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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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 Aotearoa 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.
INTRODUCTION

The Ministry of Health (MoH) engaged Health Outcomes International Pty Ltd (HOI) to conduct a review of the policy of some District Health Boards (DHBs) no longer paying for private specialist referred laboratory tests (PSRTs).

This section gives an overview of the review and its broader context.

1.1 LABORATORY SERVICES FUNDING IN NEW ZEALAND

Diagnostic laboratory testing for New Zealand patients has largely been fully publicly funded, with no charge to patients, since the 1950s. In community practice, laboratory tests ordered by doctors have been divided into two categories – schedule tests, those specific tests listed in the Diagnostic Laboratory Schedule, and other, non-schedule tests. Schedule tests have been funded on a fee-for-service basis in most community laboratories until the last few years, while non-schedule tests have often been collected by those laboratories and transferred to a public hospital where the analyses are performed.¹

Funding for community laboratory testing was devolved to DHBs in 2003. Prior to that, funding for schedule tests had largely been centrally administered, first by the Ministry of Health (and its predecessor, the Health Department), then for a short time by Regional Health Authorities, and later by the Health Funding Authority. Funding for non-schedule tests had been allocated to public hospitals via the administrative structures in place at the time (e.g., Area Health Boards/Crown Health Enterprises).

1.2 COMMUNITY LABORATORY CONTRACTING REVIEWS

Between 1985 and 2005, most community pathology practices in New Zealand were corporatised. This, in combination with the regionalisation of funding for community laboratory testing gave rise to new issues including:

- Boundary issues, with DHBs receiving funding based on the laboratory headquarters located within their district but having responsibility for funding laboratory services for all patients domiciled within their district. As a result it was necessary to negotiate funding transfers between DHBs for patients who lived in one district and had their pathology tests performed by a laboratory in another;

- Funding by DHBs of separate hospital and community laboratories; and

- Competition between laboratories for market share. In a fee-for-service funding environment, this created the risk of laboratories driving up utilisation of their services and therefore overall costs.¹

In 2002, DHBNZ commissioned a paper titled Options for Reform of Diagnostic Laboratory Services Markets.² The subsequent community laboratory contracting reviews, involving most DHBs, have been attributed to this report.¹ Examples of local arrangements that have been put in place following these reviews include:

- Contracting with a single company to provide all testing in both community and public hospital practice, replacing the previous DHB laboratories as well as the competing commercial laboratory (Taiawheliti, Otago-Southland and Nelson-Marlborough);
• The decision by the Auckland region DHBs to award the contract for private pathology services to a new provider, replacing the incumbent sole provider (Auckland, Counties-Manukau and Waitemata); and
• Contracting community laboratory services to a Commerce Commission approved joint venture between two private providers who had previously served the region in competition (Wellington and Hutt Valley).1

1.2.1 Review of Funding for Laboratory Tests Referred by Private Specialists

Historically, all community laboratory testing has been publicly funded regardless of whether the tests were referred by private or public specialists. Since November 2006, three DHBs have changed their contracts with their laboratory providers to cease funding PSRTs.

In 2005, Hutt Valley and Capital and Coast DHBs proposed to cease paying for PSRTs, other than those referred by doctors belonging to Primary Health Organisations or midwives. The principal objective in doing this was “to redirect the available funding to better uses”.3

In February 2006, the then Minister of Health agreed in principle to DHBs discontinuing payment for laboratory tests referred by private specialists.26

Following consultation with their communities, Hutt Valley and Capital and Coast DHBs implemented the policy to cease payments for PSRTs from 1 November 2006. The policy came into effect through Hutt Valley DHB’s five-year contract with Aotea Pathology for community laboratory services (on behalf of both Hutt Valley and Capital and Coast DHBs).

An evaluation by the DHBs of the first year of this policy, released in February 2008, indicated that the initiative had largely met its goals, including:

• $1.6 million in savings (compared to an estimated $2 million); this figure was subsequently revised downward as detailed in section 3.3.1;
• Funding diverted to other public services such as bariatric surgery;
• Few operational difficulties;
• No patients applying for hardship funding (though there were some questions as to how easy this funding was to access); and
• Little evidence of GPs actively subverting the system by ordering tests for their specialist colleagues.3

In part, the decision to proceed in two DHBs ahead of the rest was to identify and resolve any operational issues. However, the previous two Health Ministers made clear their intention that all DHBs should follow suit in an effort to achieve national consistency on access to laboratory services. Other DHBs consulted their communities and made adjustments to laboratory contracts, to enable similar policies and practice. However, to date, only one other DHB (Tairawhiti) has implemented the policy.

Tairawhiti District Health (TDH), in its 2005/06 District Annual Plan, indicated this change in service was to occur with anticipated savings of $65,000 per annum. In May 2006, the TDH Board approved reviewing the funding of PSRTs and agreed in principle to the ending of this funding. In October 2006 all relevant stakeholders were formally consulted and invited to provide feedback.

On the basis of the feedback received and its consideration, the then Minister of Health’s agreement in principle, and the summarised intentions of the South Island DHBs at the time, the Board agreed to proceed with the service change. Hutt Valley DHB’s PSRT pricing schedule was reviewed and adjusted to meet TDH’s overheads and volumes delivered. The service change commenced on 1 September 2007, together with the commencement of a new single provider of pathology services within Tairawhiti, TLab.

* According to the September 2007 SISAL report, South Island DHBs had held discussions and as a result, were in the process of undertaking initial steps to consult with their communities, supported by SISAL.
In general, the slow response of other DHBs to this change reflected several factors: relatively small levels of savings for many of the individual DHBs, potential backlash from private specialists in their communities, and the need to resolve other laboratory contracting issues first. The policy remains controversial, as outlined below.

Moreover, the policy may be perceived as discouraging appropriate use of private sector resources. In December 2008, the current Minister of Health placed a moratorium on any further implementation of this policy by DHBs until its impact has been reviewed.5

1.2.2 Potential Benefits, Issues and Risks

As highlighted above, the principal benefits of the policy are potential cost savings for DHBs. The Ministry of health has estimated that up to $20 million annually could be reprioritised to other publicly funded services.4

Additionally, the policy addresses “a longstanding anomaly in which private laboratory tests [were] funded but other private diagnostic procedures, such as x-rays, ultrasounds or MRIs, were not”.3 The policy also reduces incentives to order unnecessary tests, since the tests are no longer “free” from the patient’s perspective.

There has been some resistance to the policy of some DHBs no longer paying for PSRTs. Private specialists and insurance companies opposed the policy from the beginning.5 There has also been resistance from general practitioners and from some pathologists, their staff and employers.

The response from the public to the Hutt Valley/Capital and Coast consultation was mixed: many supported the idea of diverting the savings to funding for needed public services while others expressed concern about access to public specialist services and paying for laboratory tests which they felt they had already paid for with their taxes.5 The DHBs noted that 48% of the 191 submissions received were in favour of the proposal and 52% were against, with 66% of specialists being against it.3

Criticisms of the policy have focused on a number of perceived issues and risks including: 4,7,8,9,10,11,12

- Whether the expected savings would be realised;
- Whether the savings, if realised, would be sufficient to justify the operational costs to DHBs and to community laboratories of implementing the policy (including, for example, administrative costs to laboratories of invoicing individual patients and absorbing the risk of bad debts);
- Whether the savings, if realised, would be better spent on other services by DHBs;
- Concern about reduced patient access to subsidised services, and the risk that some patients may forego tests due to a lack of affordability – leading, for example, to a decrease in the volume of specialist investigations or precautionary tests to diagnose serious conditions at an early stage;
- A resultant increase in serious health problems, with potential for “increased use of public hospital services flowing from late diagnosis of otherwise manageable conditions”; 
- Concern about a lack of national consistency with respect to charging for privately referred tests due to the fact that only three DHBs have made this change to date;
- Cost-shifting risks (e.g., GPs ordering laboratory tests on behalf of specialists’ patients; GPs ordering more tests prior to referring patients to specialists);
- Potential for increased medico-legal risk for doctors (e.g., limited ability to refer patients for appropriate tests, creating pressures to circumvent funding provisions through cost-shifting practices);
- An increase in pressure on public hospital services;
- Concern that the policy, while addressing one anomaly as outlined above, creates new anomalies: in particular, a) that DHBs continue to fund other health services when patients seek private treatment – e.g., the cost to patients for medications is the same irrespective
of where treatment is prescribed; and b) that 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;

- A decrease in morale of those working in the private specialist health sector due to a perception that their work is not valued by society and an increased tendency for them to leave New Zealand;
- A deterioration in the (traditionally positive) working relationship between public and private practitioners; and
- An increase in premiums and corresponding pressure on the private insurance market if all DHBs implement this policy.\(^7\)

Moreover, a central criticism of the changes and the wider contracting reviews has been that they have been undertaken without a comprehensive national policy framework for the provision of laboratory services. Related to this issue are claims that the policy is inconsistent with overarching health policy – e.g., the Primary Health Care Strategy’s aims of improved population health and improved access to services.

### 1.3 Review Objectives

The Ministry commissioned a review of the policy of some DHBs no longer paying for PSRTs. The objective of the review was to provide a report analysing the costs and benefits of the policy, its impact on patients both public and private, the health sector and the wider population. This review will inform the further development of policy on DHBs’ funding of laboratory tests, including privately referred tests.

