation.

11. Where States and Territories do not have pathology accreditation implementation programmes, the Commonwealth should offer to provide those programmes.

12. In the absence of State or Territory accrediting machinery, the Commonwealth's National Association of Testing Authorities based accrediting machinery should be employed.

13. Commonwealth inspection reports and recommendations obtained via the National Association of Testing Authorities system should be forwarded to State and Territory accreditation boards where constituted, and pro rata cost sharing arrangements be negotiated.

14. Service companies be permitted to provide premises, equipment and staff to accredited Approved Pathology Practitioners at commercial rates. All documentation specifying the conditions for the provision of such resources be available for inspection at the granting and annual renewal of Approved Pathology Practitioner status by the Department of Health in conjunction with the Health Insurance Commission.

15. The Health Insurance Act be amended specifically to prohibit fee splitting.

16. SP (specialist pathology) Medicare benefits be payable only to accredited specialist pathologists who are recognised by the National Specialist Qualification Advisory Committee.

17. OP (other pathology) Medicare benefits be available to accredited medical practitioners, and certain recognised accredited scientists.

18. OP (other pathology) Medicare benefits remain applicable to tests self determined by accredited recognised specialist pathologists.

19. Appropriate resources be devoted -

    to the Health Insurance Commission to ensure continued development of its Medicare claims review systems;

    to the Department of Health to permit the administration of the Approved Pathology Practitioner scheme to be significantly upgraded and maintained; and

to the National Association of Testing Authorities to enable it to accredit Approved Pathology Practitioners effectively.

20. As a matter of urgency, the existing Medical Services Committee of Inquiry system be replaced with a Medical Tribunal system along the lines of that originally recommended by the Committee in its 203rd Report.

21. After appropriate consultation with the medical profession, the Health Insurance Act be amended to ensure that the offences, recovery and disqualification provisions of the Act can be effectively and efficiently used to combat medical fraud, and where applicable, medical overservicing.

CHAPTER 3

SP/OP MEDICARE BENEFITS

- Requirements of the MBS and the Health Insurance Act
- Implications of current statistics
- Views of witnesses
- Optimising returns using SP billing
- Conclusions and recommendations

Requirements of the Medicare Benefits Schedule (MBS) and the Health Insurance Act

3.1 To understand the issues surrounding the overwhelming dominance of pathology services rendered at the SP fee level it is necessary to review what the MBS and the Health Insurance Act require for the charging of SP,OP and HP fees.

3.2 The Medicare Benefits Schedule has an 11 'Part' structure, with Part 7 listing fees for recognised pathology services. Part 7 is broken down into 9 'Divisions' with the fee structure in Divisions 1 to 8 being either two-tiered (SP or OP fee levels) or three-tiered (SP or OP or HP fee levels). In all cases SP (specialist) fees are higher than OP (other) fees which, in turn, are higher than HP (hospital) fees.

3.3 The difference between the various fee levels is significant and varies according to the characteristics of the medical service to which they apply. Only APPs can perform tests in the multi-tiered Divisions 1 to 8 of Part 7.

3.4 Some 219 individual or multiple-estimation pathology services are listed in Part 7 of the MBS, with current fee structures as follows:

fee structure	number of medical services	%
single tier (Division 9 only)	13	5.94
2 tier SP/OP (Divisions 1 to 8)	188	85.84
3 tier SP/OP/HP (Divisions 1 to 8)	18	8.22
	219	100.00

3.5 Sub-section 16A(1) of the Health Insurance Act (refer Appendix 4) provides that Medicare benefits are not payable in respect of a pathology service (except prescribed services in Division 9 of Part 7 of the MBS) unless a practitioner has determined that the service is necessary for the adequate medical care of the patient concerned, and the service was rendered 'by or on behalf of' an APP. The request must be addressed to that APP by the practitioner who determined the service was necessary or by another APP.

3.6 An example of a two-tiered SP/OP pathology MBS service follows. Although somewhat esoteric in its appearance (quantitative estimation of gold etc.) this high cost service, listed in Division 2 (Chemistry) of Part 7, was the 11th most common pathology test (out of 206 multi-tiered tests) in the June 1984 quarter i.e. 1/3/84 to 30/6/84. During this quarter 119,807 pathology tests of the following nature were carried out - 86,509 or 72.21% as Item 1345s at the SP rate:

> Quantitative estimation of - Arsenic; Copper; Gold; Lead; Mercury; Strontium; Zinc; any other element not specified in any other item in this Division; Folic acid; Vitamin B12; Any other vitamin not specified in any other item in this division; Alcohol; Ammonia; Neo-natal bilirubin (direct and indirect); Cholinesterase; Coproporphyrin; Erythroporphyrin; Uroporphyrin or any other porphyrin factor; Carboxyhaemoglobin; Delta ALA:5HIAA: Iron (including iron-binding capacity); Oxalate; Oxosteroids; Oxogenic steroids; PBG: Urine oestriol; Transketolase or any other substance not specified in any other item in this Division -
>
> Each estimation
>
> Item 1345 SP all states: fee $ 34.50 (as at 1/7/85)
>
> Item 1346 OP all states: fee $ 25.90 (as at 1/7/85)

3.7 Division 9 of Part 7 of the MBS has 13 'specified simple basic pathology tests' which non-APPs can perform. Each of these tests has a single set fee which in most cases corresponds to an OP rate. Overall Division 9 pathology tests represent a very minor segment (approximately less than 1.4% - refer Table 14) of all tests rendered under Part 7 of the MBS.

3.8 Furthermore, as shown in Table 14 (at rear of chapter) two items (2342 - microscopical examination of urine, and 2346 - pregnancy test by one or more immunochemical methods) dominate (greater than 93%) these 13 non APP tests in Division 9. Two other tests in Division 9 - item 2382 'Casoni test for hydatid disease' and item 2388 'Schick test' - had one or zero tests performed during each of the four quarters listed in Table 14.

3.9 The conditions relating to the tiered Medicare pathology benefit structure are set out in the MBS Book at paragraphs 217 to 222 of Part C, section 1 of 'Notes for the Guidance of Medical Practitioners - information on interpretation of the MBS'.

3.10 For the purpose of assessing Medicare benefits for an item listed in Part 7 Divisions 1 to 8 which is requested or determined to be necessary, the following subparagraphs of paragraph 217 stipulate the conditions under which SP, HP and OP schedule fees apply :[1]

(3) The 'SP' Schedule fee in Division 1-8 applies only where:

(a) the service was performed by an approved pathology practitioner, who was a recognised specialist pathologist, or by a recognised specialist pathologist employed by an approved pathology practitioner;

(b) the approved pathology practitioner has a request in writing (which conforms to the requirements of the regulations under the Health Insurance Act) from another medical practitioner or a dental practitioner;

(c) the person in respect of whom the service was rendered was not at the time of the request a private in-patient or in receipt of an out-patient service at a recognised hospital; and

(d) recognised hospital or Government (including university and Government authority) laboratory facilities and/or staff were not used in the performance of the pathology service.[2]

(4) The 'HP' Schedule fee applies to specified items in Divisions 1-8 where pathology services are rendered to private in-patients of recognised hospitals where recognised hospital or Government laboratory equipment and/or staff is used.[3]

(5) The 'OP' Schedule fee in Division 1-8 applies in other circumstances, namely :

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1 Statutory rules to the Health Insurance Act (Health Insurance Variation of Fees and Medical Services (No. 31) 1984 No. 286) detail the circumstances to be met for benefits to be paid at 'SP', 'HP' or 'OP' rates for pathology services.
2 ibid., Statutory rule 13.
3 ibid., Statutory rule 15.

(a) the service was performed by an approved pathology practitioner who is not a recognised specialist pathologist, and he does not employ a recognised specialist pathologist; or

(b) the service was performed by an approved pathology practitioner who is, or employs a recognised specialist in pathology but all the conditions of rule 3 above were not met.[4]

3.11 In addition paragraph 218 of the MBS Book's notes set out two further conditions where pathology services 'self determined' by the APP may attract SP or OP benefits depending on the circumstances, as follows:

> An approved pathology practitioner who has been requested to perform one or more pathology service may deem it necessary in the interest of the patient to carry out additional tests to those requested. This situation may be handled in two ways:
>
> (a) The approved pathology practitioner may arrange with the referring practitioner to forward an amended or a second request. His account will then be issued in the ordinary way and the additional services will attract full benefits at the 'SP' rate where the approved pathology practitioner is a recognised specialist.
>
> (b) He may determine that the services were necessary. In this case his account or receipt for the requested services will observe the requirements of paragraph 217 (6) (a) (request in writing). His account or receipt for the additional service will indicate that he determined the services were necessary and the date the determination was made (paragraph 217 (6) (b)). These services attract benefit at the 'OP' rate.[5]

Implications of current statistics

3.12 Current statistics on pathology services (in particular tables 3, 5, 7, 11, 13A, 13B in Chapter 1 and Tables 14, 15 in this Chapter) support the following observations:

4 Statutory rules to the Health Insurance Act, op.cit., Statutory rule 17.
5 ibid.

(a) most pathology tests performed by APPs (including the top 25 pathology groups) are billed at the SP rate;

(b) the number of specialist pathologists in the top 25 pathology groups appears to be insufficient to permit each specialist pathologist individually performing or 'effectively supervising' (except in a very general managerial sense) the very large numbers of tests billed at the SP rate, especially given that many of the pathology groups have several branch laboratories in different locations and/or States/Territories;

(c) the low incidence of pathology tests billed at the OP rate by the top 25 pathology groups suggests that:

(i) each pathology group scrupulously accords with the requirements of paragraph 218 (a) of the MBS Book's notes where a specialist APP in the group arranges/confers with the referring practitioner to forward an amended or second request for pathology tests the specialist APP has deemed necessary in the interest of the patient in addition to those tests originally requested by the referring practitioner; and/or

(ii) tests 'self determined' by specialist APPs in these groups are incorrectly billed at the higher SP rate instead of the OP rate (deliberately or otherwise); and/or

(iii) 'self determined' tests not re-requested as per (i) above are very few (less than 1.7%) in number;

(d) significant reductions in the cost of pathology may result from a shift in billing for pathology tests from SP to OP items, however for the top 25 pathology group relatively modest cost increases could be expected to result initially if all Division 1 to 8 Part 7 items were restricted to specialists and all items billed at the SP rate.

3.13 The issues underlying the above four points are not without debate and require further discussion to put them in perspective.

3.14 As well as the evidence in Tables 13A and 13B that the overwhelming majority (on average 97.83%) of pathology tests rendered by the top 25 pathology groups were billed at the SP rate, Table 11 shows that for all APPs (where there is a two or three tiered benefit structure) the greater majority of pathology tests (on average 84.71%) are provided at SP rates.

3.15 The suggestion that the number of specialist pathologists in most of the top 25 pathology groups is insufficient needs to be tempered by three further matters-

(a) debate over the exact meaning of the term 'perform' in paragraph 217 (3) of the MBS Book's Notes; and

(b) the fact that some of the top 25 pathology groups also employ practitioners who are specialists in other fields of medicine (e.g. cardiologists) and practitioners who are in training for admission to the RCPA; and

(c) Section 16A of the Health Insurance Act permits pathology services 'to be rendered by or on behalf of' an APP (refer Appendix 4).

3.16 Given (c) above, the exact meaning of the word 'perform' - as in the SP requirement that 'the service was performed by an approved pathology practitioner who was a recognised specialist pathologist, or by a recognised specialist pathologist employed by an approved pathology practitioner' - is open to debate. Its meaning may be interpreted variably, for example:

- the specialist pathologist him/herself carries out all the steps in the testing and analysing procedure (impractical); or
- the specialist pathologist is present in the laboratory during the period when the test is performed (perhaps of no consequence if 'normal' test results occur most of the time); or
- the specialist pathologist oversights the testing procedure in a managerial sense even if he/she is not physically present (not necessarily effective); or

- the specialist pathologist gives an opinion on unusual or abnormal test results where necessary and is jointly responsible with other peers for the operations of the group's laboratories (may be effective and the specialist may have a legal duty of care, but should SP fees apply to all 'normal' test results not commented on ?).

3.17 If the last of the interpretations above is adopted then it is feasible for a pathology technician within a pathology group employing few specialist pathologists to carry out many tests billed at the SP rate even though the specialist may never see, pass judgement on or be only remotely involved in the performance of these tests as the results are within predetermined acceptable limits.

3.18 A more extreme case would be where a specialist pathologist 'lends' his/her name as a part or full time 'silent' partner to a non specialist APP practice so it can bill all tests at the SP rate. The quality of the tests may be satisfactory prior to the 'acquisition' of the specialist but the addition of the specialist's name, even on a part-time basis, significantly increases the fees charged and hence the practice's profits.

3.19 The situation is somewhat exacerbated by pathology groups which operate a chain of laboratories such that a specialist pathologist visits each laboratory only occasionally and communicates with each laboratory on mainly administrative, marketing or cash flow matters.

3.20 The employment of other specialised practitioners and/or qualified scientists in pathology laboratories, whilst a laudable medical practice and an understandable business practice, also appears to sit at odds with the intention of current requirements for SP billing.

3.21 A further argument also applies here. The acknowledged high (and growing) degree of automation in pathology laboratories today brings the appropriateness of SP fees for highly automated tests more and more into question, especially where little or no professional opinion is given on the results if they are not abnormal or unusual.

3.22 Against this is the argument that specialist pathologists give close, personal expert supervision of technicians (who operate these machines) in addition to general oversighting and where appropriate commenting on test results. The success of this argument depends on the actual effectiveness and manner of such supervision. In pathology groups with many branch laboratories there appears to be less scope for sustaining the 'close professional supervision' argument if there is no on-site specialist pathologist and/or if the laboratory's policy is to seek the opinion of its corporate specialist pathologist only after testing has produced abnormal or unusual results.

Views of witnesses

3.23 Witnesses of all types have expressed concern to the Committee about SP/OP pathology billing. Senior officers and practitioners of the DoH, the HIC, the RCPA, specialist pathologists (including several in the top 25 groups), representatives of large pathology corporations and pathology technicians (including technicians currently employed in the top 25 pathology groups) have all acknowledged that there are serious questions surrounding the dominance of SP billing in all APP laboratories.

3.24 In his submission to this inquiry Dr T Wenkart, Medical Administrator of Macquarie Pathology Services detailed eight 'main cost generating areas of fraud and abuse in pathology' which included the following two:

> Where practitioners can make arrangements to employ pathologists to provide a name and consequently charge out at the SP rate - yet have the pathology practice 'in-house' and not a true referral service.
>
> Self-generated requests after the referral has occurred. This is a legitimate need but one which we know has been abused.[6]

3.25 The MBS Book's notes, at paragraphs 212 and 213, implicitly recognise the dangers inherent in 'in-house' APP referral arrangements (where 'arms length' referral principles may be compromised) but it relies on an unclear test of 'pathology services necessary for adequate medical care' as a criteria for determining the validity of services rendered in such circumstances. The notes state:

> 212. An approved pathology practitioner would not be in breach of an undertaking by way of the ordinary partnership/group practice arrangements regarding costs and income, where the pathology services are necessary for the adequate medical care of patients. That is, bona fide arrangements where pathology services are necessary in the terms of the Health Insurance Act would not be regarded as breaches of undertakings.
>
> 213. The critical issue whether partnership or group practice arrangements are involved or not, is whether the requesting or rendering of pathology services eligible for Medicare benefits is influenced by considerations other than the need for the services for the adequate medical care of the patients concerned.

6 PAC Transcript of Evidence, v. 12, p. 4694.

3.26 The RCPA is aware of dubious SP billing practices in some large commercial laboratories and instances of specialist pathologists who are currently 'lending' their name to laboratories. The RCPA President, Professor Herdson, and Vice-President, Dr Davies, made the following comments to the Committee at a public hearing (3 September 1984):

Dr Davies : Relevant to this is another provision that I have recommended there, that benefits be paid only to medical practitioners or senior scientists as defined by NPAAC. The reason for this is that these people are traceable. The medical practitioners are registered, they all have a big investment in their education and experience and they are likely to care about abiding by a code of conduct for which penalties can be applied. But the laboratories operated by business interests have not that restraint on them. Firstly, they are not restrained by the rules of medical practitioners in relation to advertising or marketing their product, or representing it to the GPs. This is relevant to the question you asked: 'Does the GP know?'. In many cases I believe that the material is misrepresented to them with an apparent array of scientists and so on in the laboratory who are really there in very small numbers compared with a good ...

