Health Outcomes International Pty Ltd
HEALTH, COMMUNITY AND SOCIAL DEVELOPMENT CONSULTANTS

MINISTRY OF HEALTH

REVIEW OF THE POLICY OF SOME DISTRICT HEALTH BOARDS NO LONGER PAYING FOR LABORATORY TESTS REFERRED BY PRIVATE SPECIALISTS

FINAL REPORT

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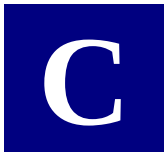

CONTENTS

EXECUTIVE SUMMARY

The Ministry of Health (MoH) engaged Health Outcomes International Pty Ltd (HOI) to undertake a review of the policy of some District Health Boards (DHBs) no longer paying for private specialist referred laboratory tests (PSRTs). This review provides analysis of the impacts of the policy on patients' access and service utilisation (both private and public), provider behaviour (e.g., cost-shifting), costs and savings in the DHBs that have implemented the policy.

Although diagnostic laboratory testing for New Zealand patients has largely been fully publicly funded for over 50 years, three DHBs have, since 2006, changed their contracts with laboratory providers to cease funding PSRTs: Capital & Coast, Hutt Valley and Tairawhiti. The policy aligns public funding of community laboratory tests with that of other private diagnostic procedures such as x-rays, ultrasounds and MRIs. It also reduces incentives to order unnecessary tests, since the tests are no longer "free" from the patient's perspective. The Ministry of Health has estimated that if all DHBs adopted the policy, up to $20 million annually could be reprioritised to other publicly funded services.

However, critics of the policy have highlighted a number of issues and risks including potential negative impacts on access, incentives for cost shifting, and associated clinical and fiscal risks. The Minister of Health has placed a moratorium on any further implementation of this policy by other DHBs, pending the review of its impacts.

REVIEW METHODS

The review included investigation of community laboratory utilisation data and DHB financial data, review of relevant background documents including a recent evaluation by Capital & Coast and Hutt Valley DHBs, submissions to DHBs from national organisations and professional associations, DHB documents, and Ministry background papers.

The review team also interviewed a total of 55 stakeholders including representatives from DHB Planning & Funding, Community and DHB laboratory managers, general practitioners, specialists, private hospital managers, Primary Health Organisation managers, Ministry of Health, professional bodies/associations, and health insurers.

Available data did not support a robust quantitative analysis of shifts in the utilisation of laboratory services ordered by private specialists. Accordingly, the review was strongly reliant on anecdotal feedback from stakeholders. This limited the extent to which definitive conclusions could be drawn. Key data limitations included:

- A lack of baseline data on PSRT volumes prior to the policy coming into effect;
- Inability to distinguish tests ordered by specialists in private practice from those ordered in the public system;
- The introduction of the PSRT policy coinciding with establishment of new laboratories and the replacement of fee-for-service funding with bulk funding arrangements; and
- A range of external factors likely to affect test volumes, such as the introduction of new guidelines, PHO initiatives and changes to in-house laboratory testing protocols.

KEY FINDINGS

The cessation of funding for PSRTs at Capital & Coast, Hutt Valley and Tairawhiti DHBs has generated significant **savings** for the DHBs – especially in Wellington/Hutt where there is a greater concentration of private specialists.

Savings to the Hutt Valley and Capital & Coast DHBs (where PSRTs represent approximately 6% of total community laboratory test volumes) have averaged $1.4 million per annum to date. While the DHBs did not reallocate PSRT savings directly to other specific services, the DHBs were able to identify additional services that the DHBs funded at the margin. These savings were made possible through additional revenue from PSRTs as well as other sources.

Savings to Tairawhiti DHB (where PSRT volumes are not monitored but are likely to represent a smaller proportion of total volumes than in the Wellington DHBs) were prospectively estimated at $65,000 per annum. This figure, based on Hutt Valley and Capital & Coast experience, adjusted for local conditions, was factored out of the total fixed price in the laboratory services contract. Overall savings from the new contract were applied to deficit reduction.

These savings only take account of the immediate, direct costs of PSRTs and do not include allowance for any longer term costs that might be associated with delayed tests or cost shifting.