The review provides analysis of the impacts of the policy including:

- The impact on patients, both private and public (e.g., have private patients reduced the number of tests, or foregone tests altogether, as a result of the Policy? How has the Policy impacted on public patients?);
- Operational costs for DHBs to implement the Policy;
- Costs for community laboratories to implement the Policy, including the administrative costs of invoicing individual patients per ‘visit’ and absorbing the risk of bad debts;
- Whether the ordering patterns of General Practitioners (GPs) for laboratory tests alter, to order more tests prior to referral to a specialist;
- The degree of cost-shifting, if any, that has occurred in DHBs which have implemented this Policy, e.g., have specialists asked GPs to order laboratory tests on behalf of their patients? Have speciality groups in the public sector faced increased demand from patients diverting from private practice care due to the extra laboratory costs?
- Savings to DHBs of implementing the Policy including a breakdown of how the savings have been utilised by the DHBs, and the rationale for determining how the savings were used.

Further details on each of these impacts and how they were assessed are discussed in Section 2.
2.1 Overview of Review Methodology

To address the review objectives summarised in Section 1.3, the review team:

- Developed an agreed review framework;
- Interviewed key stakeholders from DHBs, community laboratories and other organisations;
- Acquired and analysed relevant information and data available from these organisations;
- Undertook analysis of the costs and benefits of the policy and its impact on patients both public and private, the health sector and the wider population.

2.2 Review Framework

The review framework is summarised in Table 1. It identifies the impacts of interest, the questions the review team addressed to fulfil its terms of reference, methods applied, and data sources. The availability of data to support the review was determined in consultation with key stakeholders.

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<td>Access to services</td>
<td>Have private patients reduced the number of tests, or foregone tests altogether, as a result of the policy?</td>
<td>Interviews with GPs, community laboratory managers, DHB staff, professional bodies, private hospitals. Review of CCDHB/HVDHB evaluation findings.</td>
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<td>How have private insurers responded to the changes and how has this affected access for private patients?</td>
<td>Interviews with private health insurers.</td>
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<td>Patterns of service utilisation and cost-shifting</td>
<td>Have the ordering patterns of GPs for laboratory tests altered, to order more and prior to referral to a specialist?</td>
<td>Interviews with GPs, community laboratory managers, DHB staff. Comparison of service volumes for laboratory tests ordered by GPs, pre and post policy implementation, for all schedule tests, selected key schedule tests (biopsies).</td>
<td>Community laboratory data on tests ordered by GPs as a percentage of total tests, pre and post policy implementation was investigated.</td>
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<tr>
<td></td>
<td>What was the rationale for determining how the savings were used?</td>
<td>Interviews with DHB finance/planning and funding personnel.</td>
<td>Qualitative only.</td>
</tr>
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</table>
2.3 Stakeholder Engagement

The scope of stakeholder engagement undertaken for the review is summarised in Table 2. The total number of interviews conducted exceeded the contracted scope of work. Additional interviews were undertaken in recognition of the importance of stakeholder feedback, given the lack of appropriate quantitative data to support the review.

Table 2: Scope and methods of stakeholder engagement

<table>
<thead>
<tr>
<th>Stakeholder group</th>
<th>Number of stakeholders interviewed</th>
<th>Locations/Organisations</th>
<th>Method of consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHB Planning &amp; Funding personnel</td>
<td>7</td>
<td>Capital &amp; Coast and Hutt Valley DHBs (4)</td>
<td>Face to face interviews with Planning &amp; Funding staff (including the authors of the CCDHB &amp; HVDHB evaluation report on the PSRT policy) and some of the laboratory managers. Telephone interviews as a backup method. Requests for documentation and data as appropriate.</td>
</tr>
<tr>
<td>DHB Laboratory Managers</td>
<td>3</td>
<td>Taiaoirwiti DHB (3)</td>
<td>Telephone interviews as a backup method. Requests for documentation and data as appropriate.</td>
</tr>
<tr>
<td>Community Laboratory managers/ finance personnel</td>
<td>5</td>
<td>Aotearoa Pathology (2)</td>
<td>Scheduled visit to each laboratory to conduct face to face interviews with key informants. Follow up as required by email and/or telephone. Requests for documentation and data as appropriate.</td>
</tr>
<tr>
<td>General surgeons (2), gastroenterologists (3), orthopaedic surgeons (2), plastic surgeon (1), perfusionist (1), rheumatologist (1), oral surgeon (1), cardiologist (1).</td>
<td>12</td>
<td>Capital &amp; Coast and Hutt Valley districts (7)</td>
<td>Telephone interviews                                                                IDI</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Taiaoirwiti district (3)</td>
<td></td>
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<td></td>
<td></td>
<td>Nelson Marlborough district (2)</td>
<td></td>
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<tr>
<td>PHOs/GPs</td>
<td>8</td>
<td>Capital &amp; Coast and Hutt Valley districts (5)</td>
<td>Telephone interviews</td>
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<tr>
<td></td>
<td></td>
<td>Taiaoirwiti district (2)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Healthcare Aotearoa GP representative (1)</td>
<td></td>
</tr>
<tr>
<td>Private hospitals</td>
<td>3</td>
<td>Wellington (1)</td>
<td>Telephone interviews</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Taiaoirwiti (1)</td>
<td></td>
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<td></td>
<td></td>
<td>Hawkes Bay (1)</td>
<td></td>
</tr>
<tr>
<td>Ministry of Health</td>
<td>4</td>
<td>NZHIS Service Analysis</td>
<td>Face to face meeting and data requests Telephone discussions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Health &amp; Disability Services Strategy Directorate</td>
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</tr>
<tr>
<td>Stakeholder group</td>
<td>Number of stakeholders interviewed</td>
<td>Locations/Organisations</td>
<td>Method of consultation</td>
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<td>----------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------</td>
</tr>
<tr>
<td>Professional bodies and associations</td>
<td>7</td>
<td>New Zealand Medical Association</td>
<td>Telephone interviews Requests for documentation as appropriate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Royal College of Pathologists of Australasia</td>
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<td></td>
<td></td>
<td>Royal New Zealand College of General Practitioners</td>
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<td>Royal Australasian College of Physicians</td>
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<td>Royal Australasian College of Surgeons</td>
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<td></td>
<td>New Zealand Association of Pathology Practices</td>
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<td>New Zealand Private Surgical Hospitals’ Association</td>
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<tr>
<td>Health Insurers</td>
<td>4</td>
<td>Southern Cross</td>
<td>Telephone interviews Requests for documentation/data as appropriate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tower</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Sovereign</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>New Zealand Health Funds Association (represents 10 member insurance companies accounting for 98% of insurance policies)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>Patient with rheumatoid arthritis (Wellington)</td>
<td>These people contacted the reviewers at their own initiative and provided written submissions.</td>
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<tr>
<td></td>
<td></td>
<td>Health researcher (Wellington)</td>
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</table>

### 2.4 Quantitative Analysis

A number of data sources were investigated as potential indicators of patient access and cost-shifting impacts. It was recognised and acknowledged that the nature and extent of quantitative analysis was dependent on the willingness and ability of key organisations to provide access to data, and the suitability and veracity of the data to support the purposes of the review.

The possible use of the following data was investigated:

- Community laboratory data (from Ministry of Health Analytical Services and/or directly from laboratories) on service volumes and costs pre and post policy implementation for all schedule tests and selected key schedule tests, by referrer type (GP, specialist in private practice, other), and by patient demographics including ethnicity;

- Community laboratory information on administrative costs of implementing the policy (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);
• DHB information on administrative costs of implementing the policy (including establishment and ongoing costs);
• DHB expenditure data on community laboratory tests pre and post policy implementation; and
• DHB financial data/analyses identifying savings and how these were allocated to other services.

Additionally, the reviewers consulted with the Ministry of Health Service Analysis Team regarding the work being undertaken as part of the National Pricing Programme, and with other Ministry of Health analysts regarding potential data sources and methodologies for the review.

Laboratory Claims Data Warehouse data on community laboratory service volumes was obtained from Ministry of Health Analytical Services. Laboratories were not willing to supply data directly, instead referring the reviewers to Analytical Services. All the laboratories consulted (Aotearoa, TLab and Medlab South) expressed confidence in the accuracy of the labs warehouse data for their service volumes. Additionally, Capital and Coast and Hutt Valley DHBs provided service volume and financial data. Tairawhiti DHB, TLab and Aotearoa Pathology provided financial information related to PSRTs.

Investigation of these data sources revealed that the data would not adequately support a robust quantitative analysis of any shifts in the utilisation of laboratory services ordered by private specialists relative to GP-ordered tests or public hospital services, for a number of reasons, including that:

• The number of laboratory tests ordered by specialists in private practice prior to introduction of the policy cannot be identified. Both Aotearoa Pathology and TLAb commenced service provision on the same dates as their respective DHBs' private charging policies came into effect. The previous laboratories did not collect data on the number of PSRTs. From 1 November 2006, tests provided by Aotearoa Pathology are flagged in the labs data warehouse as DHB-funded (D), privately charged PSRTs (P) or ACC-funded (A).

• Although GPs and specialists can be identified in labs warehouse data by their provider numbers (which could be used to identify GPs and specialists through linkage to Medical Council Registration Tables), tests ordered by specialists in private practice (which are not DHB-funded) cannot be distinguished from tests ordered by specialists in the public system (which are DHB-funded).