PAC Member: That is appalling. That places the patient and the doctor at risk.

Prof. Herdson : Precisely. The other thing to put into the equation is that the technology has advanced enormously over the last 20 years. I was working in Chicago for a decade, maybe 15 or 20 years ago, just at the time that some of this very modern automated technology was coming in. There, with just as variable standards in medical practice, the best being excellent the worst being terrible, we witnessed the commercial firms coming in and, with their high-grade technology, being able to churn out the results at a great rate, the interpretation of which can only be done by someone who knows both quality control and medicine.

PAC Member: What is to prevent a pathology business from being in the hands of a pathologist, or supervised by a pathologist, but still having all those other elements you talk about at the lower levels ?

Dr Davies : It is possible for that to happen. I am aware of some specialist pathologists who are attached to laboratories that are commercially operated and are lending their name to it for the purpose of obtaining SP benefits...[7]

3.27 People employed at other levels in the industry have tended to support the type of concerns expressed above. Typical of in-camera evidence given by trained pathology technicians, including some currently employed in the top 25 pathology groups, are the following comments (Z - the specialist pathologist referred to here by the technician - is one of the top 25 pathology groups).

PAC Member : Let us come on to the more general principle, I take it if somebody in X (town where branch laboratory is located) had to get a test for a patient - I am talking about a GP - that doctor would get blood to you for that ? What would happen after that ? Where does Z (specialist pathologist) get involved ?

Witness : Z himself was never involved.

PAC Member : So you would give the referring GP the results ? What would happen then ? The bill would go out from Z in Y (city where specialist pathologist's head office is) ?

Witness : No, the account was generated in X.

PAC Member : But it was sent out under the name of Z?

Witness : Yes.

PAC Member : It worries me that the so-called specialist pathologist in theory is being paid because he supervises the tests, comments on any abnormalities and all that sort of thing. In fact, with many of the tests that would be performed, possibly with the exception of histopathology, you would really be the person doing them.

7 PAC Transcript of Evidence, v. 12, pp. 5140-1.

Witness : Yes.

PAC Member : In general situations - in all the biochemistry and all the haematology done in X, where did Z come into it, apart from collecting the money ?

Witness : About once every 18 months he would come down and throw a party for the local GPs.

PAC Member : Possibly there would be the odd test for which you would not have the facilities in X - that material would then be sent to Y ?

Witness : Yes.

PAC Member : Otherwise it is really just a business arrangement ?

Witness : That is right.

PAC Member : He employs people like yourself and is then able to charge at the higher rate as a specialist pathologist ?

Witness : Yes.[8]

3.28 At another in-camera hearing a specialist pathologist (one in the top 25 pathology groups) stated the following:

PAC Member : The argument would be that much of the pathology which is performed by the SP pathology laboratories, whilst in theory it is under your supervision, control, et cetera, is really performed by people with much lower qualifications and people who in some cases would be employed by the APPs, would they not? Anybody can employ a technician.

Witness : A technician.

PAC Member : A technician, yes. The vast majority of your tests would be performed by machines and technicians working the machines ?

8 PAC In-camera Transcript of Evidence, 89/9/B(101).

Witness : Yes. But there is nobody there to guide them or to suggest what the clinical implications of the tests are. They are just test generating factories, and the results go back to the GPs without comments. No-one would ever know whether they were correct. If you do not have a pathologist or somebody very responsible around people tend to get very sloppy and lazy. Their controls might not be right, their quality is not good enough or their standards are a bit off. A lot of it is human error and that SP rate provides for supervision by a specialist pathologist and not for the actual doing of the test. I think that anybody gets sloppy without someone responsible around.[9]

3.29 Others in the profession have a different perspective on this matter. A senior member of the DRS commented to the Committee on the appropriateness of specialist billing for automated biochemical and microbiological investigations as follows :

> I do not think there is anything wrong with machines automatically doing blood tests that can be done automatically by machine. The only problem is that that is being billed as a specialist investigation and the medical benefits are being paid for it as a specialist system when it is in fact almost an automatic machine test. I do not think there is any question about the quality of what is coming out of the machine. It is a simple truth. I do not know what the pathologists (RCPA) said, but the vast majority of the basic biochemical and microbiological investigations do not need a pathologist to look at them. A technician who has a science degree and is used to looking at microscopy is perfectly adequate. The report goes out under a pathologist's name and is accounted under a pathologist's name when the pathologist may not have looked at it. From the quality assurance point of view there may be no reason for him to look at it, so it depends what your accreditation is getting at. It has been suggested that we should pay benefits only on investigations that are actually looked at by pathologists themselves.[10]

9 PAC In-camera Trascript of Evidence, 89/9/B(100).
10 PAC Transcript of Evidence, p. 5200.

Optimising returns using SP billing

3.30 APPs with specialist status can, by judicial 'for-profit' interpretation of the MBS, optimise their returns. The RCPA Vice President commented on this, saying to the Committee :

> What happens is that the average pathology practice, offering a full range of services, loses on some items and makes up on other items. The net effect has been to come out in just a reasonable satisfactory state. By selectively doing or pushing items that are on the plus side, one can do a lot better than average. Accreditation would again address that problem by requiring laboratories to provide a full range of services and not to be selective.[11]

3.31 Among the various methods available to SP APPs to achieve this 'for-profit' end are:

- undertaking a variety of tests in automatic response to a general or poorly worded request; and/or
- choosing amongst like or overlapping SP MBS items for the one (or combination) which pays the highest return.

3.32 Several examples and allegations of these types of profit maximising practices have come before the Committee.

3.33 One employee of a large pathology laboratory (in the top 25 groups) with SP status alleged to the Committee that his laboratory has a policy of deliberately (mis)itemising high cost pathology tests for males who have had a vasectomy.

3.34 The Committee understands that the intention of the particular pathology test the employee questioned is to check for presence of sperm in semen after a vasectomy has been performed. The MBS options available for billing are set out in Table 15 (at the rear of this Chapter). Essentially they are either item 2201 (SP fee $6.90)/2202 (OP fee $5.20) or 2215(SP fee $34.50)/2216 (OP $25.90).

3.35 The employee maintained that his SP APP laboratory has a policy of charging for item 2215 instead of the more relevant item 2201 - a difference of $27.60 per patient per test. Item 2201 is considered more relevant in these cases as all that is required is a simple test for the presence of sperm and not a quantitative analysis. The Committee also understands that in most of these types of cases usually no sperm is detected.

11 PAC Transcript of Evidence, p. 5151.

3.36 The Committee also notes that this non-practitioner employee was operating a remote regional/branch laboratory of the SP APP without a specialist pathologist in attendance (either daily or on a regular basis). Thus there is also the argument that the more appropriate item should be the OP rate, i.e. MBS item 2202 - giving a difference of $29.30 per patient per test.

3.37 Interestingly, it appears that there are not enough services rendered under MBS items 2201/2202/2392 (refer Table 15) to cover the number of vasectomies performed. HIC data shows that 5,998 vasectomies (MBS Items 6249-$106 / 6253-$130) were performed during the March 1985 quarter. Yet only 3,656 tests were rendered under MBS items 2201/2202/2392. Some 6,168 services were rendered under MBS item 2215 and 5,679 under MBS item 2216.

3.38 An apparently common example of an SP APP undertaking a variety of tests in automatic response to a general or poorly worded request concerns testing for sexually transmitted diseases. Often, the Committee understands, a referring doctor will request a 'V.D.R.L. test'. MBS item 1772 (SP fee $5.70) specifically covers such a test.

3.39 However, it appears that many SP APPs routinely interpret a request for a V.D.R.L. test to mean the undertaking of several associated tests at the SP rate as well. Often at least three tests are provided - for example MBS items 1772, 1793 and 1805 for a combined return of $34.30 - giving a difference of $28.60. All these tests are automatically provided in the first instance regardless of whether the V.D.R.L. test is non-reactive.

3.40 One specialist pathologist who had issued instructions for such a 'screening' approach to V.D.R.L. tests has a chain of laboratories in his State which, with the aid of the medical and non-medical staff therein, process hundreds of pathology requests daily. The specialist pathologist claims :

> not to know personally if the odd one of these tests is unnecessary .... it is difficult for my staff to interpret what is wanted and sometimes a few extra tests may slip through.[12]

3.41 When asked if his decentralised laboratory staff had general instructions that apply when they get a V.D.R.L. test request he replied :

> they do the lot, if they have read the request they should theoretically do the V.D.R.L. only, but they are human beings doing twenty or thirty a day and all of them are done the same way, they slip through and do more than one.[13]

3.42 The specialist pathologist also said that his laboratories also used this (screening) approach with four other types of 'general' test requests.

12 PAC 89/9/B(I) Pt. 13.
13 ibid.

3.43 The Committee understands that professional opinion on the medical necessity for this type of laboratory policy suggests that it is inappropriate as a standing policy, and that such a testing approach is only warranted under specific circumstances for certain types of cases. It is also contrary to Section 19(5) of the Health Insurance Act which states :

> Unless the Minister otherwise directs, a Medicare benefit is not payable in respect of a health screening service, that is to say, a professional service that is a medical examination or test that is not reasonably required for the management of the medical condition of the patient.

3.44 The Committee has also been advised, on many occasions and from many different areas of the profession and the public, of pathology overservicing in the area of allergy testing. It has been alleged that until a recent revision of the MBS many practitioners were habitually ordering batteries of allergy tests for their patients and that the follow-up to these tests 'locked' many patients into questionable and expensive treatment methods. Pathology fees of $200 - $500 were common per patient per consultation in some cases of allergy testing abuse.

3.45 The relevant Part 7 MBS item numbers are as follows :

Identification of one allergy -

item 1903 SP fee $11.40
item 1904 OP fee $ 8.55

Identification of each allergen referred to in item 1903 or 1904 in excess of one -

item 1905 SP fee $5.70
item 1906 OP fee $4.30.[14]

3.46 HIC data shows that these items have been very popular. For example, during the March 1985 quarter 220,568 services were rendered under this group of MBS items, in return for Medicare benefits of $1,077,102.80.[15]

3.47 As a result of recent recommendations made by the MBS Review Committee, after 1 July 1985 only 4 such Part 7 allergy tests can now be undertaken per patient per referral.

3.48 However Medicare benefits for allergy testing are not confined to the pathology part (Part 7) of the MBS. In Part 6 (miscellaneous) Division 9 of the MBS there are also two allergy items as follows :

> Skin sensitivity testing for allergens, using one to twenty allergens :

14 MBS fees as at 1 July 1985.
15 HIC DOS data as at 2 July 1985, thus lower MBS fees apply here to items 1903, 1904, 1905 and 1906 aggregates.

item 987 MBS fee $21.00

Skin sensitivity testing for allergens, using more than twenty allergens :

item 989 MBS fee $32.00.[16]

3.49 It has been suggested to the Committee that APPs and GPs are doing this form of allergy testing, using allergens freely available from laboratories and that $54 is being charged in the case of one to twenty allergens - $21 rebatable from Medicare and the remainder a non-rebatable item. Two different accounts and two different receipts are then being given to patients.

3.50 The RCPA has commented on this saying :

> ...it is possible that some laboratories have started doing this if it is lucrative. We have heard reports that it is a problem and a potential area of abuse.[17]

3.51 Tables 16 and 17 (at the rear of this Chapter) show that the number of MBS item 987 and 989 services being rendered is significant. Notably the higher fee service, MBS item 989, is most popular. If 1984 MBS fees are used, then approximately $2,819,000 MBS fees have been paid for some 101,432 MBS item 987 and 989 pathology services during the period covered by Tables 16 and 17.

3.52 The Committee understands that the usefulness of these allergy tests, and the often expensive courses of treatment which may follow such allergy test results, is questioned by many medical practitioners.

Conclusions and recommendations

3.53 In its examination of SP/OP Medicare pathology benefits the Committee has carefully considered the following points made by Professor Herdson, President of the RCPA :

1 In the context of the medical scheme operating in New Zealand for about 40 years, the practice of pathology was virtually confined either to hospital laboratories or to a limited number of private laboratories, both headed up by pathologists - on the private laboratory side, the Government paid a fee for service to the pathologists, who could not charge additionally, and no other persons, medical practitioners or otherwise, could be paid for or charge for medical laboratory testing.

16 MBS fees as at 1 July 1985.
17 PAC Transcript of Evidence, p. 5151.

2 Turning to the Australian scene, the College position is that ideally all medical laboratory tests should be undertaken in accredited laboratories under the direction of medical pathologists and that no others should be allowed to charge for or receive fees for laboratory tests.

3 Presently, there are sufficient pathologists in Australia (on a pathologist per population basis) to provide for this recommendation (item 2 above) but it is recognised that there are geographic and population density problems in some of the vast 'outback' areas of Australia. However, at least in the large centres, 'pathology services by pathologists' could be achieved forthwith.

4 All medical laboratories should be accredited - the present NATA/RCPA scheme is moving appropriately and should be supported.

5 There is no place for commercial laboratories providing services.

6 Pathologists are the only ones who can provide the vital interpretative and consultative interface between the doctor seeking diagnostic and monitoring help and the laboratory.

7 Greater efforts are required in the teaching of senior medical students and junior hospital medical staff in the best use of laboratory (and other diagnostic) procedures.[18]

3.54 The Committee concludes that :

> In the long run, it would be preferable for Australia to move in the direction New Zealand has as far as limiting the provision of pathology services.

3.55 The Committee fully supports the RCPA President's comments on accreditation (refer Chapter 2), and commercial laboratories and teaching (refer Chapter 4). However, it does not support the claim, implicit in point 2 above, that only recognised specialist pathologists should be allowed to charge for and receive MBS fees for laboratory tests if this means that only the SP fee level will apply to all such tests.

18 PAC Transcript of Evidence, pp. 5130-5133.

3.56 The Committee concludes that :

If pathology services were only available at the SP (specialist pathology) rate there may only be a relatively modest but, nonetheless, significant initial increase in overall pathology costs as most pathology is currently supplied at the SP (specialist pathology) fee level.

It could be expected that commercial laboratories will, if they have not done so already, move to 'acquire' specialist pathologists.

Accreditation of Approved Pathology Practitioners and assessment of their laboratories may (if it is robust enough) counteract the 'lending' of specialist pathologists' names but, by itself, not necessarily hinder the 'for-profit' attitude of some laboratories.

It is likely that making private pathology available only through specialist pathologists would result in an even stronger concentration of suppliers to the market.

Evidence suggests that there are insufficient specialist pathologists 'supervising' tests effectively enough to warrant SP (specialist pathology) fees being charged for all tests done at laboratories with SP (specialist pathology) status.

It appears that many of the tests done at SP fee levels by large commercial laboratories may not be necessary.

The Medicare fees for many pathology services may be inappropriately high judging by the substantial discounts (e.g. 40%) offered by some private laboratories to other Approved Pathology Practitioners.

The widespread application of advanced technology has greatly reduced the cost of many pathology investigations and the Medicare benefits do not appear to have been proportionately reduced.

3.57 The Committee recommends that :

22. The procedure for revision and monitoring of the Medicare Benefits Schedule be regularly reviewed to ensure that changes to the Medicare Benefits Schedule are timely and responsive to allegations of widespread abuse, and reflect cost reductions which stem from the development of technology which underlies many Medicare Benefits Schedule items.

23. Certain minor procedures, such as collecting blood for pathology testing (Medicare Benefits Schedule items 907, 955) and carrying out certain simple pathology tests (e.g. Medicare Benefits Schedule items 987, 989, 2334 to 2342 and 2352 to 2392 inclusive) should not attract Medicare Benefits Schedule benefits when they are performed in association with attendances for which Medicare Benefits Schedule benefits are payable. These procedures should be incorporated in the general attendance items.