All three DHBs described the **administrative costs** of implementing the policy as "negligible" and principally related to putting a new contract in place. There have also been minor post-implementation costs such as communicating with GPs and specialists to discourage cost-shifting practices.

Costs to laboratories include establishing and managing systems for invoicing patients who do not physically present at a collection room, and recovery/write off costs associated with bad debts. Administrative and debt-related costs are covered by laboratory service fees at Aotea Pathology (bad debts were high initially for Aotea Pathology but have subsequently reduced) and are absorbed by TLab within its overall administrative costs.

Average **costs per patient** per encounter are in the order of $62-$86 per patient in the Wellington region, with the lower estimate sourced from the DHBs' evaluation of their PSRT funding policy and the higher estimate from Southern Cross Healthcare figures. However, the costs of some individual tests can run to several hundred dollars. Moreover, there are patients who face high costs where multiple tests are required.

It appears that the policy disproportionately affects patients without insurance cover for PSRTs, who have to undergo complex procedures requiring multiple tests, or who have chronic conditions requiring regular ongoing tests. This may have implications for the health of these individuals as well as downstream costs to the health system. If the policy is implemented more widely, it should include hardship provisions to mitigate these risks.

The policy has had some **unintended effects**, including:

- Patients choosing to delay tests, reduce the number of tests, or forego tests to avoid costs;
- Patients transferring from private specialist care into the public system; and
- GPs ordering tests at the request of private specialists in order to avoid costs for patients.

While the extent of these impacts could not be verified, the consistency of anecdotal advice received from clinicians suggests they are occurring to a sufficient extent to be of concern. For example, of ten interviewed specialists in the Hutt Valley, Capital & Coast and Tairawhiti districts, seven said that they ask GPs to order tests to avoid costs for their patients, and all were aware of private patients being lost to the public system due to the costs of ongoing tests – with three of these specialists reporting significant numbers of patients moving to the public system.

Similarly, most of the interviewed GPs said that they had been asked by patients and/or specialists to order tests that should appropriately be ordered by the specialist. Of the eight GPs interviewed, three said they were ordering tests on behalf of private specialists and three others were aware of this occurring but were not doing it themselves. Professional bodies were also aware of such cases, having been advised by their members that this was occurring.

In contrast, the three DHBs advised that they believed cost shifting had occurred initially but had subsided and was not widespread. The DHBs also noted that they had not observed any impacts on demand for public hospital services as a result of the policy.

The only way to reliably identify the extent of cost shifting would be to conduct a clinical audit on a sample of files, including follow up contact with the GPs and specialists involved.

Despite concerns about clinical risks, no cases have been identified where adverse health outcomes have actually occurred. However, it is important to note that adverse outcomes may take longer to emerge and could be difficult to attribute to the PSRT policy.

Hutt Valley and Capital & Coast DHBs have discretionary financial assistance available for people needing ongoing tests, who face exceptionally high costs and who are in financial hardship. However, nobody has accessed this assistance to date. It is unclear whether this reflects a lack of need, lack of awareness of the hardship exemption, the level at which the threshold for assistance has been set, or other barriers to accessing the assistance.

Currently, some **private health insurance** policies cover PSRTs and others do not. If all DHBs nationally were to cease funding PSRTs, insurers are likely to increase their premiums to offer more coverage for PSRTs. This should help to mitigate some of the current gaps in coverage (some gaps would remain, as there are patients who use private specialists without having insurance coverage). Some concomitant substitution of demand toward publicly funded services is also to be expected. However, the impact on premiums, and therefore on the public system, seems likely to be relatively small.

Other impacts of the policy include:

- A private hospital has started using a point-of-care analyser which is not externally validated. Anecdotally, one of the reasons for this practice is that it reduces costs to patients undergoing complex procedures who would otherwise face high lab test charges.
- Laboratories, doctors and DHBs have received patient complaints, most of which were related to patients being surprised that they would be charged by the laboratory. The three DHBs and Aotea Pathology said complaints had reduced over time.
- Laboratories bear financial risks associated with patients not being informed of test charges prior to testing. In cases where the patient does not physically present at a collection room, the laboratory is reliant on the specialist to advise the patient of these charges.
- Specialists, GPs and professional association representatives were widely opposed to the policy, which they saw as inequitable and introducing clinical risks associated with delayed or foregone tests. Similarly, private insurers and professional associations have raised concerns about the current lack of evidence about longer term impacts on health outcomes and costs.
- Although almost all of the interviewed clinicians would prefer the reinstatement of funding for PSRTs, there was an acceptance from most that the policy would be more equitable, and therefore more acceptable, if adopted nationally.
- Clinicians and professional associations were dissatisfied with the level of consultation and communication from DHBs prior to and during implementation of the policy.
- There is some concern that in the future laboratories could take advantage of their monopoly positions by increasing their fees for private patients, and that private patients could end up paying more for the same service than publicly funded patients as a result.

RECOMMENDATIONS

If the Ministry decides to undertake further policy development work toward wider cessation of funding for PSRTs, it is recommended that the Ministry:

- Conduct modelling to fully cost the policy including potential national savings, risks and long-term costs, taking into account the cost of hardship exemptions and potential adverse impacts of patients foregoing tests;
- Undertake research with consumers in greater Wellington and Tairawhiti who have chronic conditions, in order to better understand the nature and extent of the policy's impacts for this group;
- Develop provisions to ensure patients do not face unreasonably high out-of-pocket costs as a result of the policy;
- Consider whether the policy should apply to all PSRTs or only those ordered for diagnostic purposes;
- Improve the quality of data collection to enable PSRT volumes and cost-shifting practices to be measured and monitored; and
- Ensure an adequate level of communication with consumers, clinicians and professional bodies to accompany the implementation of the policy.

Impacts	Review Questions	Methods	Potential data sources
	Have specialists asked GPs to order laboratory tests on behalf of the specialists' patients?	Interviews with GPs, community laboratory managers, DHB staff.	Qualitative only.
	Have specialty groups in the public sector faced increased demand from patients diverting from private practice due to the extra laboratory costs?	Interviews with DHB staff, GPs, professional bodies.	Qualitative only.
	Has the policy had other impacts? (e.g., private hospitals buying and using analysers for testing that is not quality assessed (or accredited) and maintained by a lab?	Interviews with DHB staff, GPs, professional bodies, private hospitals.	Qualitative only.
Costs and cost savings	What were the operational costs to DHBs to implement the policy? What were the savings to DHBs of implementing the policy?	Interviews with DHB finance personnel, planning and funding personnel, and/or DHB community laboratory contract managers. Analysis of DHB costs based on qualitative advice. Analysis of savings based on DHB financial data.	DHB financial data. Advice from DHB finance personnel and DHB managers of community laboratory contracts about cost and savings structures.
	What were the costs for community laboratories of implementing the policy?	Interviews with community laboratory managers. Analysis of community laboratory costs (including establishing invoicing systems, ongoing staffing FTE to manage invoicing and communications associated with the policy, bad debt ratios [initial and steady state], any offsetting fees charged for administrative costs, and whether these cover the additional costs).	Advice from community laboratory managers about cost structures.
	How have the savings been utilised by DHBs?	Interviews with DHB finance/ planning and funding personnel.	Advice and/or documentation from DHB finance/ planning and funding personnel.
	What was the rationale for determining how the savings were used?	Interviews with DHB finance/ planning and funding personnel.	Qualitative only.

The risk of a decrease in PSRT utilisation occurring is greatest in cases where:

- PSRTs are not covered under the patient's private insurance (or the patient is not insured); and
- The costs are significant due to the nature or frequency of the tests.

If all DHBs adopted the policy, the risks of this occurring could therefore decrease as private insurers could be expected to adjust their policies to offer coverage for PSRTs (see section 3.1.2). However, some patients choose to pay for a private specialist despite not having private insurance. For example, inflammatory arthritis was cited as a condition that can result in severe pain and loss of function, frequently from onset. It was argued that it these factors that drive sufferers to seek the fastest possible treatment, and not necessarily ability to pay.[29] This perspective was also reinforced by the experience of the patient with rheumatoid arthritis who wrote to the review team.