Moreover, even if measurable, any shifts in test ordering patterns could not reliably be attributed to the private lab tests charging policy because:

• The introduction of the policy coincided with the commencement of new bulk funding arrangements with the new laboratories whereas fee-for-service funding arrangements were in place prior to the policy being introduced. Both the change in funding arrangements, and the establishment of new laboratories, may have independent effects on test volumes.

† Aotearoa Pathology had conducted an audit of reported versus recorded volumes in the Laboratory Claims Data Warehouse. The audit found a mismatch in early months where HealthPAC had not lodged all claim files. This has since been corrected. Moreover, data matching carried out by Capital and Coast and Hutt Valley DHBs showed that the labs warehouse data is accurate for Aotearoa Pathology, with the exception of cases in the first three months where tests were initially identified as PSRTs and later found to be eligible for DHB funding. These have not been changed in the labs data warehouse.

‡ As such, a manual process would be required to identify individual specialists’ private and public sessions and match tests to these. Even then, comparison of test ordering patterns pre and post private charging policies would need to be undertaken with caution and on a large sample of specialists for a reasonable period of time, to avoid biases caused by shifts in individual specialists’ working arrangements.

§ For example, the Capital & Coast and Hutt Valley DHBs’ evaluation report notes that the fee-for-service regime gave laboratory providers a financial incentive to encourage more testing where possible, whereas the fixed fee contract provides an incentive to reduce costs by reducing unnecessary testing.
• Shifts in ordering patterns of GPs for laboratory tests can occur for many reasons. Specialists may, prior to laboratory charging for PSRTs, have been ordering tests that may be more appropriately ordered by GPs, so a proportion of any overall movement in ordering from private specialists to GPs may be appropriate. For example, prior to the PSRT change, patients with elective surgical and specialist health insurance may have found it less expensive to use specialists than GPs. Similarly, price signals may encourage specialists to become more judicious in their ordering of tests.

• Patterns of laboratory test ordering by GPs are also influenced when new guidance is released such as Best Practice Advisory Centre publications. Examples were cited of guidelines for haemoglobin testing for diabetes and faecal occult blood tests for bowel cancer that had altered utilisation patterns for these tests. PHOs have also had incentives to reduce high volumes of laboratory testing through the Performance Management Programme. Moreover, changes to in-house laboratory testing protocols can change volumes markedly for individual tests.

• As GPs order substantially more tests through community laboratories than specialists, any substitution effect from specialists to GPs would be diluted in the overall percentage figures.

Accordingly, the review is more heavily reliant on qualitative stakeholder feedback than was originally envisaged. Possible methodologies for further quantitative analysis/modelling are described in section 3.4.

2.5 DOCUMENTATION

Existing analyses/reports were reviewed, including:

• The March 2008 Capital & Coast and Hutt Valley DHBs’ impact evaluation report on cessation of PSRT subsidies.
• Various submissions to DHBs from a range of national organisations and professional associations.
• DHB Board papers and other relevant internal documents.
• Laboratory information.
• Ministry/Ministerial briefing papers and other key reports provided by the Ministry.
• A critique of the Capital & Coast and Hutt Valley DHBs’ impact evaluation report from a PhD candidate researching access to rheumatology services in the greater Wellington region.
• A written submission from a patient with rheumatoid arthritis in Wellington.

2.6 ETHICAL CONSIDERATIONS

In carrying out this review, HOI followed the Code of Ethics and Guidelines for the Ethical Conduct of Evaluations of the Australasian Evaluation Society (AES).††

†† For example, microbiology test volumes reduced in the Wellington/Hutt region when Aotea Pathology’s contract commenced (see Appendix B, Figure 9). Aotea Pathology advised that this may be most significantly due to changes in laboratory protocols for testing genital microbiology samples and faecal samples, as well as a general trend to reduce the number of urine samples and throat swabs submitted for microbiological analysis.

‡‡ For example, Capital & Coast and Hutt Valley data showed that GPs accounted for approximately 75% of testing ordered by doctors in the 12 months prior to the PSRT change and 79% in the 12 months following the change. As total test volumes also declined by 13.2% between the two years and other factors impact on laboratory testing (as discussed above), the materiality of the impact on GP ordering was unclear.
2.7 **DISCLAIMER**

This review was undertaken in accordance with an agreed scope of work, budget and timeframe. Wherever possible, the review team sought to maximise the use of quantitative data and to validate stakeholder feedback through reference to source documentation. However, the reviewers relied significantly on feedback provided by individual commentators which has not been independently verified. These commentators hold senior positions within DHBs, community and hospital laboratories, the medical profession, private hospitals, PHOs, Ministry of Health, professional bodies/associations, and health insurers and are in a position to be well-informed on the PSRT charging policy and its impacts.

2.8 **ACKNOWLEDGEMENTS**

The reviewers’ sincere thanks are due to the staff of Capital & Coast DHB, Hutt Valley DHB, Tairawhiti DHB, Nelson-Marlborough DHB, South Canterbury DHB, Aotea Pathology, TLab, Medlab South, NZHIS, and to the many GPs, specialists, professional body, private hospital and insurance industry representatives and other stakeholders for making available their time and resources to participate in this review.

2.9 **AUTHORS**

Julian King and Russell Holmes, Health Outcomes International

**www.aes.asn.au/about**
3 FINDINGS

3.1 ACCESS TO SERVICES

3.1.1 PRIVATE PATIENTS’ ACCESS TO COMMUNITY LABORATORY TESTS

Available data does not adequately support quantitative analysis of the extent to which private patients have reduced the number of tests, or foregone tests altogether, as a result of the PSRT charging policy (see section 2.4).

According to Laboratory Claims Data Warehouse data (Table 3; also see Appendix B, Figures 1-5), total Schedule A test volumes within the Capital & Coast/Hutt Valley and Taiwhiti districts have reduced since commencement of the new contracts. For example, volumes recorded for the first two years under Aotea Pathology’s contract are 11% lower than those of the preceding two years. Hutt Valley DHB suggested this may reflect the change from fee-for-service funding arrangements to fixed-fee contracts, among other factors.

<table>
<thead>
<tr>
<th>Table 3: Schedule A Test Volumes</th>
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<tr>
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<tr>
<td><strong>DHBs</strong></td>
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<tr>
<td>Capital &amp; Coast and Hutt Valley</td>
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<td>Northland and Auckland Region DHBs</td>
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<tr>
<td>Mid North Island***</td>
</tr>
<tr>
<td>South Island</td>
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<tr>
<td>-------------------</td>
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<tr>
<td><strong>DHBs</strong></td>
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<tr>
<td>Taiwhiti</td>
</tr>
</tbody>
</table>

Source: Laboratory Claims Data Warehouse

Note that for the period shown, Laboratory Claims Data Warehouse appeared to be missing data for many of the DHBs including Waitemata, Counties Manukau, Taiwhiti, Hawkes Bay, Wairarapa, Nelson-Marlborough, West Coast, Canterbury, South Canterbury, Otago and Southland. As such, the data presented here is for contextual information only and needs to be interpreted with caution.

*** The “Mid North Island” DHB grouping used in this table includes Waikato, Lakes, Bay of Plenty, Taiwhiti, Hawkes Bay, Taranaki, MidCentral, Whanganui, Wairarapa.
Analysis by Capital & Coast and Hutt Valley DHBs found that total subsidised test volumes reduced from 2,232,575 in the year before the new contract, to 1,936,904 in the first year of the new contract - a drop of 295,671 or 13.2% fewer tests. PSRTs, at 129,825 in the first year of the contract, represented just under half of the drop in subsidised volumes. However, the available data could not indicate whether PSRT volumes had decreased under the new funding arrangement, relative to previous years.

Subsequent labs warehouse data for the first two years of the contract (November 2006 to October 2008) shows that PSRT volumes have averaged 6.2% of total volumes, but may be trending slightly downward (Appendix B, Figures 6-7). This downward trend may be caused by a number of factors as discussed in section 2.4.

STAKEHOLDER FEEDBACK

The GPs and specialists who were interviewed gave anecdotal accounts of instances where patients were foregoing, delaying or reducing the number of tests. Professional bodies also reported feedback from members that patients were not going ahead with tests due to cost.

Some doctors characterised these effects as “teething problems” that had reduced over time. Nevertheless, there was general agreement that although the change was now embedded, there were still problems with some patients “skimping on tests” and that this raised patient safety concerns. Examples included:

- Patients with chronic conditions, such as arthritis, heart conditions, skin conditions or hepatitis who require regular blood tests, choosing to forego some of these;
- A sports doctor noted that some athletes were waiting for injuries to heal naturally rather than have blood tests for arthritis;
- Pressure from patients to breach accepted protocols/good practice by not ordering precautionary tests (e.g., retesting of abnormal faecal occult blood tests or ANA skin tests), with several doctors commenting that they would like clearer guidelines for these cases;
- Patients without health insurance who had saved for private treatment but hadn’t taken lab test costs into account. In some cases, these patients decided to defer their treatment;
- Pressure on plastic surgeons not to send skin lesions for histology where they think these are likely to be benign. It is routine practice for all removed skin lesions to be referred for histology and a proportion of these are found to be malignant. Specialists were concerned that this may lead to a “false drop” in the recorded number of cancers and other serious conditions due to a drop in the rate of diagnosis, leading to increased mortality and costs downstream.