3.58 The Committee is concerned that health screening may represent a substantial proportion of the increase in expenditure on pathology services. It is comparatively easy to detect screening, and for Medicare to query eligibility for benefits, when the tests ordered clearly cannot relate to the same illness. It is much harder to detect screening when the regular ordering of tests relates to one kind of illness only. For example, it would be expected that a physician specialising in clinical haematology would order examinations of blood on almost every patient he/she sees, but this may be aberrant behaviour for a general practitioner. It is more difficult still to determine whether screening has taken place when a test or tests are ordered in respect of every consultation with a general practitioner, but the nature of the tests varies from patient to patient.

3.59 In the case of the V.D.R.L. test cited above, the Committee acknowledges that in the interests of public health the performance of additional pathology tests may be a prudent measure. However, the billing and requesting of such tests still needs to accord with the recognised MBS system.

3.60 Although Medicare benefits are not payable for screening services unless the Minister otherwise directs, the Committee recommends that :

24. The Health Insurance Commission continue development of its review systems to ensure that the use of pathology tests for health screening is blocked and no Medicare benefits are paid in these instances.

3.61 The Committee concludes that:

> It is too late, difficult and inefficient to take effective action against pathology screening via ex post legal channels once an abuse has been detected. Preventative action via Medicare Benefits Schedule reform is preferable. Ex post legal action and attempts at restitution and recovery have been shown to be clumsy, inefficient and costly.

3.62 Formidable problems currently arise in such cases because of:

- difficult and different State evidence requirements;
- the fact that there is usually a very large number of pathology tests in question in any one case; and
- in some instances Section 129(3) of the Act can inhibit legal proceedings.[19]

3.63 In the area of legislation the Committee concludes that:

> There are parts of the Health Insurance Act and its Regulations which need amendment to clarify their meaning, limit their application, and facilitate prompt legal remedies.

19 The Section of the Act creating the offence (s.129(1)) is one of strict liability and the elements of the offence are relatively easy to establish. However under s. 129(3) the practitioner is left with a very wide defence provision which he/she only has to establish on the civil standard on the balance of probabilities. Whilst the APP is made strictly liable for the accuracy of the information produced by persons under his/her control, the system by which he/she conducts his/her operations would make it relatively easy to discharge his/her onus by proving, once a case to answer has been established, that he/she did not know and had no reason to suspect that the material to which the charge relates, was false.

3.64 To this end the Committee recommends that:

25. Consideration should be given to the introduction of specific penal provisions in the Health Insurance Act stating that an offence is committed when services have been incorrectly itemised at the SP (specialist pathology) rate instead of the OP (other pathology) rate.

3.65 At present such breaches can only be dealt with under Section 129(1) and significant difficulties are experienced in proving documents (e.g. pathology referral/request forms) to be false in a material particular.

3.66 The Committee also recommends that:

26 Relevant legislative amendments should be introduced to clarify and limit the application of the term 'supervision' in respect of tests billed at the SP (specialist pathology) rate.

27 SP (specialist pathology) Medicare Benefits Schedule fees should only be payable for pathology tests done at branch laboratories of a pathology group (or at central/other laboratories) where a recognised and accredited specialist pathologist is in resident attendance and personally supervising testing.

28 The Health Insurance Act should be amended to prohibit the discounting of Medicare benefits.

3.67 The Committee believes that the rules and conditions surrounding 'self determined' tests need to be tightened up considerably.

3.68 The Committee concludes that:

> In respect of 'self determined' tests ('self determined' by the specialist Approved Pathology Practitioner or non-specialist Approved Pathology Practitioner) the initiating practitioner often has no say in their provision, nor does the patient or the Health Insurance Commission. Yet the initiating practitioner may be held

responsible overall for the pathology costs he or she incurs, the patient who was not consulted may have to pay an additional moiety, and Medicare pays most if not all of the additional bill.

While it is ethical, and may be good medical practice in certain circumstances, for specialist pathologists to 'self determine' that additional or different tests to those requested by the originating practitioners should be performed on specimens while they are conveniently to hand, the procedures and controls on 'self determination' should be clarified and such tests better accounted for.

3.69 The Committee recommends that, for 'self determined' tests:

29. Both the Medicare bills and relevant test results should be required to state clearly which services were 'self determined', bringing this to the attention of both originating practitioners and their patients, and also facilitating any follow-up enquiries that may be judged necessary by the Health Insurance Commission.

30. A sampling system for routine auditing of 'self determination' should be introduced by the Health Insurance Commission. This could be based upon matching original requests (that are currently required to be held by pathologists) for pathology reviews with the consequent reports of results and bills.

31. 'Self determination' should be restricted to individual case by case decisions or authorisations by the responsible specialist pathologists. This should eliminate the common current arrangements whereby generic instructions are given to technical staff so that whenever a particular investigation is requested by an originating clinical practitioner other (usually additional) tests are performed at extra cost.

TABLE 14 - DIVISION 9, PART 7, MBS PATHOLOGY SERVICES*

quarter	number of item 2342 and 2346 services*	item 2342 and 2346 services as a % of all Division 9 services	number of Division 9 services	Division 9 services as a % of all Part 7 tests
March 1985 (1/1/85-31/3/85)	68 904	93.78	73 476	1.35
December 1985 (1/10/84-31/12/84)	67 248	94.69	71 019	1.31
September 1984 (1/7/84)-30/9/84)	69 001	94.80	72 788	1.34
June 1984 (1/3/84-30/6/84)	68 786	94.67	72 659	1.38

* item 2342 = microscopical examination of urine, item 2346 = pregnancy test by one or more immunochemical methods; Division 9 = 13 specified simple basic pathology tests that non-APPs who are practitioners may perform (covers items 2334 to 2392 of the MBS), Part 7 = pathology services part of MBS, data extracted from HIC DCS data as at 23/7/85.

TABLE 15 - SERVICES AND BENEFITS FOR MBS ITEMS 2201, 2202, 2215 2216 AND 2392*

		Number of Services per quarter	Medicare benefits paid per quarter $
Items 2201/2202 - Semen examination for presence of spermatozoa			
2201 (SP fee $6.90)	Mar 85	3 179	17 962.25
	Dec 84	3 149	17 790.30
	Sep 84	3 087	17 440.95
	Jun 84	2 927	15 475.00
		12 342	68 668.50
2202 (OP fee $5.20)	Mar 85	336	1 430.65
	Dec 84	379	1 623.35
	Sep 84	433	1 839.35
	Jun 84	381	1 529.99
		1 529	6 423.34
Items 2215/2216 - Semen examination - involving measurement of volume, sperm count, motility (including duration) and/or viability, Gram stain or similar, morphology by differential count			
2215 (SP fee $34.50)	Mar 85	6 168	172 900.90
	Dec 84	5 805	162 766.40
	Sep 84	6 539	183 308.50
	Jun 84	6 735	177 346.27
		25 247	696 322.07
2216 (OP fee $25.90)	Mar 85	4 679	95 615.00
	Dec 84	4 649	94 376.07
	Sep 84	4 775	95 799.06
	Jun 84	4 918	93 501.65
		19 021	379 291.78
Item 2392 - ($5.20) Semen examination for presence of spermatozoa (this is a Division 9 test which a non APP practitioner may perform, see also Table 14, one set fee applys to this test based on the OP rate)			
	Mar 85	141	596.90
	Dec 84	157	667.25
	Sep 84	161	682.20
	Jun 84	284	1 129.20
		743	3 075.55

* based on HIC DOS data as at 24/7/85, current (1/7/85) MBS fees quoted.

TABLE 16 - MBS ITEM 987 SERVICES *

	1/2/84 to 30/6/84	1/7/84 to 30/9/84	1/10/84 to 31/12/84	1/1/85 to 31/3/85
ACT	246	237	162	212
NSW	4 100	2 861	3 233	3 455
Vic.	2 479	2 095	2 411	2 423
Qld.	466	273	477	576
SA	389	424	350	412
WA	941	831	846	752
Tas.	154	75	50	120
NT	64	51	42	43
Unallocated	-	1	-	-
Total	8 839	6 848	7 301	7 993

* MBS item 987 fee as at 1/7/85 is $21 per service, service is 'skin sensitivity testing for allergens, using 1 to 20 allergens', based on HIC DOP data.

TABLE 17 - MBS ITEM 989 SERVICES *

	1/2/84 to 30/6/84	1/7/84 to 30/9/84	1/10/84 to 31/12/84	1/1/85 to 31/3/85
ACT	563	391	608	499
NSW	13 629	9 173	8 881	7 912
Vic.	3 158	2 405	2 304	2 118
Qld.	3 065	2 144	2 010	1767
SA	1 518	1 201	1 260	1 220
WA	1 143	980	866	859
Tas.	280	146	151	187
NT	13	-	-	-
Total	23 369	16 440	16 080	14 562

* MBS item 989 fee as at 1/7/85 is $32.00 per service, service is 'skin sensitivity testing for allergens, using more than 20 allergens', based on HIC DOP data.

CHAPTER 4

'ENTREPRENEURS' AND PATHOLOGY

- Benefits and dangers
- Concerns voiced by the profession
- Conclusions and recommendations

Benefits and dangers

4.1 Corporate structures in medicine are an accepted part of today's environment. Large and small companies own individual installations such as private hospitals, pathology laboratories, general practitioner clinics etc. Some have gone further and integrated vertically and/or horizontally in their provision of medical services e.g. a chain of GP clinics linked to a particular pathology group within one (complex) corporate structure.

4.2 Currently, one aspect of this commercial approach to the provision of medical services - the emergence of the incorporated 'medical entrepreneur' - poses a serious threat to the quality of patient care in the community and has the potential to distort the allocation of Commonwealth Medicare benefits. Many individual practitioners as well as professional medical organisations such as the AMA, GPSA, DRS, RACR and RCPA have expressed to the Committee their grave concerns about the infiltration and marketing operations of 'medical entrepreneurs'.

4.3 The principal concern of the medical profession is that the 'medical entrepreneur' is characterised by his/her ranking the pursuit of profit and market control over and above patient care.

4.4 These people may or may not be medical practitioners and usually possess a very highly developed sense of organisational ability and business acumen. 'Entrepreneurs' usually, but not always, appear to work just within the bounds of the law, pay lip service to professional ethics and vigorously scrutinise regulatory measures (both professional and governmental) for loopholes and areas of imprecise interpretation/specification.

4.5 The AMA's medical news magazine 'Medical Practice' reported in its June 1985 edition that:

> The RACR is seeking urgent talks with the Commonwealth and NSW Governments to ensure that radiology does not experience the 'scandals' seen in pathology in the 1970's.[1]

1 'Medical Practice', Australasian Medical Publishing Co. Ltd., Glebe, June 1985, No. 30, pp. 18-21.

4.6 It went on to state that entrepreneurial schemes currently being offered to doctors to participate in the establishment of expensively equipped centres 'imply a considerable amount of overservicing'.[2]

4.7 At its meeting the AMA Federal Council resolved that the Association's President should convene a meeting of representatives of appropriate bodies to develop recommendations about entrepreneurial activities in medicine. At the meeting 'grave concerns' about a number of businessmen attempting to become silent partners in practices were expressed to the AMA Federal Council.

4.8 At the AMA's recent Federal Assembly the then President, Dr Thompson, said the Association was concerned about entrepreneurial developments in medicine. He said there was concern that:

> Unless one was very careful one could end up with a 'depersonalised' sort of situation in medical practice. But provided that such activities were conducted legally, the people employed had a proper contract which protected their interests; there were no kickbacks, the referral process did not abuse the national health scheme; and people behaved ethically, it was very difficult to object. The area is one which must, and will, be examined.[3]

4.9 The Committee believes that many of the entrepreneurial medical schemes currently in operation violate these last two conditions outlined by Dr Thompson, i.e. they abuse the national health scheme and involve unethical behaviour.

4.10 An example of a 'medical entrepreneur', whose corporate medical marketing operations, general practice style and professional ethics are currently of serious concern to both the profession and the Government, follows. This particular general practitioner (referenced as Dr X in the examples below) operates a large complex commercial practice which, among other things, includes several suburban clinics. Each of these clinics refer almost all their pathology tests to Y Pty Ltd - a pathology company owned and operated by Dr X.

4.11 Investigations of this 'entrepreneurial' doctor have found that, among other things:

- Dr X has a high incidence of collecting blood for pathology (MBS Item 955, fee $3.40), in May 1984 there were 232 cases where the collection of blood by Dr X had been itemised but no pathology had been subsequently requested or performed;

2 'Medical Practice', op.cit.
3 ibid., July 1985, No. 31, p. 16.

- virtually all Dr X's pathology tests were performed by Y Pty Ltd;
- Medicare benefit payments to Y Pty Ltd in May 1984 totalled $144,667 for 9904 pathology services, this represents an average cost of $114.91 per patient and 7.87 services per patient (compare with data in Table 8D, Chapter 1);
- Medicare benefit payments to Y Pty Ltd during May 1984 resulting from Dr X's requests totalled $86,363.87 for 5723 services, this averages $130.26 per patient and 8.63 services per patient;
- the balance of pathology services performed by Y Pty Ltd for which Medicare claims were processed in May 1984 were requested by 16 other medical practitioners, of which 13 were practice partners of Dr X;
- perhaps because of tax reasons Medicare benefits paid to pathology laboratories in June 1984 as a result of tests requested by Dr X fell dramatically to $605.70, of which $122.80 was paid to companies other than Y Pty Ltd;
- in July 1984 Medicare benefits paid to Y Pty Ltd as a result of pathology tests requested by Dr X totalled $284,020.35 for 22,553 services, this represented a cost of $125.67 per patient and 7.98 services per patient (compare with data in Table 8D, Chapter 1);
- Dr Z, a practice partner of Dr X's also requests all his pathology tests from Y Pty Ltd, for the two month period May - June 1984 Medicare benefits totalling $20,314.10 were paid as a result of Dr Z's requests for 1370 services, this represents an average cost of $75.24 per patient and 5.67 services per patient (compare with data in Table 8D, Chapter 1);

- a review of pathology services ordered by Dr X and Dr Z has revealed abnormally high instances of certain services, these included the apparent routine ordering of Item 1401 (SP MBS fee $23.00), this test is restricted to one per annum for proven cases of an unusual medical condition known as hyperlipidaemia and was one of an apparent routine series of tests ordered by both Drs X and Z;

- similarly Item 1313 estimation of glycosylated haemoglobin (SP MBS fee $20.50) appears to be routinely ordered, this test is restricted to 3 services per annum for patients who require management of established diabetes; and

- generally the review revealed numerous instances of pathology tests attracting benefits in excess of $500.00 being ordered by Dr X for each patient on the same day.[4]

4.12 This doctor, his various practices, partners and associated companies are under detailed investigation at present as part of an intensive joint effort by the HIC, DoH, AFP and DPP.

4.13 Perhaps the most disturbing thing about such a case as the one above is that, instead of being a lone example, it is symptomatic of a relatively new breed of 'medical entrepreneurs'.

4.14 Another example of the type of 'entrepreneurial' matter of concern to the Committee is at Appendix 3. These two advertisements for doctors are linked with a complex commercial medical empire. A significant financial segment of this empire is its pathology service which contributes significantly to the overall cash flow of the corporate group.

4.15 There would appear to be an implicit suggestion of overservicing in the phrase 'those with entrepreneurial skills will find our organisation most attractive'. While the principal practitioner behind this organisation has been quoted as welcoming 'a new quality of competitiveness' evidence suggests that his current record on pathology and prior corporate dealings characterise the 'profit first' motive of the group.

4.16 Turning to another aspect of commercial pathology laboratories' operations there appears to be a recurrent problem with aggressive marketing and over-zealous servicing by new

4 PAC file 82/9/B(2) Pt. 6.

entrants in the market. For example a review of a newly established laboratory in one of the smaller States revealed that between 1 February 1984 and 30 June 1984:

- services ordered by the practitioner who owned and controlled the laboratory constituted 56% of all services performed;

- the laboratory had repeatedly direct billed and patient billed for the same service;

- the practitioner concerned in the running of the laboratory had direct billed and patient billed him/herself for the same pathology services, (contrary to the form of Undertaking under Section 16B of the Health Insurance Act); and

- the laboratory had pathology tests performed by another large commercial laboratory in another (distant) State and, on return of the accounts from the other laboratory, added additional items and forwarded the amended accounts to the patients concerned.

