



All change for the New Zealand laboratories

Ross Boswell, Andrew Tie

Since the 1950s, diagnostic laboratory testing for New Zealand patients has been fully funded by the Government with no charge to the patient. In community practice, laboratory tests have been divided into two categories: “schedule tests,” a list of about 80 specific tests listed in the Diagnostic Laboratory Schedule, and “non-schedule tests”—the remaining ever-expanding list of investigations.

Schedule tests are funded fee-for-service in most community laboratories, while non-schedule test specimens are commonly collected by those laboratories and transferred to a public hospital where the analyses are performed. The requirement for funding has been that the test is requested by a doctor (or in some circumstances a dentist or midwife), that the patient is not an inpatient in a public hospital, and that the test is for diagnosis and not for immigration, industrial, research, or insurance purposes. New Zealand citizens, residents, and certain other categories of patient are eligible for funding but foreign patients, in general, are not.

Prior to 2003, the funding for schedule tests was administered centrally by the Health Department (later the Ministry of Health), then by Regional Health Authorities, and then by the Health Funding Authority. The funding for non-schedule tests was held by the applicable Hospital Board, then Area Health Board, then Crown Health Enterprise (CHE), and currently by the District Health Board (DHB). In most parts of New Zealand, that is the DHB within which the patient is domiciled—but in Greater Auckland the Auckland CHE and now Auckland DHB holds that funding for the whole region.

Because the funding for schedule tests was previously held centrally (except for the relatively brief experiment with four Regional Health Authorities), the domicile of the patient and the location of the laboratory were immaterial. Laboratories that were “recognised” to claim the laboratory benefit were able to claim for all of the qualifying work they did, and were able to operate regionally or even nationally.

Within this funding regime, community pathology laboratories grew to serve their populations and clinical practitioners. The funding schedule was seldom adjusted, but advances in technology and increases in test volumes and efficiency allowed laboratories to provide testing of increasingly high quality, both in technical terms and in terms of customer satisfaction, while remaining profitable. This profitability attracted commercial interest, and between 1985 and 2005 most community pathology practices in New Zealand ceased to be medical partnerships and became divisions of national or international corporations.

In 2003, the funding for community laboratory testing was devolved to DHBs. Since the laboratories’ operations in many cases extended beyond DHB boundaries, the funding was settled upon the DHB within whose district the laboratory headquarters lay. This produced anomalies where, for example, funding for some patients tested in Auckland was claimed from the Otago DHB. A complex system of “horse-trading”

grew up behind the scenes with DHBs agreeing to transfer funding according to the domicile of the patient.

In 2002, the incorporated society of DHBs, DHBNZ, commissioned a paper by Simon Terry Associates Ltd entitled *Options for Reform of Diagnostic Laboratory Services Markets*, (Reinhard Pauls) August 2002, which led them to consider the wisdom of continuing the existing arrangements where, when the community funding was transferred to them, most DHBs would fund separate hospital and community laboratories, and where in most cases they allowed competition between providers for community laboratory testing.

Because the competition was for market share, given a fee-for-service funding contract, it was perceived to drive up laboratory utilisation and therefore overall cost.

The outcome of this review has been the current community laboratory contracting round, involving most DHBs throughout the country. Solutions that have been sought are different according to the perception of local circumstances:

- In Otago-Southland, and in Nelson-Marlborough, a single company has been contracted to provide all testing in both community and public hospital practice, driving out both the previous DHB laboratories and the competing commercial laboratory. The Commerce Commission forbade a merger of the private providers.
- In Wellington and Hutt Valley, an initial proposal to award a sole provider contract to a consortium of DHB laboratories and a private provider was overturned, and the community contract awarded to a joint venture between the two private providers who previously served the region in competition, with Commerce Commission approval
- In the greater Auckland region, the contract for private pathology services from mid-2007 has been awarded to a completely new provider, thus eliminating the current sole provider.

Pathology practices of decades' standing have been terminated and disestablished. Private specialist practice is the target of specific intervention in at least one region (Wellington-Hutt Valley), where patients of private specialists will no longer have state funding for their pathology services.

Pathologists and their staff not surprisingly have vigorously challenged the processes and decisions, particularly those practices disadvantaged or eliminated. However, the real surprise to pathologists, and to administrators and boards, has been the unexpectedly high level of spontaneous public support and protest, exceptional for a clinical service with a normally low profile. Sceptics appear unconvinced that the savings expected will be better spent on other services by managers. Critics argue that estimates of transition costs are not available, or are ignored by contracting DHBs.

Legalistic process and devices such as probity reports have been used as a shield from criticism by DHB planners focused on reduction of cost and business risk. Clinical service consequences and clinical risk seem to have little influence in the final selection of providers.