An example was provided in a written submission to the review team from a patient with rheumatoid arthritis:

“To reduce the amount that I have to pay for [blood] tests, my rheumatologist has dropped the full liver function test and replaced it with the AST component only... To further reduce the cost, I have elected to only have my blood tests every three months. I do not know whether I am taking a risk by doing this.”

It is not clear how widespread these effects are. Most specialists and GPs suggested small numbers of patients would be involved, but it appears that some patients with chronic conditions may be disproportionately affected.

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*** The DHBs’ calculations are summarised in Appendix B, Table 5. The DHBs’ figures differ from the labs warehouse data presented in Table 3 for several reasons. Firstly, the current review exclusively used labs warehouse data extracted 8 September 2009, whereas the DHBs used data extracted 14 December 2007 for the ‘pre contract’ volumes and used Aotearoa Pathology’s internal data for the first year of the contract as at the time there were issues with missing data from the data warehouse (see section 2.4). The DHBs’ analysis also included all testing funded by the two DHBs – including hospital laboratory tests which do not appear in labs warehouse data. Moreover, hospital laboratory volumes were assumed to be the same in both years. This is why the figures are the same for 2005/06 and 2006/07 in Table 5, as indicated in note 5 in that Table.
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 if these factors that drive sufferers to seek the fastest possible treatment, and not necessarily ability to pay, 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”. 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”.

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) 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”.

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.

Similarly, TLab charges patients according to a modified version of Hutt Valley’s pricing schedule, which Taiahwiti 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)”.

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.

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.
Examples of high prices for common PSRTs, including GST but excluding the laboratory service fee, are:

- Frozen section histology: $135.19
- Bone marrow haematology: $317.34
- Cell marker cytology: $341.77

Some other tests, less commonly ordered by private specialists, attract higher prices. Examples include:

- Lymphoproliferative: $725.73
- BCR-ABL: $736.35
- Acute Leuk: $767.51

Cardiac surgery appears to be the most common example of a complex procedure requiring multiple tests – both during the operation itself and in the first few days of recovery. Aotea Pathology data shows that the top ten patient invoices for lab tests during the first 12 months of the policy were all for pre-operative, intra-operative and post-operative tests for cardiac surgery and ranged from $1,356.13 to $1,660.94 per patient.8

These costs were not always paid by patients out-of-pocket. It appears to Aotea Pathology that a significant number of patients having surgery in private hospitals which generate lab testing are covered by medical insurance and the insurers pay for the tests.

One specialist also commented that surgical patients were not always given an accurate estimate of lab test costs. This is because the precise number of tests required varies between individual patients. This raises ethical issues for specialists as not providing patients with an accurate price prior to undergoing a procedure breaches the Code of Health and Disability Services Consumers’ Rights and the Royal Australasian College of Surgeons Informed Financial Consent Policy.31,32

Another circumstance in which multiple or frequent tests may be required is with chronic conditions (e.g., arthritis, heart conditions, skin conditions or hepatitis, among others). These patients may face lab test charges for many years, and the numbers of people with these conditions is likely to increase with population ageing and growth.9,29

An example was provided of patients with Inflammatory Arthritis (IA). These patients are often prescribed disease-modifying anti-rheumatic drugs (DMARDs) to control the condition. Blood tests are required each month to monitor the efficacy and side-effects of the drugs. Typical annual costs were cited of $799.32 per year for blood tests including monthly blood count, C-reactive protein (CRP), erythrocyte sedimentation rate (ESR), and liver function tests. Additional tests may also be required. Usually, these patients can expect to be taking DMARDs for life and therefore the monthly test costs will be ongoing.29

Similarly, the patient with rheumatoid arthritis explained how having to pay for laboratory tests on top of the cost of treatment had created a significant financial burden for her and her family:

“It is recommended that people who are being treated with medication for rheumatoid arthritis have a blood test once a month to monitor their condition, and to monitor the possible adverse side effects of the medication that they take... It is likely that I will need to continue having these blood tests for the rest of my life... The reality for me is that from 1 November 2006, my monthly blood test cost me $62.16 per month including GST. Over 12 months, these blood tests would have cost me $745.92. Over my lifetime, the cost of the tests will run into many thousands of dollars. This is unfair.”

Hardship Exemption

Hutt Valley and Capital & Coast DHBs have established ‘hardship criteria’ to exempt individual patients from having to pay more than $500 in a six month period for community laboratory tests ordered by private specialists. However, to date no patients have approached the DHBs to access this provision. The exemption may not have been sufficiently publicised for all patients to be aware of it. The DHBs have advised GPs and specialists of the exemption but it was acknowledged that
there may be scope to promote it more. The DHBs’ evaluation report noted that material on the hardship funding would be published on the DHB websites, but this has not been done to date.

Moreover, the application process may limit uptake if it is perceived as overly burdensome. Patients wanting to access the exemption need to apply to the Planning and Funding Division of Hutt Valley DHB, providing personal details, consent for the DHB to discuss their condition with their GP and specialist, evidence of expenditure, a diagnosis provided by the patient’s private specialist showing that the condition is unlikely to be resolved within two years and that tests are likely to be required on a regular basis for an indefinite period, and evidence of hardship such as a Community Services Card or High Use Health Card. Applications are assessed on a case-by-case basis through the DHB’s contract manager and community laboratories Oversight Advisory Group.

Another factor may be the level at which the threshold for assistance has been set. The two rheumatology examples cited above involve significant ongoing costs to patients yet fall below the threshold set by the DHBs of $500 in a six-month period.

### 3.1.2 Health Insurer Response to the Changes

Currently, where the costs of PSRTs are not covered by DHBs, the additional costs to patients are covered under some health insurance plans but not others. Some policies exclude the costs of some or all of these tests – for example, it is common for policies to pay for tests associated with a surgical event but some of these policies do not cover tests associated with any non-surgical specialist visits – such as a chronic condition requiring ongoing tests. Some policies cover the lab test fee but not the laboratory service fee.

As premiums are set on the basis of national costs, and the three DHBs that have adopted the policy to date represent a small proportion of the national population, insurers advised that premiums have not been affected by the changes to date. The insurance industry representatives who were consulted, agreed that if the PSRT charging policy was adopted nationally, insurers would offer more cover for PSRTs in their policies. Premium increases should therefore be expected.

Any movement in premiums can be expected to have some effect on take up of private insurance, with some policyholders choosing to rely solely on the public system. As the Health Funds Association points out, “there are complex dynamics at work, with the take up of health insurance dependent upon premiums, people’s tolerance to risk and perceptions of performance of the public system. Any moves which shift costs on to the private sector – whether out of pocket or insurance funded, can be expected to result in a shift in demand at the margin onto the public sector, with resulting cost implications”.

Insurance industry stakeholders commented that if the policy were adopted nationally, the rise in premiums could be significant. However, PSRTs appear to represent less than one-quarter of a percent of health system costs and less than 3% of the annual value of insurance claims. Therefore the overall effect on premiums seems likely to be relatively small.

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*** The Ministry of Health advised that laboratory services account for approximately 4% of health system costs. PSRTs represent around 6% of laboratory tests (for Hutt Valley and Capital & Coast DHBs). If this proportion holds nationally, then PSRTs represent approximately 6% x 4% or 0.24% of health system costs. The true percentage may be lower as PSRTs are likely to represent a smaller volume of tests outside the main centres.

*** The Health Funds Association of New Zealand Annual Report 2009 reports total claims paid of $712.2 million for the year ended 31 March 2009. Per capita extrapolation of Capital & Coast and Hutt Valley DHB savings to the five major centres with tertiary hospitals, and Taarawhiti DHB savings elsewhere, suggests national PSRT savings in the vicinity of $12 million or 1.6% of the value of insurance claims. The Ministry’s estimate of $20 million represents 2.8% of insurance claims.
3.2 Patterns of Service Utilisation and Cost-Shifting

3.2.1 Ordering Patterns of GPs for Laboratory Tests

Available data does not support robust quantitative analysis of the extent to which the ordering patterns of GPs for laboratory tests have altered, to order more and prior to referral to a specialist; or the extent to which specialists have asked GPs to order lab tests on behalf of the specialists’ patients (see section 2.4).

The apparent level of PSRTs within total test volumes (e.g., 6.2% for Aotea Pathology) only represents identified PSRTs, i.e., where cost shifting has not occurred. It would be difficult for laboratories to distinguish instances of cost-shifting to GPs amongst the vast majority of regular GP-ordered lab tests. However, possible and probable occurrences have been identified.

For example, TLab advised that it has received many test orders from specialists, completed in the specialist’s handwriting, but signed by the GP. There have also been a few cases where GPs ordered tests without requesting that results be copied to a specialist, and the specialist subsequently contacted TLab to follow up these results which they believed they had requested.

TLab initially attempted to track and monitor the extent of cost-shifting but abandoned these efforts as it was neither possible to identify all possible instances nor to verify suspected instances within the available staff time and resources. For example, GPs ordering tests often request that specialists receive a copy of results, and there can be clinically appropriate reasons for doing so.