4.17 The Committee is encouraged to see that Commonwealth authorities are now well aware of malpractices like those mentioned above. The complexity and detail of many of these cases make effective prosecution action (as opposed to prosecution for minor offences) very difficult, requiring many resources and much time. Only in a limited number of cases like those mentioned above has the Commonwealth been successful and effective in follow up action. Importantly the HIC is now developing and implementing system changes to prevent and/or signal pathology overservicing as well as counselling doctors directly (and indirectly via the profession) when early signs of abnormalities appear (refer Chapters 2 and 3).

4.18 The difficulty of coming to grips with 'entrepreneurs' in medicine has been recognised for some time. Dr S Wohl, in his book on 'the Medical Industrial Complex' states:

> While I strongly criticise some of the activities of big business, I also clearly recognise their positive contribution and the fact that they must be included in any scheme for reforming the system. If one approaches the matter from a neutral ideological position, one can probably see

both ... the beneficial and adverse consequences of, as well as a certain hindsight inevitability to, the new manner of health care delivery. On the credit side, for example, the for-profit systems claim to be working towards cost containment and uniform standards. On the debit side, the for-profit companies practice deliberate overutilisation and choose, when they are free to choose, affluent patients and high mark-up treatments only. But it is also true that some doctors have come a far way all by themselves toward acting (and being perceived by the public as acting) very differently from the selfless apostles of cure. In many ways the medical profession itself directly and indirectly abetted the for-profit takeover of its sacred calling.[5]

4.19 In discussing what he calls 'medi-glomerates' Wohl makes the very relevant point (especially in the case of some large Australian pathology companies):

> If these corporate entities were independent, autonomous companies each competing with the others, there would be less cause for concern. The problem is, however, that they are often closely interrelated in not always perceivable ways by common ownership of stock, shared board members, frequent instances of joint ventures and frequent transactions among themselves. They are sympathetically aware of one another, whether they are obviously competing or not, and the consequences for the public are not always happy ones.[6]

Concerns voiced by the profession

4.20 Concern about 'entrepreneurs' and the for-profit attitudes of some commercial laboratories have been expressed to the Committee by all levels of the profession.

4.21 The Vice-President of the RACR stated that:

> The problem with pathology laboratories is that a commercial operation being promoted by advertising can attain a large

5 Wohl S., 'The Medical - Industrial Complex', Harmony Books, New York, 1984, pp. 2-3.
6 ibid., p. 87-88.

> subsegment of the market and can actually be turning over very large volumes of work so that they do influence the results. We are aware that the average consultant specialist practice around Australia runs a fairly uniform average fee per patient seen, and yet there are other labs that draft way above this fee and that can only represent greater amounts of work being done on patients. If we analyse their patient profiles, it is very likely, in my opinion, that many of those patients are relatively well and not the mix of seriously ill patients who go to the regular consultants, so that the actual overusage is much greater than appears from the raw figures. This is why I think substantial savings are possible because much of that work would not be done.[7]

4.22 In this context the Vice-President also stated that he had:

> ...looked at the figures provided for differences in pathology utilisation in different States and I believe that as much as $20m of the present bill could be removed if incentives were taken out of the system, if poor quality work was stopped by accreditation and if work was done at a proper standard. It is difficult to define overservicing, as everybody who has been involved with it states, but what I think is happening is that a number of pathology services are being performed which are marginally useful to the patient but for which there is at present a double motive, one being that it certainly could be useful to the patient but also (the doctor).[8]

4.23 The argument, put to the Committee by several witnesses associated with large commercial laboratories, that such laboratories operate more effectively because they have better quality control, has been questioned by many professional pathologists.

4.24 A witness for the RACR commented:

> I would find it very difficult for them to substantiate that claim. Quality control is more complex than producing the correct results from the machines at some times

7 PAC Transcript of Evidence, p. 5142.
8 ibid., p. 5138.

when you are testing them. It really lies in the specialist pathologist giving an informed opinion on the results going out, being satisfied they are correct and that they are medically useful. Conventional specialist pathologists do advise their referees to order less tests or more appropriate tests during discussions with them. In other words, a big stratum of true professional service still exists. It is perhaps losing ground in terms of total volume or share of the benefits paid to organisations which simply turn out numbers. It would be very interesting to have accreditation and enable inspectors to go in and look at the quality control. There are two types of quality control - a sort of concert performance done once a month when the external tests come in and the day to day one, all through the 24 hours - and there could be a big difference in the performance of those.[9]

4.25 While the Committee believes that its conclusions and recommendations (in Chapter 2) on APP accreditation, laboratory inspection/assessment and the tightening up of the APP scheme generally may address this issue, it is mindful of the following remark of the RCPA Treasurer:

> I believe that, possibly, some of the very large commercial pathology practices perform quality work and that the quality assurance would be of the same order as that provided by a so-called consultant pathologist or a hospital pathologist. However the large commercial laboratories would be possibly getting an enormous volume of work, much of which would be totally unnecessary. I think that this is where the amount of money that is being spent is perhaps being misspent. A large amount of that is done. Although the quality may be fine, it is (not) great to produce a whole lot of normal results. I believe that most of these (apparently unnecessary) tests are requested by general practitioners.[10]

9 PAC Transcript of Evidence, pp. 5142-3.
10 ibid., p. 5143.

4.26 One specialist pathologist described some GP request forms as:

> ...like the scenario to an MGM spectacular. Sometimes the paper is not big enough for GPs to write all the tests down in three columns and you could knock up a bill of $300 very quickly where, ordinarily speaking, the full blood count and the general biochemical lookat would cost about $50.[11]

4.27 At a 1983 RCPA Council seminar on undergraduate teaching in pathology the serious disadvantages that large scale automation and computerisation in pathology has raised in terms of under/post graduate education were discussed. Among the disadvantages noted was the following:

> There is a slow but inexorable decline of diagnostic pathology (particularly biochemistry and haematology) from a consultative and interpretive service to a numbers game. Computer storage of haematology files involves serial results from the standard 8 parameter automated instruments; no record is kept of the clinical history, the interpretation of red cell changes, or suggestions for further investigation. Numbers are easy to produce and easy to store; the qualitative aspects of pathology are suffering, and the type of information that we tell students is important has become inaccessible.[12]

4.28 Relevant to this point is the following observation of a specialist pathologist witness:

> ...in private practice, it is possible for skilled practitioners to operate on much lower test volumes and many do. They critically assess what tests they should order but the commercial labs, in particular, have fostered, among the younger practitioners going into practice, a continuation of the (over) ordering patterns of hospital. The result is one which makes life a little easier for the new practitioner and much more profitable for all the parties concerned.[13]

11 PAC Transcript of In-Camera Evidence, PAC file 82/9/B(100).
12 Refer Enclosure F of RCPA submission 20 June 1984 (PAC Transcript of Evidence, pp. 5122-5128).
13 PAC Transcript of Evidence, p. 5144.

4.29 A more subtle form of 'entrepreneurial spirit' also appears to be embodied in the reporting system of large commercial pathology groups. A spokesman for the DRS noted that :

> ...these massive pathology groups in Melbourne and Sydney and elsewhere are only responding to what is now normal practice by large numbers of local doctors servicing peripheral areas. From my experience, the way they report their investigations points towards overservicing. They have a great capacity for advising further investigation for mildly abnormal results on initial investigation.
>
> In fact I know it is tapped into the word processor. For instance, a slightly low platelet count, which is a common finding and of little clinical significance if the individual is not bleeding or bruising, commonly occurs in a viral infection. I know that in one big pathology group in Melbourne it is automatically tapped in - 'suggest repeat in 14 days' - for a mildly low platelet count.[14]

4.30 A further aspect of commercial pathology laboratories that was widely reported on, debated and legislated against in the late 1970's, yet is still understood to continue in several forms today, is the ugly 'entrepreneurial' phenomenon of kickbacks.

4.31 Representatives of a large pathology group identified such kickbacks as commonly falling into three categories today:

- kickbacks - cash is still prevalent and is usually a percentage of referrals;
- rental deals for space; and/or
- kickbacks in kind - from trips, holidays, white goods, etc.[15]

4.32 These representatives stated to the Committee that they believed that these practices were more likely to occur amongst smaller, less established laboratories which lack a solid base of genuine referring practitioners.

4.33 They argued the following:

> Basically in our experience of kickbacks, to the degree that they are called significant, in the sense of cash, you are talking about the very nature of a cash business, if you like. The larger the practices are, the more likely they are of having a very systematised control of accounting which is auditable from A to Z. The practices that I am thinking of are very much cash-oriented small practices.[16]

4.34 The Committee remains sceptical about this argument. Most witnesses have confirmed that they have some hearsay knowledge/awareness of kickbacks and usually associate such activities with the larger 'entrepreneurial' commercial laboratories. A specialist pathologist argued along the following lines:

> I think that is wrong because the small laboratory could not afford to give them. The overheads in pathology are gigantic. It leaves you with very little profit margin. If you then had to give something back, you may as well not even open the shop in the morning. I think you would need a vast revenue on which to fall back, to be giving anything away.[17]

4.35 Perhaps the strongest view expressed to the Committee about 'entrepreneurial' commercial pathology laboratories was that of the RCPA President, Professor Herdson:

> I believe that the position should be that in the long run, laboratory procedures for human beings in this country, should be undertaken only in the laboratories which are headed up by pathologists. I believe that there is just no case for laboratory tests being undertaken by people who have no direct interest in patient care. In other words, I think it is not on for companies to be having no medical input at all and to be running laboratory procedures.[18]

4.36 The Committee is aware that, at present, this ideal situation may not be practical because of the need for exceptions and what the existence of those exceptions give rise to in a market open to 'entrepreneurs'. An example of a necessary exception may be where specialists in major hospital practice are also responsible for the department which does the work in haematology and endocrinology and thus may not refer testing away from themselves. In these cases 'arms-length' referral may not be possible.

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14 PAC Transcript of Evidence, p. 5198.
15 PAC file 82/9/B(88).
16 PAC file 82/9/B(88).
17 PAC Transcript of In-Camera Evidence, op.cit.
18 PAC Transcript of Evidence, p. 5133.

4.37 The RCPA Vice-President, Dr Davies, commented on problems in allowing valid exceptions as follows:

> One of the problems with commercialisation has been that when perfectly legitimate exceptions are made those exceptions are used as a basis for arrangements that are really financially contrived rather than for the practice.[19]

4.38 The adverse side of 'entrepreneurial spirit' in pathology is not confined to the large commercial laboratory sector. The Committee is aware that small 'backyard' non-specialist APPs have approached specialist pathologists seeking the specialist's part-time or full-time 'partnership' in order to expand their operation, legitimise their public face and obtain SP fees for tests undertaken (be they 'sink tests' or otherwise).

4.39 For example, a specialist pathologist related the following incident to the Committee:

> I was phoned up one day by a little gentleman who is operating out of a fruit shop-front in (a Sydney suburb) somewhere.
>
> He used to be a courier for the pathology firm that he worked for before - a courier, he drove a car - and he now owns a pathology practice. He rang me up and propositioned me and I told him to forget it. I get phone calls from everywhere. Maybe because I am a solo practitioner they think I might be looking for a few more bob. They ask whether I will come and do this, that and the other, and the answer is no. You have couriers, you have nobodies running pathology practices, and this is one of the problems too. They can hide under something called a corporate provider number which means they do not even have to be a doctor.[20]

4.40 The Committee believes that such 'backyard' laboratories may be relatively few in number and small in industry significance when compared to the operations of the major laboratories. Laboratory inspection and assessment under the NATA APP accreditation scheme and the tightening up of the APP scheme's administration, as recommended by the Committee in Chapter 2, should satisfactorily address this problem.

19 PAC Transcript of Evidence, p. 5160.
20 PAC Transcript of In-Camera Evidence, op.cit.

4.41 General practitioners also, as clients of pathology laboratories, are seeking to do deals with laboratories (either specialist or non-specialist APP, or non-APP) often on a fee splitting basis. Such deals promote overservicing as the returns to the GP are based on the type and number of tests he/she refers. The laboratory processing the tests is not encouraged to query on clinical grounds the necessity of any apparent excessive ordering of tests. Such deals are prohibited by Sub-section 129AAA(1) of the Health Insurance Act for APPs (non-APPs are not covered by the Act).

4.42 The following incident, related to the Committee by a specialist pathologist, typifies this kind of entrepreneurial activity:

> I recently had a GP ring me and ask for a tender on $50,000 worth of work per annum. I was offered 30 minutes in which to reply and informed that six other laboratories were offering tenders. I rank back some six hours later to inform this 'gentleman' that his proposition was illegal, I had checked with officers of the Federal Health Department. He (the GP) laughed at my incompetence and informed me that:
>
> (i) his solicitor had stated that, after examining the appropriate legislation, fee splitting between companies was legal and calling for tenders was a widespread acceptable practice;
>
> (ii) the matter had been settled, he had signed an agreement whereby his company (fully owned by the GP) became a shareholder of a large respected pathology laboratory; and
>
> (iii) that while I was competent to direct a laboratory I was not competent to run a business; he (the GP) wondered how I had survived the last twenty years.[21]

Conclusions and recommendations

4.43 The Committee concludes that :

> Strengthening of the administration of the Approved Pathology Practitioner scheme - in particular regular review of Approved Pathology Practitioners upon re-appointment and the immediate introduction of mandatory

21 PAC Transcript of In-Camera Evidence, op.cit.

accreditation should quickly remove unscrupulous 'entrepreneurs' from the non-Approved Pathology Practitioner market, and to some extent dampen the undesirable side of some Approved Pathology Practitioner and specialist Approved Pathology Practitioner commercial laboratories 'entrepreneurial spirit'.

The recommendations of this Report should reveal the 'medical entrepreneurs' business practices to the profession, the Commonwealth's administration and the community and thus help generate a greater degree of public accountability. The need for such accountability is indisputable and paramount given the public funding of Medicare pathology benefits.

Further measures are needed in order to strengthen the resolve of both the profession and the Government to check the growth of undesirable 'entrepreneurial' practices in pathology. These measures involve both long and short term commitments to :

- strengthen professional ethics and their application;
- improve co-operation between the profession and the Government;
- enhance the information on 'entrepreneurial' activities available to agencies involved in reviewing Medicare claims; and
- developing a program of independent and objective research into the structure, ownership and economics of the Australian pathology industry.

The growth of the new breed of 'medical entrepreneurs' needs to be checked if the profession is to maintain its effectiveness in society and accountability to society.

4.43A As one author has put it:

> Ours is a cynical society, less willing perhaps to accept protestations of altruism or to accept altruistic behaviour at its face value than people were in the past. We no longer expect people to be motivated solely

or even primarily by a concern for service. In such an atmosphere the claims of the professions will be treated less respectfully than formerly.

They will be examined with suspicion and scepticism. In such a situation, the professions have felt the need to adopt new and more militant methods to preserve their position in the hierarchy of pay and privilege - which make protestations of an ideal of service sound rather hollow. Outsiders and critics see the professions as using their clients, often the most helpless and needy in society, as counters in the struggle for a better deal for themselves.[22]

4.44 The Committee concludes that:

> Socially undesirable 'entrepreneurial spirit' in the provision of pathology services, or in any other area of medicine, cannot be combatted by any single or simple solution. Rather a combination of techniques need to be applied at a variety of levels - the problem is one for both the Government and the profession.

4.45 The Committee also concludes that:

> Knowledge of many characteristics of the Australian pathology industry is poor in both the Commonwealth's administration and the profession generally.

4.46 The Committee therefore recommends that:

32. Sufficient resources should be made available to the Health Insurance Commission to permit it to complement the Medicare claims information provided by its systems with details derived from field surveys. Such surveys should encompass -

- searches of company records to determine the ownership of pathology companies;
- research to establish the ownership and relationship of relevant subsidiary companies to their main corporate bodies;

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22 Wilding, P., 'Professional Power and Social Welfare', Routledge and Kegan Paul, London, 1982, ch. 4, p. 111.

