to further investigate abnormal findings is tantamount to prescribing to a physician or surgeon that patient care should be related solely to the reason for referral, and that even if additional findings are made, no further investigation or care should be advanced until permission has been obtained.

As with all involved in patient care, pathologists must order further tests based on the outcome of prior testing. This is sometimes life saving. Their expertise is based on general medical training, specialist training in laboratory medicine, and clinicopathological correlation. To suggest otherwise is to relegate pathologists to the level of technicians who merely provide results at the behest of the referring doctor without interpretation.

With tongue in cheek, would one solution not be to ban pathology testing altogether? But that would not be to the financial advantage of the middleman – Veripath!

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1. Pretorius C. Utilisation of pathology procedures in the South African private pathology sector between 2003 and 2005. *S Afr Med J* 2007; 97: 51-57.

To the Editor: An editorial[1] referring to an article in the same issue of the *Journal*[2] suggests that more appropriate use of pathology investigations can save up to R115 million. Pretorius[2] states that a cost saving of 15% is potentially achievable if the lowest-cost laboratory is accepted as ideal behaviour, but *'It is debatable whether the lowest utilisation in this sample represents ideal or acceptable test utilisation'* (my emphasis). Neither author justifies or analyses the proposed saving based on patient outcomes or disease profiles. Their apparent objective is to demonstrate laboratory overuse. The debate *should* be about the value and applicability of pathology in patient care. No responsible pathologist supports over-investigation of patients, but neither should under-investigation be sanctioned.

Raath presented data from an industry-wide modelling tool of the annual statutory returns of all registered schemes and options for the period 2002 onwards at the BHF conference in Durban in July 2006, and concluded that the weighted percentage increase in benefits to pathology was a fraction of 1%. His figures contrast sharply with those of Pretorius.[2] The 2.3 billion expenditure on pathology in South Africa constitutes 4.5% of total contributions to medical schemes. Non-health care expenditure absorbs 15% of total contributions. In 2005 non-health care expenditure rose by approximately 9.6% to R7.8 billion, with the major components being administration R5.4 billion (annual increase of 10.5%), managed care fees R1.3 billion, and broker fees R0.8 billion (annual increase of 21.1%). From 2000 to 2005 non-health care expenditure increased by 89.5%.[3] Managed care expenditure therefore amounts to about 50% of expenditure on pathology.

Pathology is a referral specialty. Pathologists are medical specialists and are the bridge between the clinician and the laboratory. The Royal College of Pathologists advocates: 'Other relevant tests may be added to, or substituted for, those originally requested.'[3]

Members of the National Pathology Group (NPG) of SAMA must adhere to specific protocols for laboratory request forms – only academically defensible test profiles may appear, it must be possible to request any test individually, and the content of profiles must be listed on the laboratory request pad. Clinicians are at liberty to request any test individually, or a combination of tests.

Veripath, the managed care company that employs Pretorius, is campaigning to replace current laboratory request forms with blank paper on which tests must be handwritten. This will dramatically increase the error rate. The transcription error rate from incorrectly handwritten laboratory request forms in Australia has been estimated to reach 17%.[4] In fact, online test ordering with data transmission to the laboratory is increasingly the norm.

Is rationing the sole objective? Pathologists contribute significantly to appropriate and cost-effective laboratory testing by publishing investigative guidelines and protocols.[5] Much is made of the fact that the majority of the tests are common, of low complexity, and performed in bulk. The fee for a given test does not vary even if it is done as a single investigation during the day, after hours, or in the most remote laboratory. The cross-subsidisation of these services and tests ensures that a comprehensive laboratory service is broadly available to all patients.

The Australian system is essentially a national health system, with the state as guarantor of payment. The selective choice of certain components will not lead to a sustainable pathology service for South Africa. The Australian Association of Pathology Practices noted some of the other negative effects of the memorandum of understanding between pathologists and the Australian Government, including reforms being funding-based rather than aimed at best medical practice, discouragement of entrepreneurship due to limits to return on investment, and likelihood of unsustainability in the long run.[6]

The NPG is currently in the process of tariff revision. In an extensive preliminary submission to the Council for Medical Schemes in 2006, 17.4 million billing line items were evaluated. This indicated a financial return of approximately 10% for pathology, provided that an increase of 7.5% was to be allocated to the National Health Reference Price List (NHRPL) for 2007. From this report it is obvious that the income for all services by laboratories is not excessive.

The NPG's role is to ensure that pathology continues to fulfil