TLab extracted data for the 17 months from April 2008 to August 2009, which showed a total of 3,274 tests had been requested by a GP and copied to a specialist. TLab advised that, at historic (pre-fixed price contract) HealthPac test prices, these tests had a GST-exclusive value of $27,318. This represents approximately 30% of the projected PSRT savings for Tairawhiti on an annualised basis. TLab asserted that the types of tests ordered suggested that “the vast majority” of these cases were likely to be “requested by private specialists but countersigned by a GP to circumvent patient payment”. However, this could not be conclusively determined from the available data.

Similarly, increased ordering of tests by GPs prior to referring patients to a specialist, even if precipitated by the PSRT policy, may occur for clinically legitimate reasons. Prior to the policy, specialists may have been ordering tests that may be more appropriately ordered by GPs. Stakeholders widely agreed the policy would drive some appropriate movement.

The only way to reliably identify the level 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. As PSRTs represent a small percentage of all community lab tests, a very large sample of records would be required to reliably establish the extent of cost-shifting occurring.

Likewise, Capital & Coast and Hutt Valley DHBs’ impact evaluation could not determine the extent of this impact. The DHBs’ evaluation report notes that it was considered very likely that there would be some shifting of tests from private specialists to GPs. The risk was argued to be greater for Capital & Coast and Hutt Valley DHBs because they were the first to introduce the policy, and insurance policies had not yet changed.

For the 12 months prior to the PSRT change, the DHBs’ evaluation report noted that GPs accounted for approximately 75% of testing ordered by doctors (midwives, dentists, etc., were excluded from this figure) compared with 79% in the 12 months following the change. While there was anecdotal evidence of some pressure on GPs, and there was likely to have been some impact, it was noted that other factors also impact on laboratory testing (as discussed in section 2.4) and that the extent of the impact on GP ordering was difficult to determine, especially in the context of the overall decline in total test volumes.

**** TLab data was also requested. TLab advised that its data does distinguish PSRTs from other tests that incur a patient charge – e.g., tests ordered for employment, sports or immigration reasons.

†††† $27,318 x 12/17 = $19,283 which is 29.6% of $65,000.
The DHBs also looked at the possibility of selecting ‘marker tests’ and analysing GP ordering patterns for these. However, it was noted that this presents some difficulty. In most private specialties, the laboratory tests ordered are no different from those routinely ordered by GPs. The DHBs considered biopsies as a potential marker test as GPs are able to perform small excisions instead of specialists. However, the DHBs found that GP ordering of biopsies had not changed significantly. GPs accounted for 35.4% of biopsies for the 12 months prior to the PSRT change, and 35.9% for the 12 months after the change. 3

**STAKEHOLDER FEEDBACK**

All three DHBs (Capital & Coast, Hutt Valley and Taairawhit) advised that they believed cost-shifting from specialists to GPs had occurred initially but had subsided and was not widespread.

However, in contrast to the DHBs’ view that cost-shifting practices had largely fallen away, feedback from GPs, specialists and one of the laboratories suggested cost shifting may be ongoing in all of these districts.

Specialists in Wellington, Hutt Valley and Gisborne advised that they ask GPs to pre-order tests where possible. There are many cases where this may be clinically appropriate – for example, in shared care situations. Several specialists, however, noted that this has resulted in tests being inappropriately ordered by GPs. Of the ten specialists interviewed from these regions, seven indicated that they ask GPs to order tests to avoid costs for their patients. One indicated that if a GP declined to order tests on his behalf, he would keep trying until he found a GP who would agree to his request.

Similarly, most GPs stated that they had been asked by patients and/or specialists to order tests that should appropriately be ordered by the specialist (i.e., tests that the GPs are not expert in – for example, a GP in Wellington had been asked to order fertility treatment tests). Another GP in an Access PHO estimated that he received such requests from about 3% of his patients or their specialists. Of the eight GPs interviewed, three said they were ordering tests on behalf of private specialists and three others were aware of the practice occurring but were not following it themselves.

Professional bodies were also aware of such cases, having been advised by their members that this was occurring.

A critique of the policy and its evaluation in the Wellington region, drawing on findings from research into access to rheumatology services including interviews with seven private patients, noted: “People feel an injustice has been done, and some have found ways around it through GPs, or...the public system”. 29

All three DHBs have reinforced the “duty of care” obligations on doctors ordering tests to be responsible for follow up and acting on the results of tests, and expressed confidence that these practices had subsided. For example, after duty of care issues first arose in relation to the policy, the Chief Medical Advisors from Hutt Valley and Capital & Coast DHBs wrote to all in-region GPs and private specialists about the issue, noting that:

“Duty of care carries with it an obligation to ensure that the doctor ordering a test is responsible for both follow-up and, where appropriate, acting upon results of tests. It may, however, be difficult to do so when the test is ordered on behalf of a specialist, particularly if the GP is unfamiliar with the test and the rationale for its request.

Patients with chronic conditions under specialist review, who are undergoing regular testing as part of monitoring their condition or the effects of its treatment, may not be seeing their GP regularly. There would consequently be significant risks for patients, if tests were to be ordered by the GP for care provided by a specialist.

General practitioners may wish to provide a copy of this advice to their patients and to private specialists so they can understand why GPs are not able to request tests on behalf of a specialist. We understand GPs have been refusing to order tests on behalf of private specialists and we support them in that response”. 3

Feedback from clinicians and other stakeholders suggests these assertions take a narrow view of GPs’ duty of care. For example, GPs voiced concerns about patient welfare, especially those with

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chronic conditions and comorbidities. As such they consider they have a duty to ensure test results are communicated to the practice and followed up.29

3.2.2 Impacts for Public Sector

If greater numbers of patients were diverting from private practice into public hospital services, a measurable increase in the utilisation of these services would be expected – or, where the supply of these services is fixed and is outstripped by demand, the hospital would need to respond by tightening the criteria to qualify for elective surgery. No such effects have been observed at Capital & Coast, Hutt Valley or Tairawhiti DHBs.

The Capital & Coast and Hutt Valley DHBs’ impact evaluation examined trends in the volumes of outpatient first specialist assessments and found “no discernable impact on demand for public hospital services”.3 Tairawhiti DHB advised that it had one of the shortest waitlists in the country and that the policy had not impacted on overall demand for elective services. Similarly, the DHBs advised there had been no change in booking system thresholds.

Conversely, all of the specialists we interviewed were aware that some private patients had been lost to the public system due to the costs of ongoing tests (especially in relation to chronic conditions such as arthritis, heart conditions, skin conditions, or hepatitis). Seven specialists believed that these instances were relatively uncommon and they did not expect any discernable impact on the public system.

Three specialists – two gastroenterologists and a cardiologist – estimated that between a quarter and a third of their patients had moved to the public system. This reinforces other anecdotal evidence that the policy may disadvantage patients with particular chronic conditions requiring frequent or multiple specialist-ordered tests (see section 3.1.1).

Further reinforcing this impression, a health researcher cited data showing that waiting times for those with non-urgent rheumatological conditions were increasing and that between December 2005 and November 2007 there had been a 30% increase in referrals for inflammatory arthritis together with a decrease of around 5% of IA referrals to private rheumatologists.

3.2.3 Other Impacts and Issues

Use of Non-Accredited Point-of-Care Analysers in Private Hospital

Wakefield Hospital purchased an i-STAT point-of-care analyser; anecdotally at least in part in response to difficulties experienced with patient charging. In particular, cardiac surgery patients were facing high pre-, intra- and post-operative lab testing costs which could not accurately be estimated in advance. The i-STAT analyser enables the hospital to perform blood gas tests and other tests at a lower cost per test to the patient. Tests using the i-STAT point of care analyser were said to be half the cost of tests sent to the laboratory.

The analyser is not externally validated.5555 The literature notes that point-of-care testing should be under a quality control programme run by an accredited laboratory. Integration of data from point-of-care testing with routine laboratory data is recommended. The success of point-of-care testing relies critically on the level of support provided by a parent laboratory in areas such as evaluation and purchase of point-of-care testing equipment, comparison of equipment with reference laboratory equipment, development of a quality assurance/control programme, and training of equipment users.12

Patient Complaints

The three DHBS and Aotea Pathology reported that there had been relatively few complaints from patients related to being charged for their laboratory tests. The majority of complaints were

http://www.abbottpointofcare.com/istat/

A specialist at Wakefield Hospital advised that the analyser’s accuracy is periodically checked against parallel samples sent to Aotea Pathology for testing, training and internal quality control processes are built in to validate results produced by the i-STAT and a blood gas machine is used as back-up to the analyser.
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. 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. 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.
A number of stakeholders (including laboratory and professional body representatives) argued that the schedule of fees used by Aotea Pathology\(^2\) (and in modified form by TLab) is largely based on historic schedules and “nowhere near reflects the true cost” of some tests. While the current Aotea Pathology charges are fixed according to their contract with the DHBs, it is unclear what pricing charges laboratories would use for PSRTs in other districts (if the policy were implemented by other DHBs) or in the future.

Health insurers have also raised concerns about the PSRT policy impacting on healthcare cost inflation.\(^6\)

**Dissatisfaction with DHB Consultation**

A prevailing theme in feedback from clinicians and professional associations was dissatisfaction with the level of consultation that had been undertaken. Some stakeholders noted that their submissions had not been acknowledged or responded to. It was also suggested that decision making and implementation had been carried out “in a hurry”, leading to initial communication and teething problems.