Capital & Coast and Hutt Valley DHBs, in their impact evaluation, also attempted to gauge the extent to which patients had foregone tests. The DHBs invited all GPs (N=474) and specialists (N=124) to provide evidence of adverse impacts. A total of 9 GPs and 8 specialists responded – an overall response rate of less than 3%. Some of these respondents provided evidence that "due to reluctance to pay the charge, some patients had not complied with their request that they provide specimens for testing by the laboratory services provider".[3] The DHBs concluded, "the evidence of avoidance is anecdotal and while we know it has occurred in some cases, there is no reason to suspect that it is widespread".[3]

COSTS TO PATIENTS

The Aotea Pathology contract with Hutt Valley DHB (on behalf of Capital & Coast and Hutt Valley DHBs) allows the laboratory to charge patients of private specialists the schedule price of the test, plus a laboratory service fee (of $13.90 per encounter)[22] to cover the administration costs of collecting the fees. There is also a small intangible cost for patients, related to "additional time taken to understand their obligation to pay and to attend to their payments obligation".[3]

According to the DHBs, the prices paid are "comparable to the prices paid to laboratory providers by DHBs with fee-for-service contracts". For example, the collective Aotea Pathology price for the top ten tests (for New Zealand by volume) totalled $87.50 compared to an average $87.51 paid by DHBs to other laboratory providers.[3]

Similarly, TLab charges patients according to a modified version of Hutt Valley's pricing schedule, which Tairawhiti DHB reviewed and adjusted to reflect local overheads and volumes. TLab does not charge a separate administration fee.

Average cost per patient

According to analysis carried out by Capital & Coast and Hutt Valley DHBs, the average price paid per test during the first 12 months of the policy was $16.51. On average, three tests were carried out per patient. The DHBs' evaluation found that "the average paid per private patient appears to be $62.20 but can't presently be calculated with accuracy as patients only pay one encounter fee per day but there can be several patient visits in a day (e.g., there may be 30 tests on the day that a patient has heart surgery)".[3]

Southern Cross Healthcare analysed its own claims data around November 2008 (approximately two years after the implementation of the PSRT policy) and found that its Wellington health insurance members had submitted approximately $86 per lab test visit.[10]

Circumstances leading to high per patient costs

Three key sets of circumstances were identified in which patients may face high out of pocket costs if they do not have private insurance or if their insurance policy does not cover these tests:

- High schedule prices for specific tests;
- Complex procedures requiring multiple tests; and
- Chronic conditions requiring frequent ongoing tests.

received in the first six months. For example, in the first 12 months following the policy change, Capital & Coast and Hutt Valley DHBs received a total of 23 complaints. The majority of these were received in the period immediately after the policy change and only five complaints were received in the second six months.[3] The most common complaint related to not being told about the charge by their private specialist.

Aotea Pathology also reported a high degree of acceptance from patients of private specialists regarding the lab test charges. However, the lab has noted that private patients are more likely to ask for a copy of their results, are more resistant to pay if they are not happy about the test result, and are more resistant to pay for reflex testing (subsequent testing as determined by best practice).

TLab reported that the volume of complaints was ongoing but variable, and often related to patients being unaware they would be charged. Due to the PSRT change occurring with the commencement of TLab, patients sometimes perceive the policy as having been instigated by TLab, because "the old lab didn't charge".

Almost universally, specialists reported having patients who had complained at having to pay for their lab tests. Many were said to be unaware that they would be required to pay and were reportedly "shocked" and "angry". The specialists indicated this impacted negatively on the relationship with their patients.

In some cases, consumers were unaware that they would face out-of-pocket costs for their PSRTs until they received an invoice from the laboratory. The ordering of tests without making consumers aware of out-of-pocket costs breaches consumers' rights.[31,32] The unexpected invoices have also caused inconvenience for patients who had already filed their insurance claims. In turn, this has led to administrative inefficiencies for insurers due to double handling of claims.

Inefficiencies can also arise when insurers only cover part of the lab test costs. For example, TLab also noted that some insurers pay 80% of the invoice. Initially, the lab invoices the patient for the full amount and the patient submits the invoice to their insurer. When 80% of that amount is received from the insurer, a second invoicing process is required to recover the balance from the patient.