- precise identification of those providers, together with their qualifications, in whose names services are being billed; and

- research to establish if a specialist pathologist is actively engaged in the provision or supervision of those services billed under his/her provider number, or has 'lent' his/her name for specialist billing purposes only.

4.47 In addition, the Committee recommends that:

33. The Health Insurance Commission place a special emphasis on reviewing the claims of new (active) Approved Pathology Practitioners.

34. The Australian Institute of Health conduct a detailed industry study of the provision of pathology in Australia to assess and report various industry-wide economic characteristics.

35. The Australian Institute of Health survey and document systems of pathology accreditation and the provision of pathology services in other countries.

36. The Australian Institute of Health develop and undertake a comprehensive research program to analyse specific aspects of current changes in the Australian industry.

4.48 The apparently straight forward solution of calling for greater self regulation by scrupulous peer review and enforcement of professional codes of ethics has several disadvantages when it comes to addressing 'medical entrepreneurs' in pathology. They include problems that:

- not all pathologists are members of professional bodies such as the RCPA or AMA who may be able to act on their codes of ethics;

- such ethical codes usually only apply to individuals and not corporations or their management;

- the sanctions under such professional codes are often crude and it is not easy to make the subject weigh the social costs of his/her activities with the social costs of avoiding such activities;

- there is a danger that in some cases a professional body's priorities will be distorted by self interest if it relies too heavily on such a regulatory process; and

- the collectivisation of professional values may tend to manifest itself in a conspiracy of silence if there is division of opinion over the legitimacy of 'entrepreneurial' actions.

4.49 Thus the Committee concludes that:

> There are significant problems in the profession taking action to self regulate 'pathology entrepreneurs' via peer review and the application of professional ethics.

4.50 Despite this the Committee does not wish to downgrade the importance of peer review activities and the enforcement of professional codes of ethics. However, it does recommend that together with these traditional avenues:

37. The National Pathology Accreditation Advisory Council, in conjunction with the Department of Health, Health Insurance Commission, National Association of Testing Authorities and the Director of Public Prosecutions completely revise and strengthen the Approved Pathology Practitioner Code of Conduct in light of recent 'pathology entrepreneurial' moves.

38. The Department of Health, in conjunction with the National Pathology Accreditation Advisory Council, the Health Insurance Commission and the Director of Public Prosecutions research options and implement measures to strengthen the applicability of the Approved Pathology Practitioner Code of Conduct to legal actions concerning 'pathology entrepreneurs'.

4.51 The Committee concludes that:

> Technological advances in pathology may assist 'entrepreneurs' to overservice.
>
> Generally technological change in the field of pathology has led to a reduction in testing time, labour and cost through the increased use of multiple analysis procedures.

4.52 The consequences of such procedures mean reductions in actual costs. Also limited minimum analysis procedures are available, to the extent that one can, in some fields no longer obtain individual analysis tests except by a pathologist manually performing the tests. In many cases only multiple results from tests can be obtained (if only because it is not economic to run a piece of technological equipment for only one test).

4.53 An example of such technology is the sequential multi-channel analyser computer which has meant that one machine can provide from the one blood sample many tests in the same time or less than it would take a pathologist to do one test physically in the laboratory. The total cost of operating the machine for one test may be greater than the individual test by the pathologist.

4.54 Thus the Committee concludes that:

> The cost effectiveness of the technology which performs a number of pathology tests must be considered in the assessment of the Medicare Benefits Schedule, especially when new pathology tests are being considered for inclusion in the Medicare Benefits Schedule.
>
> Advances in technology have been rapid and have had significant effect on the operations of pathology laboratories, especially the larger commercial laboratories. These developments need to be closely monitored to allow consequential adjustments in remuneration to Approved Pathology Practitioners.

4.55 The Committee recommends that:

> 39. Where new clinical laboratory test procedures in pathology are advanced to the Medicare Benefits Schedule Review Committee, the developers and manufacturers of such tests should provide the following cost-effectiveness data before consideration is given to granting a Medicare benefit for the test -
>
> - information needed to calculate the costs of performing the test;
> - clinical sensitivity and specificity calculations based upon a patient population sufficiently large to enable reliable conclusions to be drawn about the efficacy of the test; and
> - cost and efficacy comparisons with existing tests used for the same or similar purpose.

4.56 One further matter which the Committee has considered in connection with pathology entrepreneurs (either APPs or referring practitioners) is that of improved patient awareness.

4.57 The Committee concludes that:

> In many cases where pathology abuse has occurred it appears that the patient has not been aware of the general type or extent of pathology tests being ordered.

4.58 Patients generally accept proposals for pathology tests readily. The inconvenience is often minimal, the costs to the patients are mostly if not entirely covered by Medicare benefits, and patients appear to readily believe that pathology tests will help them or at least be interesting.

4.59 The Committee concludes that:

> Better informed patients, interacting with their medical practitioners on the pros and cons of pathology investigations and having increased potential to audit the bills for services provided, could lead to more rational health care and use of pathology services.
>
> Many clinical medical practitioners appear to gradually lose touch with the minutiae of pathology as they work in general practice and the various clinical specialities. Some may rapidly lose competence in the ordering of pathology investigations and instead of ordering the most relevant and useful specific tests may order the most vaguely defined, non-specific or even the wrong tests. It is unlikely that these problems can be significantly ameliorated by any single measure in isolation, such as improved undergraduate preparation for independent clinical practice or peer review.
>
> As all pathology investigations result in reports to the originating medical practitioners, the most simple, effective and inexpensive method of bringing these costs and benefits simultaneously to the attention of all practitioners and their patients would be to record the Medicare fees alongside the results.

It may be desirable for both the patient and the referring practitioner, during a consultation, to be made more aware of the pathology tests and associated Medicare Benefits Schedule costs that were being incurred due to a referral or a request that was about to be forwarded to a pathologist.

4.60 Thus the Committee recommends that:

40. A continuous feedback of educative cost/benefit information about pathology be organised for all medical students in their clinical years and all clinical medical practitioners throughout their subsequent professional careers.

41. The introduction of regulations requiring referring practitioners to itemise all pathology requests with Medicare Benefits Schedule benefits, together with an appropriate brief description of the pathology service(s), and to, by law, provide a copy to the patient before the tests are actually formally requested.

APPENDIX 1

Medical Fraud and Overservicing Inquiry

List of Hearings

Tuesday 23 March 1982, Canberra

in camera hearing

Thursday 25 March 1982, Canberra

in camera hearing

Thursday 20 May 1982, Canberra

in camera hearing

Thursday 8 June 1982, Melbourne

in camera hearing

Thursday 1 July 1982, Canberra

Commonwealth Department of Health	Dr H C Anderson Mr J G Burt Mr N M Hill Dr G Howells Mr A J Kelly Mr J S McCauley Dr C Selby Smith
Observers	Mr J P Chandler Mr A Chapple Mr P J Hinchy
Advisor	The Hon Mr Justice P B Toose, QC CBE

Friday 2 July 1982, Canberra

in camera hearing

Tuesday 13 July 1982, Canberra

in camera hearing

Wednesday 14 July 1982, Canberra

Commonwealth Department of Health	Dr H C Anderson Mr J G Burt Dr C P V Evans Mr N M Hill Mr A J Kelly Mr J S McCauley Dr L J O'Keffe Dr C Selby Smith
Observers	Mr A Chapple Mr P J Hinchy Mr C J Louttit
Advisor	The Hom Mr Justice PB Toose, QC CBE

Monday 26 July 1982, Canberra

in camera hearing

Tuesday 27 July 1982, Canberra

Commonwealth Department of Health	Dr H C Anderson Mr J G Burt Dr C P V Evans Mr N M Hill Dr G Howells Mr A J Kelly Mr J S McCauley Dr L J O'Keefe Dr C Selby Smith
Medibank Private	Mr M J Brennan Mr J M Evered Mr G M Lewis Mr C R Wilcox
Observers	Mr A A Chapple Mr P J Hinchy Mr C J Louttit

Wednesday 4 August 1982, Sydney

Commonwealth Department of Health	Dr R R Bull Dr K H S Cooke Mr D A Devenish-Meares Dr W H Howell Mr A B McDonald Mr E R Morton Mr M J O'Brien
Doctors' Reform Society	Dr A M Liebhold Dr A J Refshauge
Hospitals Contribution Fund of Australia	Mr D L Gadiel Mr M G Longhurst
Observers	Mr A A Chapple Mr P J Hinchy Mr C J Louttit

Thursday 5 August 1982, Melbourne

in camera hearing

Commonwealth Department of Health	Mr K C Amery Dr C B Eccles-Smith Mr P J Hede Mr P D Tratt Dr I M Tullock Dr R C Webb
Dr D G Legge	
Professor L J Opit	
Observers	Ms S Geddes Mr P J Hinchy Mr C J Louttit

Friday 6 August 1982, Adelaide

in camera hearing

Commonwealth Department of Health	Mr R C Cain Dr J Y Hancock Mr J L May Dr A J O'Donnell Mr J P Toohey
Observers	Mr P Foster Mr P J Hinchy Mr C J Louttit

Thursday 19 August 1982, Canberra

in camera hearing

Tuesday 24 August 1982, Canberra

Medibank Private	Mr J Brennan Mr J M Evered Dr P E Gunton Mr G M Lewis
Observers	Ms S Geddes Mr P J Hinchy Mr K Jones Mr C J Louttit

Tuesday 7 September 1982, Canberra

in camera hearing

Commonwealth Department of Health	Dr C B Eccles-Smith

Tuesday 14 September 1982, Canberra

Mr D R Harvey	
Observers	Ms S Geddes Mr P J Hinchy Mr C J Louttit

Tuesday 21 September 1982, Canberra

Australian Medical Association	Dr F B M Phillips Dr G D Repin
Observers	Ms S Geddes Mr P J Hinchy Mr C J Louttit

Wednesday 29 September 1982, Brisbane

in camera hearing

Commonwealth Department of Health	Dr J A McDougall Mr R D Price Dr P E R Ubrich Mr R A Vendrell Mr R J Walsh Dr D P Wilkinson
Observers	Ms S Geddes Mr P J Hinchy Mr C J Louttit

Tuesday 12 October 1982, Canberra

Department of Administrative Services	Mr M F Domney Mr H D Logue
Australian Federal Police	Mr R Farmer Mr J C Johnson Mr C S Winchester
Observers	Ms S Geddes Mr P J Hinchy Mr C J Louttit
Advisors	The Hon Mr Justice PB Toose, QC CBE Mr M Johnson Dr P E Gunton Mr S Rares Dr H Stock

Tuesday 19 October 1982 Canberra

Attorney-General's Department	Mr J H Broome Mr P F McDonald Mr B J O'Donovan Mr H F Woltring
Royal Australian and New Zealand College of Psychiatrists	Dr W A Barcley Dr C Degotardi Dr J McG Grigor Professor B Raphael
National Association of Medical Specialists	Mr J P Gibson Dr T D Orban
Observers	Ms S Geddes Mr P J Hinchy Mr C J Louttit
Advisor	The Hon Mr Justice PB Toose, QC CBE

Thursday 21 October 1982, Canberra

in camera hearing

Tuesday 26 October 1982, Canberra

Commonwealth Department of Health	Dr H C Anderson Mr J G Burt Dr C P V Evans Mr N M Hill Dr G Howells Mr A J Kelly Mr J S McCauley Dr L J O'Keefe Dr C Selby Smith
Attorney-General's Department	Mr J H Broome Mr L J Curtis Mr P F McDonald Mr B J O'Donovan Mr H F Woltring
Observers	Mr A Agafonoff Mr J Chandler Ms S Geddes Mr P J Hinchy
Advisor	The Hon Mr Justice PB Toose, QC CBE

Wednesday 27 October 1982, Canberra

Commonwealth Department of Health	Dr H C Anderson Mr J G Burt Dr C P V Evans Mr N M Hill Dr G Howells Mr A J Kelly Mr J S McCauley Dr L J O'Keefe Dr C Selby Smith
Observers	Mr A Agafonoff Ms S Geddes Mr P J Hinchy
Advisor	The Hon Mr Justice PB Toose, QC CBE

Thursday 11 November 1982, Canberra

Mr C A Nettle

The Hon M J R Mackellar, MP

Observers	Ms S Geddes Mr P J Hinchy Mr C J Louttit
Advisor	The Hon Mr Justice PB Toose, QC CBE

Tuesday 31 May 1983, Canberra

in camera hearing

Monday 11 July 1983, Canberra

Australian Medical Association	Dr F B M Phillips Dr G D Repin
Observers	Mr A Agafonoff Ms S Geddes Mr P J Hinchy

Wednesday 13 July 1983, Canberra

in camera hearings

Monday 1 August 1983, Canberra

in camera hearings

Wednesday 3 August 1983, Canberra

in camera hearings

Monday 2 April 1984, Canberra

Commonwealth Department of Health	Dr H C Anderson Mr G M James Mr J W Kilpatrick Mr J S McCauley Mr K M Riordan Dr C Selby Smith Mr W T L Taylor Mr W G Turk Dr R H C Wells Mr L J Willett Mr P R Wright
Observers	Mr J Chantler Mr A Chapple Mr A B McNevin

Thursday 19 April 1984, Sydney

The Hospitals Association of NSW	Mr C R James
Capital Territory Health Commission	Mrs Y M Blake Dr K McG Doust Mr P N Guild Mr D J Lambart Dr P M Tatchell
Australian Council on Hospital Standards	Dr B R Catchlove Ms A T Porcino

Monday 30 April 1984, Canberra

Health Insurance Commission	Mr M J Brennan Mr J M Evered Dr P E Gunton Mr G M Lewis
Observers	Mr J Chantler Mr A Chapple Mr A B McNevin

Monday 21 May 1984, Sydney

Professor D McNeil	
Royal Australasian College of Surgeons	Dr B P Morgan Professor T S Reeve
Royal Australasian College of Physicians	Professor J B Hickie Dr P P Laird
Royal College of Pathologists of Australasia	Dr W E L Davies Dr N J Nicolaides Dr E Raik
Royal Australasian College of Radiologists	Dr R J Glasson Dr P C Wilson
Observers	Dr H C Anderson Mr I Buttsworth Mr J Kilpatrick

Monday 4 June 1984, Canberra

Department of Veterans' Affairs	Dr G E Brooks Mr J G Cosgrove Mr J A Costello Mr G E Fitzgerald Dr M M Kehoe Dr J Mould Mr B E O'Shannassy Dr B E Todd Mr D Volker
Observers	Mr B Falconer Mr A B McNevin Mr C J Louttit

Wednesday 4 July 1984, Canberra

in camera hearing

Macquarie Pathology Services	Dr R Sutton Dr T R Wenkart

Thursday 5 July 1984, Canberra

in camera hearings

Commonwealth Department of Health	Dr H C Anderson Dr D M Hailey Mr J S McCauley Mr A M Mackey Dr L J O'Keefe Mr W T L Taylor Dr R H C Wells Mr P R Wright
Observers	Mr B Falconer Mr A B McNevin Mr C J Louttit

Monday 3 September 1984, Canberra

in camera hearing

Royal College of Pathologists of Australasia	Dr W E L Davies Professor P B Herdson Dr E Raik
Doctors Reform Society	Dr J L Daniels Dr B M Learoyd Dr P G Lynch

Monday 10 September 1984, Canberra

in camera hearing

Thursday 4 October 1984, Canberra

Commonwealth Department of Health	Mr M A Burgess
	Mr R Hackett
	Mr L Ion
	Mr J W Kilpatrick
	Mr A M Mackay
	Mr J S McCauley
	Mr B V McKay
	Mr W G Turk
	Dr R H C Wells
Health Insurance Commission	Mr J M Evered
	Mr G M Lewis
Observers	Mr K Brigden
	Mr R Chantler
	Mr B Kimball
	Mr J C Louttit
	Mr A B McNevin
	Mr M Owens
	Mr J Ruffin

Monday 8 October 1984, Canberra

Royal Australian College of General Practitioners	Dr D P Finnegan
	Dr A E Fisher
	Dr P W H Grieve
Observers	Mr J S McCauley
	Mr C J Louttit
	Mr A B McNevin
	Dr R H C Wells