Moreover, specialists commented that the policy change was poorly communicated by the DHBs, both to the general public and directly to themselves as health practitioners. Illustrating this point, one of the interviewed surgeons believed the policy related only to pre-operative, not all surgery-related lab tests.

### 3.3 Savings and Costs

#### 3.3.1 Savings to DHBs

**Capital & Coast and Hutt Valley DHBs**

Under the contractual arrangement between Aotea Pathology, Capital & Coast and Hutt Valley DHBs, the fixed price contract covers all Schedule A test volumes and Aotea Pathology reimburses the DHBs for any PSRTs it carries out.

During the first 2½ years of the contract (November 2006 to July 2009), the DHBs were reimbursed $3.86 million by Aotea Pathology – an average $1.4 million per annum.

The DHBs’ impact evaluation states that in the first year the DHBs were reimbursed $1.6 million. However, PSRT revenues were subsequently adjusted downward. Part way into the second year, Aotea Pathology became aware that some of the encounter fee revenue had mistakenly been included in PSRT revenues. This error was corrected with a one-off downward adjustment in the second year. Subsequent monthly payments were then lower, reflecting the underlying PSRT revenue. This affected the relative revenue levels in the first and second years as shown in Table 4. As a result, despite the appearance of a downward trend, Hutt Valley DHB advised it could not determine whether revenues were trending downward over time.

<table>
<thead>
<tr>
<th>Period</th>
<th>PSRT Revenues ($m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1: Nov 2006 – Oct 2007</td>
<td>1.62</td>
</tr>
<tr>
<td>Year 2: Nov 2007 – Oct 2008</td>
<td>1.26</td>
</tr>
<tr>
<td>Year 3 (first three quarters): Nov 2008 – Jul 2009</td>
<td>0.98</td>
</tr>
</tbody>
</table>

Source: Hutt Valley DHB

The respective Boards did not directly allocate PSRT savings to other specific services. Rather, there was a broader budget process that considered overall DHB revenues and expenditures. As such, there are no Board papers or other DHB documents identifying specific services that were funded...
directly from PSRT savings. However, the DHBs' internal evaluators took note of some of the services the DHBs funded at the margin around the same time as they received the PSRT savings. These services were made possible by having additional revenue from PSRTs and other sources. The evaluation report stated that these savings enabled Hutt Valley DHB to support:

- Improved access to health and social services through a ‘one stop shop’ service in a high needs area;
- Additional primary care graduate nurse training; and
- After-hours primary care services for patients unable to find a permanent GP.

The overall savings enabled Capital & Coast DHB to support:

- Bariatric (obesity) surgery;
- Initiatives to reduce avoidable admissions to hospitals; and
- Increased investments in home and community care services.³

The Capital & Coast and Hutt Valley DHBS’ evaluation report also notes that:

“The funding released would be used to provide services that made a greater difference to the health of people in the two regions, than subsidising private patients’ laboratory tests did. The DHBS’ planning and funding groups have decision-making principles that are used to help prioritise new initiatives. They can use the principles to assess a disinvestment proposal by treating it as if it were a new funding proposal. The DHBS’ assessment of a proposal to fund private specialist referred laboratory tests does not score well (35/100) when compared to a number of other initiatives then proposed - such as funding a community paediatrician (63/100), cardio-vascular disease prevention (66/100) or mental health initiatives (62/100)”.³

The option of funding private patients’ laboratory tests scored: ******

- 1 out of 5 for targeting Māori health;
- 1 out of 5 for expert evidence of effectiveness;
- 1 out of 5 for targeting services towards those with the poorest health and highest need;
- 4 out of 5 for value for money (cost per person) at $10-$99;
- 1 out of 5 for cost saving with little or no cost offsets;
- 2 out of 5 for effectiveness per person with some benefits, or a small reduction in disability, or some increase in quality of life; and
- 5 out of 5 for the timing of the benefits, which would occur within 1 year.

“In other words, if the DHB had been considering a proposal to fund laboratory tests for private patients against other DHB priorities, they would have been very unlikely to recommend funding laboratory services for private patients”.³

**Tairawhiti DHB**

Under Tairawhiti DHB’s contractual arrangement with TLab, savings of $65,000 per annum were anticipated (1.7% of the year 1 fixed price). The anticipated savings, based on analysis of Hutt Valley and Capital & Coast DHBs’ savings adjusted for local conditions, were factored out of the total contracted price up front. As such, this represents the actual level of savings to the DHB. However, it is unclear how closely this corresponds to the actual costs borne by the laboratory in respect of PSRTs. This is because the laboratory cannot reliably identify tests that are being ordered by GPs on behalf of specialists, and therefore does not monitor these.

Tairawhiti DHB advised that these savings were allocated between the provider and funder arms, on the basis that the newly established TLab was an amalgamation of community and hospital

****** The criteria have weightings as follows: 15%, 25%, 25%, 15%, 5%, 10%, 5%.
laboratories. These savings contributed to reducing the DHB’s deficit. There was no Board paper specifying the split.

**OTHER DHBs**

Planning and Funding representatives of Nelson Marlborough and South Canterbury DHBs were consulted as part of the review. Both DHBs had (together with the other four South Island DHBs) considered implementing the policy but had decided not to proceed.

As both DHBs serve provincial and rural areas, the projected savings were modest compared to those of Hutt Valley and Capital & Coast DHBs. SISSAL estimated that Nelson-Marlborough would “likely recover less than $50,000 annually”.14 South Canterbury estimated annual savings in the range of $10,000-70,000.

Both DHBs indicated that their Boards would reconsider the policy if DHBs nationally were to move in this direction. However, as one commented, they “would need some reassurance we’re not just moving costs around” and “there would need to be substantial savings”.

In contrast, greater savings are anticipated in major urban centres with higher populations, tertiary hospitals and a greater concentration of private specialists. According to a Waitemata DHB Board Paper (available online) the Auckland Region DHBs (Waitemata, Auckland and Counties Manukau) anticipated collective savings of more than $2.5 million if the policy were implemented across the region.12

**3.3.2 COSTS TO DHBs**

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.

**3.3.3 COSTS TO COMMUNITY LABORATORIES**

For both Aotea Pathology and TLab, the establishment costs associated with the PSRT charging policy were obscured within the overall setup costs for the new laboratories (as their contracts commenced concurrently with the policy).

Both labs needed to set up invoicing systems to manage invoicing patients who do not physically present at a collection room. While the laboratories invoice privately paying patients for other reasons (e.g., testing for employment, immigration, sports or overseas travel reasons), these patients can all be charged at the time they present for testing whereas some private specialist referred test samples may be sent to the lab directly by the specialist. One laboratory advised that approximately half its PSRTs arrive by courier, with no direct patient contact.

Ongoing costs to laboratories include managing the invoicing system (including communications with patients and doctors over the charges), and bad debts (recovery and write-off). According to the Capital & Coast and Hutt Valley DHBs’ impact evaluation, the level of bad debts at Aotea Pathology initially reached 9% of the value of invoices to this patient group.3 However, Aotea Pathology advised that the cost of bad debts had now reduced to the point where the total administrative and debt-related costs are covered by the laboratory service fee. The laboratory described the charging arrangements as “business as usual”.

Aotea Pathology had anticipated significant bad debts and instigated charging at the point of collection, based on financial modelling carried out prior to implementation. Only some collection rooms have EFTPOS, and the laboratory encourages private patients to visit these locations.

TLab indicated that the administrative costs could be absorbed and that bad debts have not been a significant issue. TLab does not charge an administrative fee.

Medlab South indicated that if all six South Island DHBs were to implement the policy, it would likely need to employ an additional 2 FTE to manage the associated administrative processes if the lab was required to invoice patients directly. If private specialists were to invoice patients and reimburse the laboratory, the FTE requirement would be lower.
3.4 **Discussion**

This review has identified a number of issues that should be given further consideration if the Ministry undertakes further policy development work toward wider implementation of the policy. Due to the nature and extent of available lab service utilisation data, this review has been heavily reliant on qualitative stakeholder feedback regarding impacts on access and cost-shifting. The balance of evidence from available sources suggests that the policy has led to:

- Some patients choosing to delay some tests, reduce the number of tests, or forego tests altogether as a result of the extra costs involved;
- Some patients choosing to access specialist services through the public sector instead of private practices to avoid paying laboratory charges; and
- Cost-shifting arrangements between some specialists and some GPs to avoid costs for patients.

The extent of these effects is unclear. However, the policy may be disproportionately affecting individuals who do not have private insurance (or whose tests are not covered under their private insurance policies) and who:

- Have to undergo complex procedures requiring multiple tests; or
- Have chronic conditions requiring regular ongoing tests.

It is important to note that if patients are foregoing or delaying tests, there may be adverse health outcomes and downstream costs to the health system associated with these cases (e.g., due to later presentation and diagnosis). These outcomes and costs may take some time to emerge – possibly longer than the policies have been in place.

Such adverse health outcomes would be undesirable even if only small numbers of patients were involved. Moreover, the downstream costs to publicly funded health services could potentially be quite high in some cases. Therefore, even a small number of cases might have a significant effect on the true level of savings to DHBs from not funding PSRTs.