OBLIGATION TO PAY

As the billing organisation, the laboratory is responsible for informing the patient of a private specialist of the test charges and obtaining agreement to pay, prior to testing. This can be problematic in cases where the patient does not come into direct contact with the lab – for example, where a surgeon removes a lesion and sends it to the lab for testing. Capital & Coast and Hutt Valley DHBs asserted that unless a formal contract has been established with the referrer, there is no liability for the referrer to meet the cost if the patient refuses to pay. Therefore, the laboratory needs to ensure that a contractual liability is established in advance.[3] As such, the laboratory carries a financial risk associated with private specialists not advising patients of test charges.

South Island DHBs had looked at the possibility of surgeons charging patients for the lab tests and reimbursing the laboratory, or for lab test charges to be included within the hospital bed-day fee. It was noted that private specialists and private hospitals already charged patients for other inputs and that it would be more streamlined for patients to receive all charges itemised on one invoice. However, it was acknowledged that this proposal might meet with some resistance from private specialists.

CLINICIAN OPPOSITION TO THE POLICY

Consistent with concerns raised by professional bodies (as summarised in section 1.2.2), the GPs and specialists who were interviewed widely voiced opposition to the policy, which they saw as:

- Inequitable for patients;*****
- Inconvenient for doctors;
- Fragmenting services (i.e., impacting adversely on continuity of care);
- Diminishing the professional working relationship between clinicians in the public and private systems;
- Introducing new anomalies;†††††
- Increasing bureaucracy; and
- Introducing clinical risks associated with delayed or foregone tests.

Although almost all of these clinicians would prefer a return to all DHBs paying for PSRTs, there was an acceptance from most that it would be more equitable, and therefore more acceptable, if the policy were adopted by all DHBs.

ADVERSE HEALTH OUTCOMES AND DOWNSTREAM COSTS

Many of the submissions to DHBs by professional bodies in relation to proposals to cease funding PSRTs highlight risks of adverse health outcomes related to delayed or foregone lab tests (see section 1.2.2). Flowing from this concern is the suggestion that these adverse outcomes would cause downstream costs for DHBs which are not factored into the up-front cost savings from ceasing to fund PSRTs.

The interviewed specialists and GPs echoed these concerns but were not aware of any instances where adverse outcomes had actually occurred.

In 2007 Capital & Coast and Hutt Valley DHBs sought to identify any evidence of adverse health outcomes by inviting GPs and private specialists to provide evidence of such outcomes occurring. Of the 474 GPs and 124 known practicing private specialists, only 17 responded. They collectively identified two patients who had been temporarily adversely affected. Specialists were principally concerned with cost, GP/private specialist boundary of care issues, and noted risk of harm to patients who had elected to stop or cut down on testing.[3]

However, it is important to note that adverse outcomes may take longer to emerge, and may not be attributed to the PSRT charging policy even if this was a contributing factor. As the significance of these costs is unknown and will be difficult to measure, modelling of the potential impacts and health system costs may be warranted to inform decision making about the policy. This is discussed further in section 3.4.

MONOPOLY PRICING AND INFLATIONARY EFFECTS

Community laboratories are essentially monopolies within most regions. As such, there is potential for laboratories to charge consumers higher prices than would apply in a competitive environment, with no efficiency gain. Stakeholders have suggested that laboratories that do not receive public funding for PSRTs are likely to adjust their fees for private patients in the future and that private patients would end up paying more for the same service than publicly funded patients as a result.

Moreover, DHBs as the major purchaser of community laboratory services are able to negotiate fee levels, whereas private patients have to 'take the price' offered.[10] As a case in point, private patients pay Aotea Pathology the schedule fee plus a laboratory service fee, whereas the DHBs were able to negotiate a fixed fee contract at a 15% discount on schedule prices for the anticipated service volumes, with no service fee.

***** i.e., patients face different costs depending whether their lab test has been ordered by a GP or a specialist – even if they have identical medical conditions and are seeing the same GP and specialist. Similarly, patients are treated differently depending which DHB district they reside in.

††††† Despite aligning funding for community lab tests with that of radiological diagnostic tests, the policy has created new anomalies. For example, the cessation of public funding for PSRTs applies not only to diagnostic tests, but also to tests to monitor the effects of medications that are publicly funded.