Is the current furore merely the inevitable result of "kicking over the ant-heap," or is there more substance to it? We believe that there is real cause for concern. These

changes are being implemented at local level with no national framework or oversight.

Workforce is a critical national issue in pathology as in other areas of health. New Zealand has a shortage of pathologists (a national workforce of about 200 equating to about 1:20,000 population, compared with Australia's "severe shortage" at 1:15,000) and senior laboratory scientists. In Australia, UK, and in other countries there is strong demand for pathologists' services. The changes in contracts that force them to change location or change employer will inevitably cause some of them to re-evaluate their options, and they will leave the country.

Compared with New Zealand, remuneration for pathologists in Australia is high, and employment more settled, so the trans-Tasman traffic is heavily biased in a westward direction. Pathologists and their practices contribute to medical care in a large number of unseen (but necessary) and mostly voluntary (non-contracted) activities. An incomplete list includes clinical review meetings, accreditation, quality assurance, research, professional society and college activities, government and hospital programmes and projects, peer reviews, advice to the Health and Disability Commissioner, and the training and examination of registrars.

When service reporting workloads reach the point where there is insufficient time or enthusiasm for optional tasks, pathologists will withdraw and retrench out of necessity. This will only become apparent after time, and re-engaging the disenfranchised will be very difficult.

The changes inevitably result in disruption of established clinical relationships. Referring doctors learn to know and trust the laboratory and pathologists on whose advice they rely, and patients with chronic disease know and trust the laboratory staff they visit regularly for blood tests. The costs in health terms of disrupting these clinical relationships appear to have been discounted in the rush to cut financial costs.

The changes result in clinical risk. This is particularly marked where service is to be transferred on a given date from one sole provider of service to another, as in Auckland. There is the prospect that a current contractor may be unable to provide service to the end of its contracted period, as its staff perceive the inevitability of its closure and seek employment elsewhere. There is the possibility that the new provider is unable to recruit and train staff, and set up premises, equipment, and procedures in time to assume the workload at the beginning of its contracted period.

The decision to provoke such a transition is indeed "courageous" (in the sense that Sir Humphrey Appleby used the word), and we should take careful note of the decision-makers so that if it is successful we will know where to sheet home the credit for success.

The changes open new possibilities for cost-shifting and service reduction, and may work against innovation. In all cases, the new contract is for a lower price than the contracts that it replaces, since the driver for change is cost reduction. Such a narrow commercial focus from the purchaser will inevitably lead to commercial responses from the providers: the service provided will be at the level specified in the contract, but it is unlikely to be better or broader.

In many cases the contracts appear to have been written so as to require the laboratory to bear or share the cost of increases in workload, so the laboratory is induced to

pressure referring practitioners to reduce the numbers of tests they order. That may be commercially rational, but it may also lead to underservicing and the loss of opportunity for early diagnosis and appropriate monitoring.

Balanced against these risks is the prospect of financial saving. We have been advised that the Auckland community contract is for \$560 million over 8 years, and that it offers savings of \$15 million per annum for this 8-year period.

Community laboratory testing accounts for about half of the cost of DHB-funded laboratory services in Auckland. Assuming that no cost-shifting occurs, we are then looking at a reduction of about 10% in laboratory costs, or about 0.5% in total DHB expenditure. While every little bit helps, it is hard to escape a conclusion that in pursuing this disruptive and risky course the DHBs may be penny wise but pound foolish.

What lessons are there from this situation? Firstly, it must be determined that in future no such wholesale change to a clinical service will be undertaken without a national policy framework, ensuring that issues of national significance are not lost in the drive to achieve local cost reductions. Secondly, it is imperative that clinical risks are carefully weighed and a sustainable benchmark of service estimated when financially-driven service changes are considered. Thirdly, relatively soon it will become apparent that defects in the terms of contracts allow or encourage behaviour that is not in the interests of patients or of the health system as a whole. These defects in approach should be exposed, so they may be avoided in the next round of contracting.

When the chickens come home to roost, many of the managers responsible for these changes will have moved on, leaving the profession to contend with what may be a far less attractive future for those who remain.

Indeed, the public may one day rue the decisions of administrators and board members to cheapen the service on their behalf without first establishing the case for change, without adequately weighing risk, and without a plan beyond a budget bottom line.

Author information: D Ross Boswell, Clinical Head of Laboratory Services, Counties-Manukau DHB, Otahuhu, Auckland (and Chairman of Board of Censors and Member of Council, RCPA; Chairman of Council, New Zealand Medical Association, Wellington); Andrew B M Tie, Pathologist/Director, Medical Laboratory Wellington (and Chair of the Specialist Council, New Zealand Medical Association, Wellington)

Correspondence: Dr Ross Boswell, New Zealand Medical Association, PO Box 156, Wellington. Fax: (04) 471 0838; email: chairman@nzma.org.nz