Wednesday 7 March 1985, Canberra

The Honourable N Blewett, MP	
Commonwealth Department of Health	Mr B V McKay
Health Insurance Commission	Mr J M Evered
	Mr C R Wilcox
Observers	Mr R Alfredson
	Mr R Chantler
	Mr C J Louttit
	Mr N Levings
	Mr J Van Beurden

A P P E N D I X 2

Medical Fraud and Overservicing Inquiry

List of Submissions

Government Organisations*

Attorney-General's Department
Australian Audit Office
Australian Federal Police
Capital Territory Health Commission
Commonwealth Auditor-General
Commonwealth Department of Health
Commonwealth Ombudsman
Commonwealth Tertiary Education Commission
Department of Administrative Services
Department of Veterans' Affairs
Director of Public Prosecutions
Health Commission of NSW
Health Insurance Commission
Law Reform Commission of Australia
Public Service Board
South Australian Health Commission
Tasmanian Department of Health Services

Medical Associations*

Australian Medical Association
Australian Postgraduate Federation in Medicine, The
Australian Society of Anaethetists
Australian Society of Orthopaedic Surgeons, The
Doctors Reform Society
General Practitioners Society in Australia
Hunter Postgraduate Medical Institute, The
Medical Board of the ACT
New South Wales Medical Board
Northern Territory Medical Board
Royal Australasian College of Physicians
Royal Australasian College of Radiologists
Royal Australasian College of Surgeons
Royal Australian and New Zealand College of Psychiatrists
Royal Australian College of General Practitioners
Royal Australian College of Opthalmologists
Royal College of Pathologists of Australia
University of NSW Committee of Postgraduate Medical Education
University of Queensland Postgraduate Medical Education Committee
University of Western Australia Postgraduate Medical Education Committee
Victorian Medical Postgraduate Foundation

Other Organisations*

Acupuncture Association of Australia
Administrative and Clerical Officers Association
Association of Medical Superintendants of NSW and the ACT
Australian and New Zealand College of Medical Education
Australian Chiropractor's Association
Australian College of Health Service Administrators
Australian College of Rehabilitation Medicine
Australian Council on Hospital Standards
Australian Dental Association
Australian Federation of Consumer Organisations
Australian Federation of Festival of Light, The
Australian Hospitals Association
Australian Humanists
Australian Medical Acupuncture Society
AMA/ACHS Peer Review Resource Centre
Australian Medical Students Association
Australian Natural Therapists Association
Australian Optometrical Association
Australian Psychological Society
Australian Society for Advancement of Anaesthesia Sedation in Dentistry
Australian Thalassaemia Association
Citizenes' Committee on Human Rights (Psychiatric Violations)
Committee on Human Rights
Community Health Association Co-operative Ltd.
Darwin Private Medical Society Inc.
D.J. Moran Managements Pty Ltd.
Export and Commercial Research Services Ltd.
Hospital Benefit Fund of Western Australia
Hospital Benefits Association
Hospital Contribution Fund
Hospitals Association of NSW
Institute of Health Economics and Technology Assessment
Macquarie Pathology Services Ltd.
Mutual Health
National Association of Medical Specialists
National Association of Testing Authorities
Pharmaceutical Society of Australia
Pharmacy Guild of Australia, The
Queensland Policy Union of Employees
Right to Life Association, NSW Branch
Royal Australasian College of Medical Administrators
Rupert Public Interest Movement
Thoracic Society in Australia
United Chiropractors Association of Australasia Ltd.
Urological Society of Australia
Victorian Academy for General Practice
Victorian Hospitals Association
Voluntary Health Insurance Association of Australia

Individuals*

Agnew, Dr N V
Arnold, Dr P G
Babbage, Mr N F
Baddeley, Professor J
Bates, Mr P
Bell, Mr A
Bell, Dr D S
Biggs, Professor J S G
Bowyer, Dr R C
Bridges-Web, Professor C
Brotherton, Dr J
Brotherton, Dr M
Byrne, Dr J W
Carroll, Mr V
Carter, Mrs M
Cloher, Dr T P
Coglin, Dr M A
Cooper, Dr B D
Corbett, Dr P
Cox, Professor K R
Duckett, Dr S J
Eccles-Smith, Dr C
Ellard, Dr J
Elson, Dr N D
Farnsworth, Dr J
Fearnside, Dr M R
Finlay, Mr C N
Fisher, Mr G E
Flaherty, Dr G N
Fohler, Mr A E
Foster, Dr J L
Fraenkel, Professor G J
Ganderton, Mr P
Giblett, Mr H A
Goldrick, Dr V
Goodrick, Ms B
Gunton, Dr P G
Haddock, Mr K
Halliday, Dr B
Hammond, Mr W F
Hartup, Mr K
Harvey, Mr R
Hempton, Dr D B
Hoffman, Mr T D
Holgate, Mr R
Hunt, The Hon R J, MP
Ivil, Dr S J
Jackson, Mrs L
Jones, Dr B P
Jones, Dr G
Jones, Miss M
Johnston, Mr M
Joske, Professor R A
Kenos, Mr A
King, Mr C F
Kramer, Dr H
La Nauze, Dr J
Le Breton, Dr E G
Legge, Dr D
Lyall, Ms C F
McCaffrey, Mr J
McNeil, Professor D
McNiven, Mr K
Mackay, Dr D
Mackellar, Dr J D
Mackenzie, Mr W J
Mann, Dr A
Mathews, Dr R N
Meers, Mr N J
Moraitis, Dr S, OBE
Munro, Professor, J G C
Munster, Mr C H
Murnain, Mr J
Murphy, Mr P J
Newman, Dr R
O'Brien, Mr J P
O'Brien, Mr T
O'Callaghen, Ms A
Opit, Professor L J
Overfield, Mr W G
Pacy, Dr J R
Palmer, Professor G R
Pendrey, Mr A A E
Penington, Professor D
Pitney, Professor W R
Quinn, Dr D
Raik, Dr E
Rares, Mr S
Reid, Dr B
Reid-Smith, Ms L
Roach, Mr C M
Rodgers, Mrs P
Schoch, Dr H
Scott, Dr W N
Sender, Dr D
Shaw, Mr J
Slater, Dr F
Smith, Dr M B
Speilman, Dr R
Strauss, Dr S
Stoutjesdijk, Dr A D J
Sullivan, Dr M
Taylor, Dr H R
Thomas, Mr N
Thompson, Dr G
Toomer, Mr W F

Toose, The Hon Mr Justice PB, QC OBE
Traile, Dr M A
Tullock, Dr I
Wallace, Mrs C
Wardman, Dr W
Warneke, Mr E H
Weedon, Dr D
Wells, Dr R H C
Whyte, Dr G C
Williams, Mr L
Wolfenden, Dr W H
Yau, Dr R M

*

Many of the above government organisations, medical associations, other organisations and individuals have forwarded a number of submissions to the Committee during the inquiry.

In addition, many confidential submissions have been considered by the Committee. Parts of some of the submissions listed above have been supplied on a confidential basis.

APPENDIX 3

Advertisement for doctors

The Sydney Morning Herald

JULY 1985

DOCTOR — $100,000 p.a.

A major group of 24 hour medical centres requires the services of additional Medical Practitioners.

Due to current patient loads, the most suitable applicants will have some general practice experience and will join the practice to extend their professional expertise. Those with entrepreneurial skills will find our organisation most attractive.

It will be considered ideal if a Doctor currently practising in Sydney was to merge their practice with one of ours. We will seriously consider paying out goodwill at a commercial rate.

Remuneration will be discussed at interview but $100,000 should be taken as a realistic guide for the first year. A substantial benefits package will apply after a qualifying period.

Your immediate reply should be directed to:

(02) ————

THE ———— GROUP

G.P. — PERMANENT

Three (3) experienced general practitioners are required for practices in the Sydney metropolitan area.

The conditions are excellent as is the remuneration package which should exceed $100,000 per annum. Only those doctors keeping for a long term career in general practice should apply as our patients show considerable loyalty to their doctor and we provide a clear career and security path.

The work is interesting and diverse and the practices are growing rapidly. Please phone ————

DOCTORS — NIGHTS

Doctors are required from 7 p.m. to 7 a.m. in the Sydney metropolitan area. The work is on a regular part time basis and no travelling is normally involved.

Experience in general practice is preferred but not essential and the work is interesting and varied. Generally the patient load can be considered to be light to moderate.

These positions may well be suited to doctors currently working nights and visiting homes.

Weekend work is also available. Please phone ———— immediately.

(02) ————

The ———— Group

APPENDIX 4

Section 16A of the Health Insurance Act

16A (1) A Medicare benefit is not payable in respect of a pathology service unless a practitioner determined that the service was necessary

and-

(a) in the case of a pathology service (other than a prescribed pathology service or a service to which paragraph (b) applies) - the service was rendered by or on behalf of an approved pathology practitioner in pursuance of a request addressed to that approved pathology practitioner -

(i) by the practitioner who determined that the service was necessary; or

(ii) by another approved pathology practitioner who is not the practitioner who determined that the service was necessary,

being a request made in writing as prescribed or, if made otherwise than in writing, subsequently confirmed in writing as prescribed;

(b) in the case of a pathology service, other than a prescribed pathology service, determined to be necessary by an approved pathology practitioner (being a medical practitioner) or by the employee (being a medical practitioner) of an approved pathology practitioner in the course of that employment - the service was rendered by or on behalf of that approved pathology practitioner; or

(c) in the case of a prescribed pathology service - the service was rendered by or on behalf of a medical practitioner other than an approved pathology practitioner (in this paragraph referred to as "the first mentioned practitioner") and -

(i) the service was determined to be necessary by the first mentioned practitioner; or

(ii) the service was rendered in pursuance of a request made by the person who determined that the service was necessary, being a medical practitioner (other than an approved pathology practitioner) who, at the time the request was made, was a member of a group of practitioners of which the first mentioned practitioner was then a member.

(2)A The reference in paragraph (1) (a) to a request made in writing or to a confirmation in writing of a request shall be read as including a reference to a request or a confirmation, as the case may be, in such other form as the Minister approves, in writing from time to time.

(3) Where a pathology service has been rendered by or on behalf of an approved pathology practitioner in pursuance of a request made or confirmed as described in paragraph (1) (a), then -

(a) if the approved pathology practitioner fails to retain the written request or the written confirmation of the request for a period of 18 months after the date on which the service was rendered; or

(b) if, on being served as prescribed, at any time within 18 months after the date on which the service was rendered, with a notice in writing signed by the Minister requiring the approved pathology practitioner to produce the written request or the written confirmation of the request to an officer of the Department of Health specified in the notice, the approved pathology practitioner fails to comply with the requirement within 14 days after being served with the notice,

the approved pathology practitioner is guilty of an offence and is punishable on conviction by a fine not exceeding $1,000.

(4) In any proceedings for an offence against sub-section (3), an averment of the prosecutor, contained in the information or complaint, that a specified pathology service was rendered by or on behalf of a specified approved pathology practitioner on a specified date is prima facie evidence of the matters averred.

(4A) For the purposes of this section, where -

(a) a written request or a written confirmation of a request has been recorded on film or on any other medium approved, in writing, by the Minister from time to time; or

(b) in accordance with an approval, in writing, of the Minister, a request or confirmation (other than a written request or a written confirmation) has been recorded on a tape, disc, film or other medium,

for the purposes of storage and subsequent retrieval when required -

(c) the retention of the record so made shall be deemed to be a retention of the request or the confirmation, as the case may be; and

(d) the production, or the reproduction, of the record so made shall be deemed to be a production of the request or the confirmation, as the case may be.

(4B) Where the Minister gives an approval for the purposes of paragraph (4A) (b), he may set out in the instrument of approval any condition to which the approval is subject, and any recording that is not in accordance with such a condition shall be deemed to be not in accordance with the approval.

(5) For the purposes of this section -

(a) where a service is rendered by a person (in this paragraph referred to as "the employee") in the course of his employment by another person, then, except in the case to which paragraph (b) applies, it shall be deemed to be rendered by that other person, and not by the employee;

(b) where a person (in this paragraph referred to as "the employee") is employed by two or more persons jointly and a service is rendered by the employee in the course of that employment, it shall be deemed to be rendered by the employer principally responsible for the matter being dealt with by the employee, and not by the employee;

(c) a service shall be taken to be rendered on behalf of a person if, and only if, it is rendered by another person, not being an approved pathology practitioner, by arrangement with that person;

(d) a member of, or a member of the staff of, an authority (being a corporation) established by a law of the Commonwealth or of a State or internal Territory shall be taken to be employed by that authority;

(e) where two or more practitioners -

(i) provide professional services as partners; or

(ii) share amongst them all, or a substantial part of, the income from providing professional services,

those practitioners shall be deemed to constitute a group of practitioners; and

(f) a reference to determining a service to be necessary is a reference to determining that the service is reasonably necessary for the adequate medical care of the patient concerned.

(6) This section does not apply in relation to a service in relation to which section 21 applies.

A P P E N D I X 5

APP Undertaking and Code of Conduct

COMMONWEALTH OF AUSTRALIA

Health Insurance Act 1973

UNDERTAKING

Approved Pathology Practitioner

(Employer Applicant)

Use of Form

This form of undertaking has been drawn up by the Minister for Health under section 16B of the Health Insurance Act 1973, as amended, as a form of undertaking to be given by an applicant who wishes to become an approved pathology practitioner for the purposes of that Act. The form is for use by a person who is not a medical practitioner but who employs a medical practitioner or medical practitioners to render pathology services. The person may be an individual or a body corporate. The form is not for use by a State or by an authority of a State or of a Territory.

The undertaking may be given by being signed by or on behalf of the applicant as required on page 9 and by being delivered at or sent by prepaid post to the appropriate address specified in paragraph 13.2 of this form of undertaking together with a fee of $10 or such other amount as may be prescribed.

Particulars of Applicant (Individual)

Full name: . . . . . .

(in block letters) (surname) (christian or given names)

Address for notices: . . . . . .

. . . . . .

Premises where applicable pathology services are rendered - include all States and Territories:

(1) . . . . . .

(2) . . . . . .

Particulars of Applicant (Corporation)

Name: . . . . . .

Legislation under which incorporated: . . . . . .

Address for notices: . . . . . .

. . . . . .

State or Territory or other place of incorporation: . . . .

. . . . . .

Registered office(s) in Australia - include all States and Territories:

(1) . . . . . .

(2) . . . . . .

(3) . . . . . .

Premises where applicable pathology services are rendered - include all States and Territories:

(1) . . . . . .

(2) . . . . . .

(3) . . . . . .

Undertaking

The abovenamed Applicant ("the Practitioner") in accordance with the provisions of the Health Insurance Act 1973, as amended, and of the regulations made thereunder ("the Act" and "the Regulations" respectively) HEREBY UNDERTAKES to THE COMMONWEALTH OF AUSTRALIA ("the Commonwealth") as follows:

Acceptance

1. This undertaking is given for the acceptance of the Minister in accordance with the Act and so that it will come into force when so accepted or on such earlier date (not being a date earlier than the date of signature of this undertaking as hereinafter appears) as is fixed by the Minister.

Application

2. The medical services to which this undertaking relates and is applicable ("applicable pathology services") are pathology services in respect of which, when the services are rendered by an approved pathology practitioner, medical benefits are payable in accordance with the Act.

Compliance with Act

3. The Practitioner will -

(a) comply with the provisions in relation to applicable pathology services of the Act as from time to time amended and of the Regulations as for the time being in force; and

(b) take appropriate action from time to time to ensure that -

(i) employees of the Practitioner whose duties relate to the rendering of applicable pathology services; and

(ii) persons who by arrangement perform services for the Practitioner in relation to the rendering of applicable pathology services,

in carrying out those duties or performing those services act in accordance with the said provisions of the Act and Regulations and in conformity with this undertaking.

Code of Conduct

4.1 The Practitioner will ensure that the operations of the Practitioner in relation to the rendering of applicable pathology services are conducted in conformity with the Code of Conduct set out in the Schedule to this undertaking ("the Code of Conduct").

