Special Commission of Inquiry into Healthcare Funding

Statement of Professor Anthony Gill

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1. This statement accurately sets out the evidence that I would be prepared to give to the Special Commission of Inquiry into Healthcare Funding as a witness. The statement is true to the best of my knowledge and belief.

A. Role

2. I am the head of department of Anatomical Pathology at Royal North Shore Hospital ("RNSH"). I have been the head of department of anatomical pathology since 2022 and have been a staff specialist in the department since 2005. Prior to that, I was an intern, resident medical officer, and a registrar (in both internal medicine and pathology) at RNSH. I am also Professor of Surgical Pathology at the University of Sydney.
3. There is little community understanding of what anatomical pathologists do. Anatomical pathologists are medical specialists who make diagnoses predominantly based on looking at samples of tissues under the microscope. There is very little automation and anatomical pathology is the most labour intensive discipline of pathology. For example all diagnoses of cancer are made by anatomical pathologists in this way.
4. Anatomical pathology is a unique specialty where a small number of high complexity and costly cases account for a disproportionate degree of pathologist time and departmental resources. For example about 10% of my cases take up more than half my working day. This is not reflected in the Medicare benefits schedule which favours high volume and low complexity pathology for example routine blood tests or the type of simple small biopsies that may be encountered in community practice.

5. Under Medicare based funding, pathology can only be cost neutral if high volume simple tests are bundled with the loss making complex tests (or if only high volume simple tests are performed and high complexity loss making tests are not undertaken).
6. High complexity and high cost pathology testing is very disproportionately carried out in the acute care hospital setting where it forms a key part of high quality and cost effective healthcare. That is, by a simple application of any funding model based on Medicare rebates, anatomical pathology in the hospital setting would 'lose money' but yet it is crucial to the running of the health care system as a whole, and the hospital system in particular.
7. Accurate and rapid pathology testing both provides optimal care and 'saves money' by allowing early and correct treatment – therefore, for example, facilitating early discharge.

B. The creation of NSW Health Pathology

8. When I commenced as a staff specialist, I was employed by the Northern Sydney Local Health District ("NSLHD") at RNSH. I believe that this structure appropriately integrated high quality pathology services into clinical care in the LHD, as budgetary, governance and clinical responsibilities aligned. I felt then, and still feel, a professional and emotional connection to the staff and patients of our LHD. Our department then became part of Pathology North, and provided pathology services for the northern part of the state, up to the border with Queensland.
9. In 2012, NSW Health Pathology ("NSWHP") was established as an administrative unit of the Health Administration Corporation under s. 9 of the *Health Administration Act 1982*. My employment was transferred to NSWHP, although I have continued to physically work at RNSH and have the same clinical responsibilities to patients within the LHD. The governance of pathology services and budgetary oversight, however, have moved from each LHD in which these services are physically located, and transferred to a centralised bureaucracy based in Newcastle.

10. Many issues have arisen as a result of the separation between centralised decision-makers with budgetary responsibility and pathologists with local knowledge and insight into local problems and needs. By its nature a centralised structure lacks the agility to respond quickly to local needs, and to fully understand the different local needs of different LHDs.
11. My direct reporting line is to Dr Tom Kennedy, the Local Pathology Director. While I retain clinical responsibility, neither Tom nor I have budgetary responsibility. The scientific, technical and administrative staff do not report to me, rather they report to a divisional manager who reports to an operations manager.
12. Whilst I regularly interact with senior medical and allied health staff from the LHD and the LHD executive, I rarely meet the executives of NSWHP – at most once or twice a year. Most interactions with the executive of NSWHP are by email.
13. While the LHD is supportive of my department, it does not have the budget or position to assist. The LHDs, for example, request increasing numbers of Multidisciplinary Team (MDT) meetings involving pathology. These are integral to patient care, but there seems to be an impasse as to how these meetings should be funded. I have set this out in more detail below.