These costs will be difficult to accurately measure and attribute to the policy, and would be subject to uncertainty even if a follow up evaluation of the policy were conducted in the future. As the potential significance of these costs is unknown, modelling of the potential impacts and health system costs is recommended to inform decision making about the policy.

### 3.4.1 Extrapolating PSRT Savings to Other DHBs

Savings from one DHB cannot be directly extrapolated to other DHBs, due to differences in population profiles and available services. For example, savings will be dependent on a range of factors including, but not limited to:

- Population size and composition (by age, ethnicity, socio-economic status, etc.);
- The proportion of residents whose PSRTs are covered by private insurance;
- Proximity to a tertiary hospital and the nature and extent of private specialist services available in the district.

Accordingly, the direct financial savings from ceasing to fund PSRTs will be highest in the main centres, both in total and on a per capita basis.

Variation in local conditions needs to be taken into account if the Ministry undertakes further analysis to estimate national direct savings to the public purse associated with cessation of funding for PSRTs.

### 3.4.2 Fully Costing the Policy

The three DHBs that have ceased funding PSRTs have realised financial savings. However, these savings only take account of the immediate, direct costs of PSRTs. If the Ministry gives further
consideration to wider implementation of the policy, modelling is recommended (including scenario analysis) to:

- Estimate the potential level of downstream costs that might be associated with delayed tests or cost shifting; and
- Take into account the costs of a hardship exemption as part of national implementation;

This modelling would provide a better understanding of the relative magnitude of PSRT savings, hardship exemption costs and possible downstream costs, including ‘break-even analysis’ to assess the risk of exemption and downstream costs significantly reducing PSRT savings.

Several stakeholders argued that pathology services are highly cost-effective in terms of downstream costs avoided through early diagnosis. There is likely to be a body of literature addressing this claim which could inform the development of modelling assumptions.

### 3.4.3 Quantifying Cost-Shifting Impacts

As highlighted in interviews with laboratories, it is difficult to distinguish instances of cost-shifting by private specialists amongst the vast majority of regular GP-ordered lab tests.

A clinical audit of a sample of laboratory records could offer a more reliable means of quantifying these practices. As PSRTs represent a small percentage of all community lab tests, and the degree of cost-shifting is thought to be small, a very large sample of records would be required to establish the extent of cost-shifting occurring.

An alternative approach, involving linkage of four data sets, was identified by a Ministry of Health Senior Analyst. In overview, this approach would require linkage of Laboratory Claims Data Warehouse data with:

- Medical Council registration tables by provider numbers, to distinguish tests ordered by specialists and by GPs;
- Hospital data by National Health Index (NHI) numbers and through probabilistic matching of lab test and hospital attendance dates, to identify patients who are likely to have been referred for lab tests as part of a public hospital visit (these tests are sometimes performed by the community laboratory); and
- General practice data, by NHI and through probabilistic matching of lab test and GP consult dates, to identify patients who are likely to have been referred for lab tests as part of a GP visit.

The resultant merged data set could then be used, through a process of exclusion, to distinguish lab tests that are likely to have been ordered by a private specialist, from those that are likely to be hospital or GP-ordered.

For example, where a patient:

- Had lab tests ordered by a GP, and did not see a specialist around the time of the test – the lab tests are probably related to the GP visit;
- Had lab tests ordered by a specialist, and was not recorded as being in hospital around the time of the test – the lab tests are probably related to a private specialist visit;
- Had lab tests ordered by a GP, and saw a specialist around the time of the test but was not in hospital around the time of the test – the lab tests are probably related to the GP visit but may have been ordered on behalf of a private specialist.

This approach would still not clearly distinguish PSRTs from other lab tests and could not identify definite cases of cost-shifting, but comparison of estimated proportions of PSRTs, GP-ordered tests and public hospital-ordered tests over time could be used to derive range estimates of the possible level of PSRTs and cost-shifting.

The approach would also be limited by shortcomings in the respective data sets. For example, GP date of contact data in national primary care data may not be straightforward to reconcile.
Alternatively, general practice data could be sampled from one or more PHOs with fairly stable enrolled populations.

It was estimated that this analysis would require approximately 100-150 hours of work by a Ministry analyst with experience working with all four data sets – particularly general practice data.

3.4.4 Consumer Consultation

Consultation with patients was outside the scope of the current review. However, feedback from clinicians, as well as unsolicited submissions received from a health researcher and a patient with rheumatoid arthritis, highlighted that patients in some circumstances can face high costs related to PSRTs. If the Ministry gives further consideration to wider implementation of the policy, research should be conducted with consumers who have chronic conditions, to better understand the nature and extent of the policy’s impacts for this group.

3.4.5 Hardship Exemption

If the Ministry gives further consideration to wider implementation of the policy, it is recommended that provisions be developed to ensure patients do not face undue financial hardship as a result of the policy.

Safety net provisions of this nature are already in place for other health care services in New Zealand, and these could potentially be adapted to include PSRTs. For example:

- PSRT subsidies or exemptions could be made available to people who hold a High Use Health Card (i.e., individuals who make frequent visits to doctors) and/or Community Services Card holders (i.e., families assessed as having a low income); and/or

- A separate scheme could be established specifically for PSRTs – somewhat akin to the Pharmaceutical Subsidy Card (for individuals and family members who face high prescription costs).

3.4.6 Scope of the Policy

The cessation of funding for PSRTs has to date encompassed all laboratory tests ordered by private specialists. This has raised concerns that the policy has created a situation where some patients receive publicly funded medications but have to pay for regular and ongoing specialist-ordered laboratory tests to monitor the effects of those medications.

If the core rationale for the policy includes aligning funding for PSRTs with that of radiological diagnostic tests, then policy development should address the question of whether funding should cease for all tests ordered by private specialists, or only those ordered for diagnostic purposes.

In conjunction with this issue, consideration would need to be given to the new avoidance and cost shifting risks such a distinction would introduce.

3.4.7 National versus Regional Implementation

If the policy is implemented more widely, consideration will need to be given to the relative merits of national or regional implementation.

The principal benefits of national implementation are consistency between health districts (including policy simplicity, perceptions of fairness, and no risk of patients avoiding costs by crossing DHB boundaries).

Regional implementation, on the other hand, recognises that the level of cost savings to be achieved in districts with small populations of low socio-economic status, with a low concentration of private specialists, may not be sufficient to justify implementation of the policy at a local level.

The findings from this review suggest that some professional and public resistance is to be expected under either option, but less so if the policy were implemented nationally.
3.4.8 Monitoring PSRT Volumes and Cost Shifting

This review has highlighted a lack of data on PSRT volumes at one laboratory and the inability of any of the laboratories or DHBs to identify the extent of cost-shifting in relation to PSRTs.

Currently, Aotea Pathology is recording numbers of PSRTs due to its contractual requirement to reimburse the DHBs in respect of these tests. Conversely, as Tairawhiti DHB factored the expected level of savings out of the fixed fee paid to TLab, the laboratory is not specifically monitoring PSRT volumes, and cannot readily distinguish these from other privately charged tests such as immigration, employment or sports-related tests.

With the current lab test ordering system, neither laboratory can reliably identify cases of cost-shifting and therefore neither the laboratories nor the DHBs can monitor or ‘police’ these practices.

If the policy is implemented more widely, it is recommended that data collection and monitoring systems be developed to track PSRT volumes, and that all community laboratories be required to report these test volumes to the Laboratory Claims Data Warehouse.

It is also recommended that systems be developed to detect and follow up cost-shifting (e.g., profiling and periodic auditing of a sample of test orders that have particular characteristics, such as tests ordered by GPs with a request for results to be copied to a specialist). This would enable monitoring of the extent of cost shifting occurring over time, as well as providing a deterrent for clinicians to engage in this practice. Including a signed declaration within the lab test order might provide a further deterrent to clinicians circumventing the policy.

3.4.9 Consultation and Communication about the Policy

Feedback from clinicians and professional associations has highlighted dissatisfaction with the level of consultation DHBs had undertaken prior to implementing the policy. Although some dissatisfaction is inevitable when funding for a service is withdrawn, it is in the interests of an effective implementation process to ensure specialists, GPs and consumers:

- Are aware that the policy will be introduced;
- Have had the rationale for the policy explained to them;
- Have had an opportunity to provide feedback; and
- Have received appropriate acknowledgement of their feedback.

Clinicians and professional associations considered that some of the initial communication and teething problems that had been encountered (e.g., many patients being unaware that they would be charged in the early months of the policy) could have been avoided through better consultation and communication with clinicians and the public prior to and during implementation.

If the policy is implemented more widely, a communication campaign is recommended to ensure clinicians and consumers are fully aware of the changes and how the changes will affect them.
CONCLUSION

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.

The policy has also had 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 due to the additional costs associated with PSRTs; 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, anecdotal advice from clinicians suggests they have occurred to a sufficient extent to be of concern.

Moreover, a few patients, particularly some who have chronic conditions and some who undergo private surgery, may have been disproportionately affected financially by the policy. This may have implications for the health of these individuals as well as potential downstream costs to the health system. If the policy is implemented more widely, it should include hardship provisions to mitigate these risks.

Key findings against the Review Questions are presented below. All of these findings are based on the balance of available evidence including anecdotal advice and data. The poor quality of available data limits the extent to which definitive conclusions can be drawn.