4.2 The generality of paragraph 4.1 shall not be prejudiced or affected by the inclusion in this undertaking, or the operation of, the succeeding provisions of this undertaking.

4.3 The Code of Conduct is an integral part of this undertaking and accordingly subject to variation by the Minister as hereinafter appears and references in this undertaking to the Code of Conduct are to be read as references to the Code of Conduct as from time to time so varied.

Billing and Supervision

5.1 The Practitioner will not issue an account or a receipt or enter into an agreement under sub-section 20(3) of the Act in respect of the provision of an applicable pathology service which the Practitioner has requested another approved pathology practitioner to render or which has been rendered by another approved pathology practitioner.

5.2 An account which is capable of being used for making a claim for medical benefits shall not be issued in respect of the rendering of an applicable pathology service unless professional responsibility for rendering the service has been assumed by a medical practitioner employed by the Practitioner for the purpose.

5.3 An account in respect of an applicable pathology service in which the service is identifiable for the purpose of medical benefits as having been rendered by, or under the supervision of, a recognized pathologist shall not be issued by or on behalf of the Practitioner unless the recognized pathologist who rendered or under whose supervision the service was rendered was at the time employed by the Practitioner for that purpose.

Multiple Pathology Services

6. The Practitioner will not make with any person an arrangement in relation to the requesting or rendering of an applicable pathology service or applicable pathology services or engage in any other practice, the purpose or a purpose of which is to avoid the application or operation of a rule of interpretation relating to multiple services in respect of items in Part 7 of Schedule 1 of the Act as at any time varied.

Sharing Arrangements

7. The Practitioner will not -

(a) make an arrangement with a practitioner who requests the Practitioner to render an applicable pathology service; or

(b) make an arrangement with a practitioner who is requested by the Practitioner to render an applicable pathology service,

whereby the Practitioner, directly or indirectly, receives from any person other than the person who incurs the medical expense or the insurer of that person, or pays as remuneration to any person, any part of the fees that are payable by the person who incurs the medical expense, or of the benefits that are payable by the insurer of that person, in respect of the applicable pathology service.

8.1 The Practitioner will not knowingly enter into an arrangement with a person whereby -

(a) that person is induced or encouraged to request the rendering of an applicable pathology service by the Practitioner; or

(b) the Practitioner, without reasonable excuse, will be accorded any incentive to request, or will receive or obtain directly or indirectly any benefit, profit or advantage from requesting, the rendering of an applicable pathology service by the person.

8.2 The Practitioner shall not be taken to be in breach of sub-paragraph 8.1(b) by reason of making an arrangement which provides for the obligation-free provision to or by the Practitioner of a disposable type of blood collection equipment or other specimen collection equipment or of slides, containers or other basic materials for the collection or transportation of specimens such as blood or urine or other biological specimens.

Excessive Services

9. The Practitioner will not render, or request to be rendered, an applicable pathology service that would constitute excessive services as referred to in Division 5 of Part V of the Act. (Sub-section 79(1B)(a) of the Act provides that a reference to excessive services is a reference to professional services, being services in respect of which medical benefit has become or may become payable, that are not reasonably necessary for the adequate medical care of the patient concerned).

Supply of Information

10. The Practitioner will furnish to the Minister such information relating to -

(a) the requesting or rendering by or on behalf of the Practitioner of applicable pathology services;

(b) in a case where the Practitioner is a body corporate, the ownership and control of the Practitioner; and

(c) persons employed by and, where the Practitioner is a body corporate, the officers of the Practitioner,

as is from time to time reasonably requested by the Minister.

Variation of Undertaking

11. This undertaking is subject to variation as provided in sub-section 16C(7) of the Act if the form of undertaking for the purposes of the Act is varied at any time by the Minister under sub-section 16B(4) and shall, while it continues to be in force, be in force and have effect in the form in which it is deemed to be varied from time to time to accord with the form of undertaking as so varied.

Termination of Undertaking

12. This undertaking shall continue to be in force unless and until it ceases to be in force upon termination by the Practitioner under sub-section 16C(8) of the Act or upon such other event as causes an undertaking to cease to be in force by virtue of sub-section 16C(9).

Notices

13.1 A notice, request or other communication by the Minister to the Practitioner under or for the purposes of this undertaking shall be deemed to have been duly given if it is in writing signed by the Minister personally or by a means of reproduction which the Minister sees fit to adopt or signed by a person on behalf of the Minister and is sent by prepaid post to the address for notices of the Practitioner set out in Particulars of the Applicant on page 1 or 2 hereof.

13.2 A notice or communication by the Practitioner to the Minister under or for the purposes of this undertaking shall be deemed to have been duly given if it is in writing signed, where the Practitioner is an individual, by the Practitioner or, where the Practitioner is a body corporate, by the Secretary or equivalent officer of the Practitioner, and is delivered at or sent by prepaid post addressed to the office of the Director of the Commonwealth Department of Health in the State in which the principal place at which the Practitioner renders applicable pathology services is located or, if that place is in the Australian Capital Territory, in the State of New South Wales or, if that place is in the Northern Territory, in the State of South Australia.

13.3 A notice, request or other communication sent by prepaid post shall be deemed to have been received by the Practitioner or the Minister when it would have been delivered in the ordinary course of the mail.

Interpretation

14. References in this undertaking to the Minister are to the Minister administering the Act and include another Minister of the Commonwealth who is for the time being actin for or on behalf of that Minister and the expression "the Minister" includes a delegate of the Minister under section 131 of the Act.

15. A reference in this undertaking to a request for an applicable pathology service refers to a request as provided for by paragraph (a) of sub-section 16A(1) of the Act.

16. For the purposes of this undertaking a service shall be regarded as having been rendered by the Practitioner if the service is rendered by an employee on behalf of the Practitioner or otherwise on behalf of the Practitioner as provided in sub-section 16A(5) of the Act.

17.1 In this undertaking, except where the context otherwise requires or a contrary intention appears -

(a) expressions that are defined in the Act or in the Regulations have the respective meanings so attributed to them;

(b) "person" includes a body corporate and a public authority or institution; and

(c) words in the singular include the plural number and words in the plural include the singular number.

17.2 The headings in this undertaking shall not govern or affect the construction of the text.

SCHEDULE

CODE OF CONDUCT

i. Fees or benefits in respect of pathology services shall not be shared by, or be the subject of a sharing arrangement between, the practitioner who orders tests and the pathology practitioner who performs the tests.

ii. A pathology practitioner shall not -

(a) provide free services or payments as incentives to a practitioner to order tests;

(b) make payments to a practitioner for illusory services;

(c) make payment beyond normal commercial rates for services provided to the pathology practitioner by a practitioner.

iii. A pathology practitioner shall not advertise or detail to stimulate the ordering of pathology tests except in a manner or to an extent in or to which advertising or detailing may legally be done by a medical practitioner under the legislation controlling the practice of medicine in the State or Territory in which the pathology practitioner carries on practice.

iv. The pathology practitioner to whom pathology tests on private patients (including subsequent referrals) are referred and who performs the tests shall bill the patient or relevant insurer according to the principle that fees for pathology tests are payable by the patient or insurer directly to the pathology practitioner and the patient is not to be billed by the practitioner who makes the request for the tests.

(1) Signature of Applicant . . . . . .

Date of Signature . . . . . .

(2) Signed on behalf of and with the authority of the Board or other governing body of the Practitioner in the presence of -) (. . . . .)

. . . . . ( )

Date of Signature . . . . . .

(1) For signature by the Applicant where the Applicant is an individual person.

(2) For signature where the Applicant is a body corporate. The signatory must be an executive or representative member of the Board or other governing body of the Practitioner and the office of the signatory stated beneath the signature. The signature should be witnessed where indicated by an officer of the Practitioner and the office of the witness also stated beneath the witness' signature.

Acceptance

This undertaking is accepted on behalf of the Commonwealth of Australia.

I fix . . . . . .* as the date on which this undertaking has come into force.

. . . . . .

Delegate of the Minister for Health

Date of Acceptance . . . . . .

* If no date is fixed the undertaking comes into force on the date of this acceptance.

COMMONWEALTH OF AUSTRALIA

Health Insurance Act 1973

UNDERTAKING

Approved Pathology Practitioner

(Medical Practitioner Applicant)

Use of Form

This form of undertaking has been drawn up by the Minister for Health under section 16B of the Health Insurance Act 1973, as amended, as the form of undertaking to be given by a medical practitioner who wishes to become an approved pathology practitioner for the purposes of that Act and who is practising in his own right as an individual or in partnership or other association with another medical practitioner or practitioners. It has no application to a person who only renders pathology services in the course of his/her employment by another person. This undertaking may be given by being signed by the applicant as required on page 7 and by being delivered at or sent by prepaid post to the appropriate address specified in paragraph 13.2 of this form of undertaking together with a fee of $10 or such other amount as may be prescribed.

Particulars of Applicant

Full name : . . . . . .

(in block letters) (surname) (christian or given names)

States or Territories of registration as medical practitioner (include all registrations): . . . . . .

. . . . . .

Address for notices: . . . . . .

. . . . . .

Address(es) of Practice(s):

(1) . . . . . .

(2) . . . . . .

(3) . . . . . .

Undertaking

The abovenamed Applicant ("the Practitioner") in accordance with the provisions of the Health Insurance Act 1973, as amended, and of the regulations made thereunder ("the Act" and "the Regulations" respectively) HEREBY UNDERTAKES to THE COMMONWEALTH OF AUSTRALIA ("the Commonwealth") as follows:

Acceptance

1. This undertaking is given for the acceptance of the Minister in accordance with the Act and so that it will come into force when so accepted or on such earlier date (not being a date earlier than the date of signature of this undertaking as hereinafter appears) as is fixed by the Minister.

Application

2. The medical services to which this undertaking relates and is applicable ("applicable pathology services") are pathology services in respect of which, when the services are rendered by an approved pathology practitioner, medical benefits are payable in accordance with the Act.

Compliance with Act

3. The Practitioner will -

(a) comply with the provisions in relation to applicable pathology services of the Act as from time to time amended and of the Regulations as for the time being in force; and

(b) take appropriate action from time to time to ensure that persons who in the course of their employment carry out, or by arrangement perform, for or on behalf of the Practitioner duties or services in relation to applicable pathology services, in carrying out those duties or performing those services act in accordance with the said provisions of the Act and Regulations and in conformity with this undertaking.

Code of Conduct

4.1 The Practitioner shall conduct his/her practice(s) in relation to the rendering of applicable pathology services in conformity with the Code of Conduct set out in the Schedule to this undertaking ("the Code of Conduct").

4.2 The generality of paragraph 4.1 shall not be prejudiced or affected by the inclusion in this undertaking, or the operation of, the succeeding provisions of this undertaking.

4.3 The Code of Conduct is an integral part of this undertaking and accordingly subject to variation by the Minister as hereinafter appears and references in this undertaking to the Code of Conduct are to be read as references to the Code of Conduct as from time to time so varied.

Billing

5. The Practitioner will not issue an account or a receipt or enter into an agreement under sub-section 20(3) of the Act in respect of the provision of an applicable pathology service which the Practitioner has requested another approved pathology practitioner to render or which has been rendered by another approved pathology practitioner.

Multiple Pathology Services

6. The Practitioner will not make with any person an arrangement in relation to the requesting or rendering of an applicable pathology service or applicable pathology services or engage in any other practice, the purpose or a purpose of which is to avoid the application or operation of a rule of interpretation relating to multiple services in respect of items in Part 7 of Schedule 1 of the Act as at any time varied.

Sharing Arrangements

7. The Practitioner will not -

(a) make an arrangement with a practitioner who requests the Practitioner to render an applicable pathology service; or

(b) make an arrangement with a practitioner who is requested by the Practitioner to render an applicable pathology service,

whereby the Practitioner, directly or indirectly, receives from any person other than the person who incurs the medical expense or the insurer of that person, or pays as remuneration to any person, any part of the fees that are payable by the person who incurs the medical expense, or of the benefits that are payable by the insurer of that person, in respect of the applicable pathology service.

8.1 The Practitioner will not knowingly enter into an arrangement with a person whereby -

(a) that person is induced or encouraged to request the rendering of an applicable pathology service by the Practitioner; or

(b) the Practitioner, without reasonable excuse, will be accorded any incentive to request, or will receive or obtain directly or indirectly any benefit, profit or advantage from requesting, the rendering of an applicable patholgy service by the person.

8.2 The Practitioner shall not be taken to be in breach of sub-paragraph 8.1(b) by reason of making an arrangement which provides for the obligation-free provision to or by the Practitioner of a disposable type of blood collection equipment or other specimen collection equipment or of slides, containers or other basic materials for the collection or transportation of specimens such as blood or urine or other biological specimens.

Excessive Services

9. The Practitioner will not render, or request to be rendered, an applicable pathology service that would constitute excessive services as referred to in Division 3 of Part V of the Act. (Sub-section 79(1B)(a) of the Act provides that a reference to excessive services is a reference to professional services, being services in respect of which medical benefit has become or may become payable, that are not reasonably necessary for the adequate medical care of the patient concerned).

Supply of Information

10. The Practitioner will furnish to the Minister such information relating to the requesting or rendering by or on behalf of the Practitioner of applicable pathology services as is from time to time reasonably requested by the Minister.

Variation of Undertaking

11. This undertaking is subject to variation as provided in sub-section 16C(7) of the Act if the form of undertaking for the purposes of the Act is varied at any time by the Minister under sub-section 16B(4) and shall, while it continues to be in force, be in force and have effect in the form in which it is deemed to be varied from time to time to accord with the form of undertaking as so varied.

Termination of Undertaking

12. This undertaking shall continue to be in force unless and until it ceases to be in force upon termination by the Practitioner under sub-section 16C(8) of the Act or upon such other event as causes an undertaking to cease to be in force by virtue of sub-section 16C(9).

Notices

13.1 A notice, request or other communication by the Minister to the Practitioner under or for the purposes of this undertaking shall be deemed to have been duly given if it is in writing signed by the Minister personally or by a means of reproduction which the Minister sees fit to adopt or signed by a person on behalf of the Minister and is sent by prepaid post to the address for notices of the Practitioner set out in Particulars of the Applicant on page 1 hereof.

13.2 A notice or communication by the Practitioner to the Minister under or for the purposes of this undertaking shall be deemed to have been duly given if it is in writing signed by or on behalf of the Practitioner and is delivered at or sent by prepaid post addressed to the office of the *Director of the Commonwealth Department of Health in the* State in which the Practitioner practises or, if the Practitioner practises in the Australian Capital Territory, in the State of New South Wales or, if the Practitioner practises in the Northern Territory, in the State of South Australia.

13.3 A notice, request or other communication sent by prepaid post shall be deemed to have been received by the Practitioner or the Minister when it would have been *delivered in the ordinary course of the mail.*

Interpretation

14. References in this undertaking to the Minister are to the Minister administering the Act and include another Minister of the Commonwealth who is for the time being acting for or on behalf of that Minister and the expression "the Minister" includes a delegate of the Minister under section 131 of the Act.

15. A reference in this undertaking to a request for an applicable pathology service refers to a request as provided for by paragraph (a) of sub-section 16A(1) of the Act.

16. For the purposes of this undertaking a service shall be regarded as having been rendered by the Practitioner if the service is rendered by an employee on behalf of the Practitioner or otherwise on behalf of the Practitioner as provided in sub-section 16A(5) of the Act.

17.1 In this undertaking, except where the context otherwise requires or a contrary intention appears -

(a) expressions that are defined in the Act have the respective meanings attributed to them by the Act;

(b) "person" includes a body corporate and a public authority or institution; and

(c) words in the singular include the plural number and words in the plural include the singular number.