C. Staffing issues

14. The work within my department is for patients within the NSLHD and the North Shore Private Hospital which is co-located with the RNSH. The North Shore Private contract significantly cross-subsidises the public pathology work. In addition, we do renal biopsies from Gosford and Lismore. The team is made up of pathologists, registrars, scientists and administrative staff.
15. Our six registrars are the only registrars within the hospital who do not report to the junior medical staff unit (JMSU) of the LHD. They report to a centralized NSWHP JMSU. At busy times of year or when short staffed due to illness (for example winter surge or pre-

Christmas) there is no option to adjust staffing (for example for resident staff in one term to be moved into or out of pathology training)

16. Some of my colleagues across the state cannot even obtain administrative staff and typists from their LHD's administrative staff pool at times of critical staff shortage as they fall outside of the NSWHP budget. This creates the situation where complex pathology reports cannot be finalised as there are no typists or administrative staff.
17. My team was told by NSWHP that they would fund a 1.0FTE resident position in pathology across the state. We were keen to utilise this position and I met with the LHD JMSU to progress things. However, there was only funding for one resident position across the entire state and the NSLHD JMSU would need funding for a full year position to make staffing work across the NSLHD. NSWHP then told me there was no ability for the full year funding to be provided to one LHD's anatomical pathology department even on a rotating basis. There was also no pathway to split the position amongst different LHDs. In the end, because NSWHP and the LHDs had different staffing structures it was impossible to utilize the 1.0FTE resident position. I emphasize that this is in the context of what is a critical shortage of anatomical pathologists within NSW and around Australia and a desperate need to increase training. If we were to integrate into the LHD we could access these positions in a way that is synergistic with the hospital
18. RNSH holds regular multidisciplinary team ("MDT") meetings in which clinicians discuss the treatment of all of our cancer patients and for many other complex patients for example renal medicine, interstitial lung disease and haematology. Pathologists' involvement in these meetings is not funded. In our department there is an establishment of 12.9 FTE staff specialists. We have calculated that the equivalent of 1.6 FTE of pathologist time is spent at these meetings. We believe it also accounts for 1.6FTE of a registrar position.

19. I reached out to NSWHP to seek backfill staffing for these MDTs and was told to contact the LHD. I met with the CEO of the LHD, who agreed this is important to resolve and he would meet with NSWHP.
20. Despite the demonstrable clinical need (and desire) for these MDT meetings, it appears that neither the LHD or NSWHP wants or is able to include the cost of the pathologists' contribution to MDTs in their budget and so they are unfunded.
21. There has been an unsustainable workload for anatomical pathologists in NSW for many years.
22. To give a measure of the degree of short staffing in anatomical pathology, at our monthly staff meeting held 8 January 2024, we polled the faculty and determined that on average each staff specialist in our department is working for '12 hours' per '8 hour day'. There is no overtime etc for staff specialists, so this represents approximately 4 hours per day of unpaid overtime. Furthermore, our workload as judged by number of anatomical pathology cases, is continuing to increase steadily by 10 to 15% each year and this trend continues into this year.
23. An independent review of pathologists' workloads and staffing levels was commissioned in 2018 ('the Paxton review'). The Paxton report has not been made public, but I understand it recommended very significant increases in staffing in our department (and essentially all other anatomical pathology departments in the state). NSWHP then conducted their own review and concluded that we should only have an increase of one FTE.
24. In 2023, after increasing pressure from anatomical pathologists, there was an internal review by NSWHP of workload in anatomical pathology. According to the memo entitled *UPDATE and Clarification on the Anatomical Pathology Relative Workload Review NSWHP* the review was to be "a snapshot of the Lab's current activity".
25. However this review was based solely on COVID affected years – FY 2020/21 and 2021/22. Despite protestations from myself and others, I believe these years were chosen because

the COVID disruptions (which disproportionately affected anatomical pathology) would make the short staffing seem less dire.

