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Public Pathology AUSTRALIA

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COVID-19 Response Inquiry Panel
Via: https://www.pmc.gov.au/covid-19-response-inquiry/consultation

**COVID-19 Response Inquiry Submission**

Thank you for providing Public Pathology Australia the opportunity to contribute to the Commonwealth Government's COVID-19 Response Inquiry.

## Background

Public Pathology Australia (PPA) is the national peak body for Government owned and operated pathology services. PPA members cover all jurisdictions in Australia.

## Public Pathology Response to COVID-19

The response by the public pathology sector was effective from the earliest stage of the pandemic, covered a broad spectrum of activities including testing patients for COVID-19 in the acute health sector whilst ensuring equity of access to testing in other settings, and also facilitated the private pathology sector response. Public pathology did this at cost and in close partnership with Government.

Public pathology was the first pathology provider to test for COVID-19 in Australia, the first to establish drive through collection centres and to deliver timely SMS reporting. Public pathology providers performed the majority of acute and high risk COVID testing and were the sole provider for genomic sequencing for contact tracing and epidemiological purposes. Public pathology's reach spanned metropolitan and rural communities with laboratories located close to where testing was required to maintain clinically relevant turn-around times for test results. This enabled testing for all communities including the vulnerable and disadvantaged. Public pathology also tested for COVID-19 in quarantine hotels, medi-hotels, virtual hospitals, airports, defence, maritime and mining sectors. For a summary of the public pathology response to the COVID-19 pandemic, click here.

## Recommendations

It is important to ensure that the public pathology sector is well supported to maintain pandemic preparedness including funding to ensure public laboratories can develop new tests and participate in surveillance measures. Secure, specified block funding for pandemic preparedness for public pathology services is critical. Public laboratories develop tests for new pathogens before commercial testing kits are available for other pathology providers to commence testing. Public laboratories need to be resourced to maintain this capability. Funding is required to support ongoing scientific expertise and training in each state to enable a rapid response to novel pathogens as routine diagnostic training does not cover the skills required to respond to new pathogens.

Public pathology providers need to be appropriately funded throughout a pandemic. The 50/50 cost share National Partnership on COVID-19 Response (NPA) between the Commonwealth and the States/Territories was useful when it covered the broad range of activities that public pathology was engaged in during the pandemic. However, the 50% Medicare Benefits Schedule (MBS) fee reduction for public pathology which did not apply to private pathology providers was inappropriate when all pathology providers received funding via the MBS and the States (under the NPA) for non-MBS tests. The private pathology MBS test fee could have been perceived as a signal by the jurisdictions.



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There needed to be consistency and transparency in private pathology contracts with the States/Territories and a mechanism to ensure pricing was appropriate. For example, where specimens were pooled (tested in a group), there should have not been separate charges for each specimen tested.

Residential aged care facilities and their residents would have been better served had their usual or local pathology provider been their primary provider for COVID-19 testing instead of relying on one national contracted provider which became overburdened. The latter should have been used as a means of last resort rather than as first responder.

A significant challenge throughout the pandemic was procurement of personal, protective equipment (PPE), test materials (e.g. swabs, reagents) and testing automation which were impacted by the increased world-wide demand for COVID-19 testing. Pathology services were reliant on international supply chains and Australia was competing for supplies internationally and between states. There needs to be investment in local manufacturing of PPE, collection and laboratory consumables and diversification of testing platforms and supplies. Public pathology production of viral transport medium and a partnership with a local 3D printer for swabs worked well during the pandemic.

There needed to be greater interaction between National and State/Territory Stockpile Managers and pathology providers to ensure items purchased (e.g. consumables, Rapid Antigen Tests RATs) are fit for purpose. A central, coordinated, crisis procurement agency with links to public pathology providers would be beneficial. Nationally coordinated transport and storage logistics for the movement of critical supplies both nationally and internationally could also be considered.

There needed to be greater rigor attached to accreditation by the Therapeutic Goods Administration (TGA). By way of example, saliva RATs had very poor performance. Mandatory saliva testing had questionable effectiveness and was a burden for laboratories to validate and implement.

The pandemic highlighted the importance of real-time genomic sequencing in managing community spread and informing public health units on lockdowns. Funding for this type of testing is currently unrecognised at the national level and each jurisdiction should be funded to build and maintain this capacity. It is important to mandate data-sharing of genomic sequencing across borders to support improved tracking of cases, particularly in the early phases of an outbreak.

Given the importance of pathology testing in a pandemic, it is important that the current workforce crisis in pathology is resolved. There is also no surge capacity in the current laboratory funding structure to meet pandemic demands. Staff skills to perform highly specialised molecular testing are relatively rare and staff shortages impede the ability of services to rapidly upscale to large testing numbers in a 24/7 environment. There is no designated funding for public pathology services to support delivering safe and optimal sample collection methods, advising on infection control, test performance and turnaround time, conducting assessments of new test methods and technologies, and attending public health meetings as subject matter experts. This lack of resourcing also significantly hampers the ability of public health laboratories to undertake important translational research in real time to inform and guide the pandemic response.



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In the past there has been a general lack of recognition of the challenges faced in delivering testing services in remote and regional areas, including Indigenous communities. While testing is more challenging and expensive, early diagnosis is vitally important in prioritising management of inpatients and outpatients in smaller towns and communities. The use of higher cost rapid PCR testing is essential in this circumstance, but this has not been rebated on the MBS.

Prior to the pandemic, there was no federally coordinated planning on how to provide testing services to regional and remote communities, which became exacerbated once lockdowns and border restrictions were instituted. It is important to acknowledge and support the strength of public pathology services within each state and territory to perform laboratory testing in remote and Indigenous communities, rather than outsourcing to other entities which then require considerable assistance from public pathology services.

Data systems for rapid and efficient transfer of results to Health Departments are not optimised, leading to significant workarounds during the pandemic to facilitate the data required by Public Health Units to coordinate the response. Traditionally only positive results of notifiable diseases are transferred. During the pandemic, all positive and negative results and additional data was required. There needs to be systematic data linkages developed and maintained between laboratories and Public Health Units.

There was no system for self-registration of patients attending a COVID clinic or a process to send results directly to patients via SMS, as traditionally all results go to a requesting doctor through traditional practice software. This was developed during the pandemic and has since ceased. This would need to be funded in the event of further outbreaks.

During the COVID-19 pandemic, the public-private laboratory interface could have been better managed to reduce duplication, better coordinate equipment, streamline multiple lines of communication and improve specimen transfer processes.

Public pathology actively provided advice to State, Territory and Commonwealth Governments and global entities to assist in managing the COVID-19 pandemic. This occurred via a range of means such as direct participation in State Health Emergency Operating Committees, operation of the Public Health Laboratory Network and liaison between Public Pathology Australia and Governments. This was critical to the COVID-19 response and will be essential in future outbreaks.

Please contact Public Pathology Australia on (07) 3102 4094 or email contact@publicpathology.org.au should you require further information in relation to this submission.



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