17.2 The headings in this undertaking shall not govern or affect the construction of the text.

SCHEDULE

CODE OF CONDUCT

i. Fees or benefits in respect of pathology services shall not be shared by, or be the subject of a sharing arrangement between, the practitioner who orders tests and the pathology practitioner who performs the tests.

ii. A pathology practitioner shall not -

(a) provide free services or payments as incentives to a practitioner to order tests;

(b) make payments to a practitioner for illusory services;

(c) make payment beyond normal commercial rates for services provided to the pathology practitioner by a practitioner.

iii. A pathology practitioner shall not advertise or detail to stimulate the ordering of pathology tests except in a manner or to an extent in or to which advertising or detailing may legally be done by a medical practitioner under the legislation controlling the practice of medicine in the State or Territory in which the pathology practitioner carries on practice.

iv. The pathology practitioner to whom pathology tests on private patients (including subsequent referrals) are referred and who performs the tests shall bill the patient or relevant insurer according to the principle that fees for pathology tests are payable by the patient or insurer directly to the pathology practitioner and the patient is not to be billed by the practitioner who makes the request for the tests.

Signature of Applicant . . . . . .

Date of Signature . . . . . .

Acceptance

This undertaking is accepted on behalf of the Commonwealth of Australia.

I fix . . . . . .* as the date on which this undertaking has come into force.

. . . . . .

Delegate of the Minister for Health

Date of Acceptance . . . . . .

* If no date is fixed the undertaking comes into force on the date of this acceptance.

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APPENDIX 6

RCPA position on peer review

PEER REVIEW

Position Document for the R.C.P.A.

Prepared by Professor E.S.Finckh and Dr R.A.Osborn

31st August 1984

1.0 Preamble

1.1 Peer review is now looked upon by Governments and by the medical profession as a means of ensuring that adequate standards of medical practice are achieved and maintained without coercion from outside the profession.

1.2 Decisions as to standards are to be left to those within the profession as being the most appropriate to decide which activities are to be judged and the levels of performance to be reached.

1.3 Although performance may be judged by absolute standards it is clear that consideration of questions of cost to the community and to individuals should also be taken into account.

1.4 In addition to the assessment of what is being achieved in terms of practice (for example whether procedures are necessary or not, or whether they are adequately prepared or not) it would appear necessary to review how results are being achieved (*for example by unethical or overcostly means*). The attitudes to these matters may differ with different sections of the profession.

1.5 Although it is commonly held that "Peer Review" as it applies to doctors implies review of each specialty internally, it is the view of the R.C.P.A. that this can only apply to certain aspects of medical practice, and

that in other aspects it is desirable that doctors of other specialties should be involved in assessment. It appears desirable that Fellows of the College (but not necessarily the College itself)should be involved in medical audit of the activities of surgeons, physicians and others in different specialties.

1.6 The subject "Peer Review" as it applies to Pathologists should therefore be considered under three headings, Peer Review of Pathologists by Pathologists, Peer Review of Pathologists by Non-Pathologists and Peer Review of Non-Pathologists by Pathologists.

2.0 Peer Review of Pathologists by Pathologists

As a result of the efforts of the R.C.P.A. pathology has been a leader in the field of "peer review" if taken in its strictest sense of review by members of the specialty itself. All the programmes discussed in 2.1 are undertaken on a voluntary basis and therefore not every laboratory has participated in them. It will be necessary to make participation in quality assurance programmes (Q.A.P.) mandatory for laboratory accreditation.

2.1 Assessment of quality assurance has been made regularly by the College itself with respect to all subspecialties (chemical pathology, immunology, microbiology, haematology, serology and anatomical pathology). This has been undertaken by the College itself. Specimens are sent to participating laboratories at regular intervals (second weekly, monthly or in some cases, several times per year). Assessment of performance relative to other laboratories is returned rapidly. All results are confidential and the names and results of other laboratories are not revealed.

In addition, many laboratories participate in external quality assurance programmes provided by commercial or other organisations (such as Burroughs Wellcome). Such participation is encouraged by the College.

2.2. The R.C.P.A. has also recognised that standards should be set and achieved in laboratory equipment and procedures that would not be assessed by the above quality assurance programme.

Negotiations with the National Association of Testing Authorities, Australia, has resulted in the establishment of a joint system for the voluntary registration of medical laboratories (N.A.T.A./R.C.P.A. registration). This is now being actively set in train and a number of laboratories and laboratory groups have now applied for assessment and registration. Assessment for such registration covers staffing, accommodation, equipment, test procedures, reporting of results and records keeping systems.

2.3 It must be appreciated that the quality assurance programme can do no more than test basic competence in common areas of laboratory diagnosis and cannot hope to assess competence in the almost infinite variety of testing situations.

3.0 Peer Review of Pathologists by Non-Pathologists

3.1 The College has supported the concept of hospital laboratories being assessed by surveyors from the Australian Council on Hospital Standards and encourages compliance with any corrective recommendations which are made. The surveying teams usually consist of hospital administrators (both medical and non-medical), senior members of the nursing profession and clinicians.

3.2 In addition and more importantly, pathologists are constantly subjected to critical appraisal by their clinical colleagues. Test results and diagnostic reports on tissues must be reliable and accurate in order to assist with the total management of patients.

4.0 Peer Review of Non-Pathologists by Pathologists

This falls under two headings:

4.1 The practice of pathology by non Pathologists and

4.2 other forms of medical practice.

4.1 It is the cause of concern to the R.C.P.A. that much of the pathology being undertaken at present in Australia is not done in laboratories subjected to Peer Review.

a. The quality assessment programmes described in 2.1 are undertaken on a voluntary basis and are therefore mostly undertaken by the larger and better laboratories. Many laboratories and especially those not headed by qualified Pathologists rarely participate in quality assurance programmes.

b. The vast majority of registered "pathology providers" are not trained Pathologists and are outside the influence of the R.C.P.A.

4.2 Peer Review of Non-Pathologists by Pathologists

As stated in 1.5, Pathologists should be involved in medical audits with hospitals, clinics and where possible in practice outside hospitals. Thus they should play a part in assessing such matters as the appropriateness of medical or surgical procedures, control of infection, the effectiveness of chemotherapy or radiotherapy, the management of haemostatic problems including the use of blood and blood products. This list is not intended to be comprehensive and examples can be found in all disciplines of pathology.

5.0 Educational Aspects

The objectives of peer review should be to improve and maintain standards of medical practice and not merely to criticise. The detection of deficiencies is therefore only part of the objective, the correction of deficiencies being of greater influence.

5.1 The present quality assurance programmes of the R.C.P.A. are already intended to be educational and corrective as well as assessive.

5.2 A problem of education programmes is that since they are not compulsory they "preach to the converted". It will therefore be necessary to introduce some degree of coercion into future programmes, probably as part of the accreditation scheme.

6.0 Action required

Although it has been hoped over the past 6-10 years that the measures already being undertaken, supported, or urged by the College, would result in a widespread raising of standards of practice in pathology, it now seems clear to the College that the only way to ensure such results would be by the compulsory accreditation of laboratories.

1. It is therefore urged that accreditation on a State basis, but to uniform standards laid down Federally become mandatory.

2. The N.A.T.A./R.C.P.A. accreditation programme already provides a basis by which laboratory procedures could be assessed.

3. The N.A.T.A./R.C.P.A. programme is also designed to be used as part of the Australian Council of Hospital Standards accreditation. It could also quite appropriately be used as a basis for State accredidation, thereby allowing those already assessed in this way to be excused further assessment.

A P P E N D I X 7

NATA submission

SUBMISSION TO

JOINT PARLIAMENTARY COMMITTEE OF PUBLIC ACCOUNTS

INQUIRY INTO MEDICAL FRAUD AND OVERSERVICING

FROM

NATIONAL ASSOCIATION OF TESTING AUTHORITIES, AUSTRALIA

20 July 1984

For a number of years there has been concern expressed by members of parliament, by government officials and by professional groups regarding the provision of pathology services in Australia particularly from the points of view of technical competence, and hence validity of the test data, and amount of overservicing and hence overall cost of the services.

There have been a number of suggestions that accreditation of laboratories providing such services would overcome both these major concerns.

We submit that while the two matters are both very important, they are quite separate. The International Standards Organisation defines laboratory accreditation as a formal recognition that a testing laboratory is competent to carry out specific tests or specific types of tests. Accreditation is therefore concerned with assessment of technical competence and the ability of a laboratory to generate reliable data.

The National Association of Testing Authorities, Australia (NATA) operates a comprehensive national laboratory accreditation system on behalf of the Federal Government with the collaboration of each State Government. It is primarily concerned with testing, measurement and calibration activities but also is concerned with research to the extent that research activities require testing, measurement and calibration services. Accreditation is offered in all fields of science and technology and in all parts of Australia.

This submission puts forward proposals aimed at meeting the needs of the Commonwealth Government and State Governments for accreditation of all pathology laboratories at a level of technical competence appropriate to community expectations in terms of both professional standards and cost effectiveness.

BACKGROUND

NATA was established by a decision of the Federal Cabinet in 1946 to operate Australia's laboratory accreditation system. Its primary functions are:

(a) to define standards for good laboratory practice;

(b) to assess laboratories for compliance with those standards;

(c) to encourage all laboratories to achieve those standards.

This recognition of competence or accreditation follows a process of evaluation by expert assessors who examine a laboratory for compliance with predefined criteria which address all elements of laboratory operations, namely:

staff
equipment
accommodation and facilities
quality assurance
laboratory practices

and accreditation is granted only when full compliance is demonstrated.

NATA defines in general terms basic criteria applicable to all fields of testing and has more specific statements for each field of testing. The specific criteria for pathology laboratories are detailed in "Medical Testing - Requirements for Registration" published in February 1984 which is attached to this submission.

Specific criteria are developed in collaboration with laboratories and those concerned with their work and in this way NATA is able to provide an accreditation to meet the specific needs of all users of laboratory services.

Australia has given strong support to the concept of laboratory accreditation. There were 1387 NATA accredited laboratories at 30 June 1984. Their distribution between public sector and the private sector is as follows:

Commonwealth Government	111
State and Local Governments	150
Universities/Tertiary Institutions	32
Private Sector	1094
	1387

PROCEDURES

The Association's work in each field of testing is directed by a Registration Advisory Committee. These Committees consist of eminent scientists, each a specialist in his field. Their prime functions are establishment of criteria for accreditation of laboratories, assessment of applicant laboratories and surveillance of the standard of operation of registered or accredited laboratories.

The backbone of NATA is its panel of assessors. At present there are nine hundred and thirty eight assessors who work on a voluntary basis. Membership of this panel is drawn from Commonwealth and State Government departments, private industry and tertiary education institutions. The Association endeavours to limit the use of a particular assessor to three days each year, although interstate assessments occasionally require longer periods. Each assessor is, before he visits a laboratory, provided with information submitted by the laboratory management, or otherwise available to NATA. This is supplemented by a detailed briefing by one of the Association's scientific officers. Assessors are supported by NATA staff officers whenever they visit laboratories.

The NATA scheme of periodic technical and quality audit of testing laboratories by independent, objective assessors has proved to be a most effective approach to the upgrading and maintenance of high standards of laboratory management and operation.

ACCREDITATION OF PATHOLOGY SERVICES

A document "A Proposal for a Scheme to Accredit Pathology Services in Australia" was published by The Hospitals and Health Services Commission in 1974. This was followed by the establishment of The National Pathology Accreditation Advisory Council which has produced a number of draft standards and check lists which are intended to form the basis of accreditation programs to be implemented by the State Governments.

While some States have enacted the necessary legislation, no accreditation system has yet been established - a fact which has disappointed a number of organisations and individuals concerned with the quality of pathology services.

In October 1982 The Royal College of Pathologists of Australasia (RCPA) invited NATA to join it in establishing a voluntary program for accreditation of pathology laboratories. Since that time NATA has developed its criteria and procedures and is now accepting applications for accreditation from pathology laboratories.

NATA's expertise is in the administration of an accreditation system. The technical expertise is provided by the voluntary contributions of individuals nominated by the RCPA, the Australian Society for Microbiology, Australian Association of Clinical Biochemists and the Australian Institute of Medical Laboratory Scientists.

Our discussions to date indicate that the NATA/RCPA program will have wide acceptance from all classifications of laboratories throughout Australia.

The Ministers for Health in all States have been provided with details of the program and have expressed support for our initiative. We are confident that our criteria and practices will be acceptable to the present pathology accreditation legislation in both New South Wales and Victoria. This would obviously eliminate any duplication of effort and costs.

NATA has an international reputation for its pioneering work in this area and has a number of mutual recognition agreements with similar bodies overseas. Of particular interest is its relationship with the Testing Laboratory Registration Council of New Zealand (TELARC). This body was modelled on NATA and close links exist between the two bodies.

In New Zealand, the assessment and registration of medical laboratories has been delegated by the Health Department to TELARC.

ROSS REPORT

The Report of the Committee of Inquiry into Commonwealth Laboratories under Professor I G Ross published in November 1983, covered in some detail, the accreditation of pathology services. The Committee's recommendations relevant to this submission are:

Rec G44	The Commonwealth identify The National Association of Testing Authorities as the authority which it will recognise for the accreditation of service laboratories in fields other than the production of pharmaceutical and biological products for therapeutic use.
Rec G46	All other accreditation systems operated independently by Commonwealth agencies to be transferred to The National Association of Testing Authorities.
Rec G47 (i)	All Commonwealth laboratories whose principal function is to provide testing services, whether to government agencies (including its own departments) or to outside bodies, be required to secure and maintain accreditation by the National Association of Testing Authorities.

Rec G47 (ii) Research laboratories and also service laboratories whose sole function is to provide testing services to particular research laboratories, and service laboratories with functions other than testing (eg design) be exempt from the above Recommendation G47(i), but that

(iii) The laboratories, especially the service laboratories, referred to in (ii) above, examine and report to their managements on the advantages of securing accreditation by the National Association of Testing Authorities as a form of proficiency audit.

Rec G48 (i) The Commonwealth require that non-Commonwealth laboratories to which it contracts the delivery of scientific services be accredited by the National Association of Testing Authorities.

(ii) This requirement not apply to laboratories from which the Commonwealth commissions work, particularly investigations, not encompassed by the National Association of Testing Authorities system.

Rec G49 Whereas Recommendation G48(i) covers pathology laboratories, and whereas the National Association of Testing Authorities is committed to institute a scheme of accreditation based on draft standards published by the National Pathology Accreditation Advisory Council:

the requirement of Recommendation G48(i) be applied in such a way as to include private-sector pathology laboratories for whose services the Commonwealth meets the greater part of costs through the Health Insurance Commission.

Clearly, the Ross Committee was of the opinion that NATA provided a most efficient, cost-effective mechanism for accreditation of laboratories in all fields of testing.

FINANCIAL ARRANGEMENTS

A full statement of NATA's accounts is provided in the attached annual report. NATA receives approximately fifty percent of its income as a direct grant from the Commonwealth. Commonwealth laboratories are exempt from payment of fees but all others pay subscriptions which provide approximately thirty-five percent of total income. Other sources provide fifteen percent of income.

The accounts do not show, however, the substantial contribution by way of voluntary service provided to the Association by its assessors and committee members. It is estimated that if NATA had to pay for these services, an additional $600 000 per year would be required. The Ross Report notes that this feature of NATA's operation is one that should be "husbanded". Indeed it is the principal reason why NATA's operating costs/laboratory are at least thirty percent below any equivalent body in any other country.

NATA's fees depend on the size and complexity of the laboratory under assessment.

There is an application fee of $800 and an annual charge which currently ranges from $600 up to $4000. We expect that major hospital laboratories will be required to pay approximately $2500 per year and smaller service laboratories approximately $1000 per year.

CONCLUSION

NATA believes that the questions of technical competence and overservicing should be recognised as two separate problems and that accreditation for technical competence will not achieve the Government's goal of containing costs due to overservicing.

Accreditation for technical competence will, however, ensure that test data generated in laboratories will be valid and useful. Unreliable data are, in the best case, a total waste of money and, are in the worst case, dangerous.

NATA provides the Government with a ready made, highly reputable, efficient and cost effective mechanism for implementing a system for the technical accreditation of laboratories providing pathology services. It is a system in which Commonwealth and State Governments, laboratories and professional bodies have representation without the high overheads necessarily associated with similar services provided directly by government.

We commend the National Association of Testing Authorities to your attention.

NATA Documents

The following documents are enclosed for additional information:

1983 Annual Report
1983 Directory
Medical Testing - Requirements for Registration
Rules
NATA - It's Role and Operation.