26. The review was based on Relative Time Units (RTUs) which measure the time taken to report cases based on Medicare rebates. For the reasons described above a workload metric based on Medicare rebate does not appropriately reflect the workload of complex hospital based anatomical pathology (but more accurately reflects community based pathology). Nevertheless I understand why the RTU metric was chosen – basically because it was the only data that was available.
27. It was made clear by NSWHP that this review was not to assess registrar, scientific, technical or administrative workload, or the actual workforce requirements of the department. Rather, it was to 'rank' the degree of understaffing across different departments. That is, it was a 'relative' workload review (designed to rank the relative staffing levels across different units) not an absolute workload review which would be designed to determine the appropriate levels of staffing for all units.
28. Whilst providing information for that review by way of a briefing document, I provided written evidence that our staffing was more inadequate than reflected in the data provided. I was told this written evidence 'would be considered but not included' in the review. A copy of the briefing document is at **SCI.0008.0300.0001**.
29. The findings of that review are at **SCI.0008.0301.0001**. I highlight table 1 on page 10 of that document, which I reproduce below. This summarises the amount of 'microscope' only time that the audit demonstrated was required per working day. Of note, this time does not include MDTs, teaching, administration, or research. As a guide, I think approximately half of an anatomical pathologists working day at hospital level should be spent 'at the microscope'.

Table 1. Average Hours per day pathologists spend performing diagnostic work (excluding MDTs, teaching, administration and research).

	Average time per day on diagnostic work alone (hours)**
RPAH	10.6
JHH	9.2
Liverpool	8.7
St George	8.5
Westmead	8.3
Concord	8.2
Nepean	8.0
RNSH	7.7
Gosford	6.9
Tamworth	6.7
Tweed	6.6
POW	6.4
Wagga	6.3
Orange	5.6
Coffs Harbour	5.6

*Dubbo excluded as pathologists also spend significant time performing cut-up.
**Calculated based on RTUs and presuming pathologists work 47 weeks per year. (Five weeks is less than the full entitlements for annual leave and TESL for staff specialists but the full amount is rarely taken).

30. The review proposed different models to improve staffing. Whilst I cannot comment on how much staffing was actually delivered (there was some increase at other sites); our campus certainly did not receive any more staff despite a review saying we were performing (at minimum) 7.7 hours of microscope work per day with no backfill for administration, teaching, MDTs and research; and based on a 47 week working year (staff specialists are entitled to 5 weeks annual leave, 5 weeks study (TESL) leave and 2 weeks sick leave so this should have been based on a 40 week working year).

31. In January 2024 I submitted a business case requesting 2.5 FTE staff specialists, 2.0 FTE registrars, and 2.0 FTE laboratory scientists. A copy of the business case is at **SCI.0008.0302.0001**. I provided evidence that the increase in total pathology cases for calendar year 2023 was more than 12% up on calendar year 2022 (more than 20% for renal biopsies) and that this increase was consistent on a month by month basis into the early months of 2024 and continues to increase at this rate.

32. This business case was declined (or at least not accepted), not based on clinical need but on budgetary impact. Essentially, we were told that 'we need agreement from the LHD that they would be willing to provide the additional funding for 24/25'. A copy of the relevant email correspondence is at **SCI.0008.0303.0001**. This again highlights the difficult issue of having budgetary responsibility with NSWHP but clinical responsibility to the LHD.

D. Issues of cost-shifting

33. In a structure where the governance of pathology is separated from the pathologists in LHDs, money can be "saved" in the pathology cost centre at the expense of more costs to the LHD and overall healthcare budget. Examples of this include when an urgent pathology result can both improve patient care and save money for the health system (for example by starting definitive treatment more quickly leading to better patient outcomes and more rapid discharge). Similarly having the resources to review pathology performed outside is generally quicker, cheaper and safer than repeating biopsies.

34. One example of this scenario is renal biopsies, which are very complex, and may require decisions to be made quickly for example regarding whether a patient has transplant rejection or drug toxicity. If the LHD appoints a new transplant clinician, this creates more work for the anatomical pathology department. In our department the number of renal biopsies we conduct has increased by 20% each year. They are extremely labour intensive, and the Medicare rebate does not represent the time it takes to complete them – they take

2 hours of scientist time and 2 hours of pathologist time for a rebate of $274.15, whereas other biopsies (for example a simple endoscopic biopsy) take 2-3 minutes and have a rebate of $97. If we have enough pathologists to process the biopsies more rapidly, it saves money for the system overall (such as moving the patient out of ICU or towards discharge sooner), and leads to better patient outcomes.