**Have private patients reduced the number of tests, or foregone tests altogether, as a result of the policy?**

Some patients are choosing to delay some tests, reduce the number of tests, or forego tests altogether to avoid the costs of these. The extent of this impact is unclear. However, it appears likely that the policy disproportionately affects a few individuals without insurance cover for PSRTs, who have to undergo complex procedures requiring multiple tests, or who have chronic conditions requiring regular ongoing tests.

While Capital & Coast and Hutt Valley DHBs have discretionary financial assistance available for people needing ongoing tests, facing exceptionally high costs and who are in financial hardship, nobody has accessed this assistance to date and 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.

**How have private insurers responded to the changes and how has this affected access for private patients?**

Currently, some 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.
Have the ordering patterns of GPs for laboratory tests altered, to order more and prior to referral to a specialist? Have specialists asked GPs to order laboratory tests on behalf of the specialists’ patients?

All interviewed stakeholders concurred that there is some cost-shifting through the ordering of tests by GPs at the request of private specialists. There were differing accounts as to how widespread these practices are. DHBs advised cost-shifting had occurred initially but had subsided and was not widespread. Anecdotal advice from clinicians suggests the practice is occurring on an ongoing basis and to an extent that is more than trivial – indeed, the majority of interviewed specialists in the three districts said that they ask GPs to order tests to avoid costs for their patients.

To obtain an accurate estimate of the extent of these practices, an audit of lab test requests would be required.

Have specialty groups in the public sector faced increased demand from patients diverting from private practice due to the extra laboratory costs? How has the policy impacted on public patients?

Anecdotally, some patients are diverting from private practice into the public sector due to the additional costs associated with PSRTs. All of the interviewed specialists were aware of private patients lost/sent into the public system, especially patients with chronic conditions, due to the costs of ongoing tests. Seven specialists reported that these instances were relatively uncommon and that they did not expect any discernable impact on the public system. Similarly, the DHBs noted that they had not observed any such impacts.

However, a few individual specialties may be more significantly affected. Three specialists (two gastroenterologists and a cardiologist), estimated that between a quarter and a third of their private patients had moved to the public system. Other stakeholder feedback indicated that rheumatology patients may also be significantly affected.

Has the policy had other impacts?

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 per-test costs to patients undergoing complex procedures who could 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 one of the laboratories said the number of complaints had reduced over time.

Laboratories bear the financial risk 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.

The interviewed specialists, GPs and representatives of professional associations 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 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.

A prevailing theme in feedback from clinicians and professional associations was dissatisfaction with the level of consultation and communication from DHBs prior to and during implementation of the policy.

Despite ongoing 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 charging policy even if this is a contributing factor.

There is some concern among professional bodies that in future, laboratories could take advantage of their monopoly positions by increasing their fees for private patients and that
private patients will end up paying more for the same service than publicly funded patients as a result.

**What were the savings to DHBs of implementing the policy? How have the savings been utilised by DHBs? What was the rationale for determining how the savings were used?**

The three DHBs that have ceased funding PSRTs have realised direct financial savings associated with the costs of those tests. These savings only take account of the immediate, direct costs of PSRTs and do not include allowance for any costs that might be associated with delayed tests or cost shifting.

Savings to the Capital & Coast and Hutt Valley DHBs have averaged $1.4 million per annum to date. While the DHBs did not directly allocate PSRT savings 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 and other sources.

Savings to Tairawhiti DHB were estimated at $65,000 per annum (based on Hutt Valley and Capital & Coast experience, adjusted for local conditions) and factored out of the total fixed price in the laboratory services contract (therefore this is the ‘actual’ level of savings to the DHB for the current contract, irrespective of actual volumes of PSRTs). The savings were applied to deficit reduction.

**What were the operational costs to DHBs to implement the policy?**

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.

**What were the costs for community laboratories of implementing the policy?**

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.

**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.
APPENDIX A – HARDSHIP CRITERIA (CCDHB & HVDHB)

Hardship Criteria for Exemption from Paying for Private Specialist Referred Laboratory Tests

The CCDHB and HVDHB may exempt some patients from their policy that, as of 1 November 2006, they will no longer fund private specialist referred laboratory tests (PSRT). The DHBs have agreed that there may be an exemption:

Where a patient has paid $500 or more over a 6-month period for a chronic, non-surgical condition and is likely to require ongoing tests. A hardship exemption fund may be available for those people who fit the criteria. They will be assessed on a case-by-case basis through the DHBs contract manager and community laboratories oversight advisory group.

Guiding Principles

Guiding principles have been adopted to assist in evaluating applications for a hardship exemption. They will only be available in the following circumstances:

- until a patient can be seen in the public system or
- for conditions where treatment is not available in the public system
- for conditions not otherwise covered by health insurance.

Required Information

The following information/guidance is required from applicants:

Personal Information - Name, address, phone number, GP and Private Specialist

Informed Consent - The patient must provide written consent to either Hutt Valley DHB or Capital and Coast DHB discussing their condition with their GP and private specialist.

Expenditure - Evidence of expenditure is required, and the period to which it applies. For patients that fit the criteria, DHBs will pay for expenditure on private specialist referred tests in excess of $500 in any 6-month period. The implications of this are that patients receiving any compensation from the two DHBs would incur costs of at least $1000 in the course of a year.

Condition - A diagnosis provided by the patient’s (private) specialist describing:

- the patient’s condition
- the ongoing tests that will be required
- the frequency of tests
- the period for which testing is likely to be needed.

For a condition to be considered chronic, it is unlikely to be resolved within two years and tests are likely to be required on a regular basis for an indefinite period.

Hardship - Applicants will need to provide evidence of hardship. To be consistent with other access criteria for public funding, patients are likely to have a Community Services Card or a High Health User Card.

Address for Applications

Applicants should send applications to the Community Laboratory Contract Manager, Planning and Funding Division, Hutt Valley DHB, Private Bag 31-907, Lower Hutt.
APPENDIX B – ADDITIONAL DATA ANALYSIS

Figure 1: Total monthly Schedule A test volumes - Capital & Coast and Hutt Valley DHBs

Source: Ministry of Health – Laboratory Claims Data Warehouse
Figure 2: Total monthly Schedule A test volumes - Tairawhit DHB

Source: Ministry of Health – Laboratory Claims Data Warehouse

Figure 3: Total monthly Schedule A test volumes - Auckland Region & Northland DHBs

Source: Ministry of Health – Laboratory Claims Data Warehouse
Figure 4: Total monthly Schedule A test volumes - Mid North Island DHBs

Source: Ministry of Health – Laboratory Claims Data Warehouse

Figure 5: Total monthly Schedule A test volumes - South Island DHBs

Source: Ministry of Health – Laboratory Claims Data Warehouse

Waikato, Lakes, Bay of Plenty, Tairawhiti, Hawkes Bay, Taranaki, MidCentral, Whanganui, Wairarapa
Figure 6: Monthly PSRT volumes - Capital & Coast and Hutt Valley DHBs

Source: Ministry of Health – Laboratory Claims Data Warehouse

Figure 7: Monthly PSRT volumes as percentage of total Schedule A test volumes - Capital & Coast and Hutt Valley DHBs

Source: Ministry of Health – Laboratory Claims Data Warehouse
Figure 8: Histology as percentage of total Schedule A test volumes

Figure 9: Microbiology as percentage of total Schedule A test volumes

Source: Ministry of Health – Laboratory Claims Data Warehouse
### Table 5: Capital & Coast and Hutt Valley Schedule A Volumes

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<th>Medical Laboratory Wellington</th>
<th>Southern Community Laboratories Ltd</th>
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**Notes:**
1. Source: NZHIS LABS warehouse extracted 14 December 2007
2. This includes all testing funded by Capital & Coast and Hutt Valley DHBs
3. Wairarapa volumes have been excluded from Valley Diagnostics data
4. 06/07 data is from APL own database as NZHIS data incomplete.
5. HVDHB & CCDHB labs assumed to be same in both years no data available from NZHIS
6. Figures shown are test volumes.

Total subsidised "post" 1,936,904

Drop in subsidised tests 295,671
% drop in subsidised tests 13.2%
Total PSRTs 128,825
PSRTs as % of drop in subsidised tests 44%
PSRTs as % of preceding year's volumes 5.8%
APPENDIX C - REFERENCES

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8 Health Funds Association of New Zealand. 13 November 2008. Submission on proposal to withdraw DHB funding for privately referred laboratory testing.


15 Nelson Marlborough Institute of Technology. Undated. Medical Laboratory Testing Requested by Private Specialists or from Private Hospitals. Research undertaken in conjunction with Dr Linda Liddicoat, NMIT.


18 Tairawhiti District Health Board. Undated. Private Clinician Referred Tests. CEO form letter to private specialists, Turanganui PHO, Ngati Porou Hauora, Medlab and Gisborne Hospital Laboratory inviting feedback on proposal to cease funding of privately referred lab tests.

19 Tairawhiti District Health Board. 25 July 2007. Private Specialist Referred Laboratory Tests. GM Planning & Funding form letter to stakeholders advising confirmation of decision to terminate funding of laboratory tests referred by private specialists and suspension of start date pending appointment of a single provider of laboratory services within Tairawhiti.

20 Capital and Coast DHB and Hutt Valley DHB. Undated. Hardship Criteria for Exemption from Paying for Private Specialist Referred Laboratory Tests.