35. Neuroendocrine tumour (NET) pathology is also very complex and requires complex and time consuming pathological testing. NSLHD has the only specialist NET unit for in the state and offers advanced therapies not available elsewhere (including lutetium radiotherapy). It would be considered a flagship unit in the hospital. It receives many referrals from other centres all of which require pathology to be reviewed. When this unit was established there was funding for an oncologists and nuclear medicine physician. There is no funding for a pathologist position despite the fact that it takes a 0.2 FTE role.
36. Similarly, in relation to fine needle aspiration biopsies, it is of great assistance if a cytology scientist on site attends when a procedure is done so that they can examine the slides and advise whether there is enough cellular material, or if more is needed or a core biopsy is required. This can then be done at the time, rather than bringing the patient back later to get an additional biopsy, which then costs more, delays diagnosis and increases clinical risk. There is good and consistent data demonstrating that the inadequate specimen rate reduced by 12% by having a cytology scientist on-site for the procedure. Having an additional scientist on-site would reduce costs to both the LHD and the system overall as it would require fewer biopsies to be undertaken. It would also improve patient safety (less biopsies would be needed). We continue to maintain rapid on-site cytological assessment at our campus, but many of our peer laboratories in NSWHP do not because of funding limitations.

E. Procurement

37. A further demonstration of the negative impacts of centralisation can be seen in the lack of discretion for pathologists in relation to procurement. All our major expenses have to be approved through NSWHP. Pathologists can have specific insights or put their cases forward favouring certain platforms or approaches more suited to the local environment and LHD, but these can be rejected remotely.

38. For example, NSWHP has declined to pay for Prosigna, a gene expression assay, which is utilised in testing breast cancers. The assay shows whether a patient requires chemotherapy or not. There is no Medicare rebate and it costs around $2500 per test. While Prosigna would cost NSWHP money to operate and not save them money, it would save money for the LHDs by identifying whether a patient should be treated with chemotherapy, and also improves patient care. This highlights the issues around divorcing budgetary and clinical decision making.

F. Business case for localised molecular testing

39. Molecular testing has revolutionized cancer care and is now integral to anatomical pathology testing. In 2018, strongly encouraged by the oncologists and surgeons, we sought to commence molecular testing on campus and submitted a business case for a molecular testing platform. We put together a plan so that we could pay for this testing platform with our trust funds and use Medicare rebates to fund it going forward. There is a huge benefit of conducting these tests on-site for integrated patient care. It is vital to have a quick turnaround for these tests because results are needed to discuss treatment options (for example, at MDT meetings) so patients can start treatment.

40. When we presented our business case to NSWHP, we were told that it was not within NSWHP's model to undertake testing at RNSH and that NSWHP wanted molecular testing to be centralised in Newcastle (incidentally using platforms which we did not favour or think would be fit for purpose).

41. Over two years there were a series of meetings in which we were consistently told we could not perform molecular testing on campus. These interactions included requests for business cases which we do not believe were assessed in good faith.
42. After growing clinician dissatisfaction with somatic mutation testing for solid cancers for patients treated at RNS campus, on 19 December 2018 a meeting was held between myself, A/Prof Angela Chou (another anatomical pathologist in our department with particular expertise in molecular testing), the director of Cancer Services at RNS (Prof Stephen Clarke), the head of thoracic medicine (A/Prof Ben Harris), and the director of the Sydney Vital Translational Centre (Professor Alexander Engel). The CEO of NSWHP was expected to attend to represent NSWHP, but Cliff Meldrum and Robert Lindeman attended on her behalf. At that meeting, we were explicitly told by Cliff Meldrum and Robert Lindeman that it was not in their plan to allow somatic mutation testing at the RNS campus and this was not open for discussion despite our expressed beliefs and justifications that this is in the best interest of patient care.
43. After further dissatisfaction from campus, on November 10 2020 I met with Deborah Willcox (CEO NSLHD), Roderick Clifton-Bligh, Angela Chou, Amanda Harris and Robert Lindeman to discuss the problems with somatic mutation testing for solid cancers. At that meeting Robert Lindeman accepted that there were problems with somatic mutation testing from RNS campus and that it had lost of the confidence of the clinicians on this campus. He indicated that he would commission a review by an external expert presumed to be someone from interstate. When there had been no movement on this, I met with the CEO of NSWHP, Tracey McCosker, with Robert Lindeman and Angela Chou on February 17 2021 to confirm that the promised review would be undertaken. At this meeting the CEO of NSWHP confirmed, very explicitly, that there would be an external review to address these issues but it had not yet been commissioned.

44. The next communication I had on this issue was by email on March 22 2021 stating that there will be an internal audit (conducted by the same individual who recommended the failed structure) and not an external review. The review is known as the Webb report.
45. My written submission to that review (which incidentally was not reference at all in the final report) is at **SCI.0008.0304.0001**; and summarizes in more detail the problems with this process.
46. Last year, 5 years after we commenced the process to begin molecular testing, we have arranged the purchase of a molecular platform for testing on campus with the support of the LHD and the Kolling institute of research. This was done independently of NSWHP. We are well on the way to NATA accreditation for this platform.
47. Now, 6 years after we commenced this work and after we took action through a more agile locally based approach and the platform has been purchased and installed, NSWHP have offered to collaborate with this. However this has not yet resulted in any real or actual support.
48. I think the decision making process behind attempting to centralise molecular testing in Newcastle should be independently reviewed. This review should also consider whether there was an attempt to minimize some of the failings of this structure and review the success or otherwise of molecular testing centralized in Newcastle. That is, to calculate how much the centralised testing model based in Newcastle has cost and what it has, and has not, delivered.

G. Summation of issues with the centralised model

49. Anatomical pathology is a unique specialty where a small number of high complexity and costly cases account for a disproportionate degree of pathologist time and resources. This is not reflected in Medicare benefits which favour high volume low complexity pathology of the type which is common in the community setting. The high complexity and high cost

pathology testing is very disproportionately carried out in the acute care hospital setting where it forms a key part of high quality and cost effective healthcare.

50. In my opinion, the change of structure to establish NSWHP centralised in Newcastle has been detrimental to patient care and staff morale. There have been multiple examples of poor decision making and a lack of accountability and I think the approach to statewide molecular testing of carcinomas is an example of this.
51. The centralised model has made research more difficult. For example, we now need to get ethics approval from the LHD ethics committee as well as governance approval from NSWHP (previously the LHD had authority to determine ethics applications involving local pathology projects). Often the advice from these two bodies is not aligned and the addition of NSWHP governance approval has added significant delays. For example, we have one research project governance approval submission, ref: 2023STE03875, for which all other approvals are in place that is still pending decision from NSWHP's executive director of clinical services. The project has been with him since at least 6 February, and despite several follow up emails (every two weeks or so), has still not been actioned.
52. I believe that the centralised structure has removed decision making from pathologists with local expertise and knowledge of local clinical needs, leading to ongoing financial wastage. There seems to be an emphasis on being seen to be consultative over actually being consultative.
53. The structure lacks the agility to be responsive to the changing needs of individual patients at different campuses, all of which are subtly different.
54. Rather than being seen to say no to healthcare expenditure in pathology, expenditure is often delayed by unnecessarily prolonged recruitment processes and seeking business cases, committee approvals, and external audits.
55. There is a critical shortage of anatomical pathologists in NSW, and I believe that NSWHP has normalised understaffing and under-resourcing.

56. This normalising of short staffing and under-resourcing is facilitated by a centralised model where pathologists are employed by NSWHP instead of at the LHD level. This centralised management structure runs contrary to the general trend to decentralize management to the LHD level.

Signed:

Anthony J Gill AM

Date: 16 April 2024