



Submission on proposal to withdraw DHB funding for privately referred laboratory testing

November 2007

Executive Summary

This submission is made by Health Funds Association of New Zealand (Inc).

HFANZ's submission is based on our analysis of the Wellington experience, which highlighted major flaws in conception and implementation of the policy.

HFANZ maintains that the withdrawal of DHB subsidies fails the test for good public policy, and amounts to an expensive exercise in cost-shifting with adverse and unmeasured health outcomes.

Implementation of this policy in the South Island by all DHBs can be expected to lead to:

- The imposition of \$2-3 in costs to patients for every \$1 saved from the DHB budgets;
- A one-off health inflation hit of 2% upon implementation;
- An un-modelled increase in demand for public services from DHBs as patients transfer from private to public;
- Around \$15-16 million per annum in patient charges paid by South Island patients referred by specialists for laboratory tests;
- Charges averaging \$35 per patient visit, up to \$1600 for some testing.

HFANZ urges the South Island DHBs to either:

- (a) reject the proposed withdrawal of payments for privately referred laboratory tests; or
- (b) defer consideration of the proposal for 12 months to allow for a full evaluation of the Wellington experiment, with better information and data on which to make an informed decision.

1 About HFANZ

- 1.1 Health Funds Association of New Zealand (HFANZ) is the industry body representing health insurers. Members include friendly societies, mutuals, and subsidiaries of public companies. Membership is voluntary, with HFANZ membership comprising 10 health insurers, who together account for over 98% of health insurance policies. A full list of members is attached as an appendix to this submission.
- 1.2 HFANZ was set up in 1989 and was incorporated in 1995 under the Incorporated Societies Act. HFANZ does not represent the interests of individual insurers.
- 1.3 HFANZ has a commitment to quality resourcing of health care. Working closely with members and stakeholders, HFANZ is currently developing industry standards and codes of practice. HFANZ is also responsible for examining national and international trends in health, and seeks to provide quality industry data and policy advice.
- 1.4 Voluntary health insurance is an important part of New Zealand's overall health system. It helps relieve pressure from the public system, saves tax dollars, encourages capital investment in new facilities, and provides people with greater choice in managing their health risks.
- 1.5 HFANZ is supportive of efforts in both public and private sectors to contain costs and in particular supports greater collaboration between sectors with a view to achieving efficiencies and improved health outcomes. We have major concerns with this proposal in that it furthers neither of these goals and runs counter to efforts for improved collaboration and cooperation across the health sector.

2. Background

- 2.1 Five of the South Island DHBs are consulting on a proposal to withdraw DHB funding of a portion of privately referred laboratory tests, namely those referred by specialists operating in their private capacity.
- 2.2 This proposal was first introduced by the Wellington DHBs in 2006 and since then the Ministry of Health has encouraged other DHBs to look at the proposal, with the former Minister of Health envisaging a national rollout by the end of 2008.
- 2.3 Nationwide, the Ministry of Health expects the withdrawal of funding by all DHBs to collectively save DHBs in the order of \$25-30 million per annum.
- 2.4 HFANZ made submissions opposing the original Wellington proposal. We have followed the development and implementation of this very closely and continue to have concerns that the policy is fundamentally flawed and the costs greatly exceed the benefits. In this submission, we build on our original concerns and bring in some of the evidence gained from the Wellington experiment to date.
- 2.5 Our submission addresses particular areas of concern as follows.

3 Inadequate problem definition

3.1 The policy proposal suffers from an inadequate problem definition. The consultation document frames the question as follows:

'Should public money be used to pay for private health care laboratory tests?'

3.2 This is an emotive title and does not in itself set out to address any particular health issue or outcome. The issue is framed in a financial perspective with an eye towards cost-cutting. While a focus on DHB budgets is commendable, policy issues should properly be framed in terms of the health objective or outcome which one is trying to further or promote.

3.3 It would be more appropriate to step back and approach the issue in a more constructive and holistic manner, perhaps asking:

'How do we structure lab testing arrangements to maximise health outcomes for South Island residents?'

3.4 After all, DHBs are responsible for all residents in their area. By excluding tens of thousands of South Island residents and defining them as *'the problem'* the conclusions are effectively pre-determined.

3.5 The discussion of the interaction between public and private systems under the subject heading *'The Problem'* indicates a lack of understanding of the complex interactions which occur between public and private systems.

3.6 Two fundamental errors in assumptions stand out:

- The assertion that if you are having surgery in a private hospital it is funded by insurance and insurers would pick up the tab for lab tests if the DHB didn't; and
- The claim that the payment of all lab tests publicly leads to a corresponding reduction in the ability to fund other services within the public health service.

3.7 In the first instance, although health insurance funds the majority of surgical procedures carried out privately (around 70%), it does not fund all procedures. A high number of people choose to pay for elective surgery out of pocket in order to avoid often lengthy public waiting lists and get the certainty of prompt treatment in the private sector.

3.8 Even when people have health insurance and this is used to fund procedures, there is no guarantee that the insurance will fund the cost of laboratory testing. This depends on the specific details of individual policies and the level of cover afforded by the policy type. For instance, some policies do not cover lab tests, some do, and others fund the lab test but not the daily encounter fee.

3.9 The second and more serious issue is the claim that by publicly paying for lab tests this somehow reduces the ability to publicly fund other services. While this sounds plausible on the surface, in order to support such a claim, there is a need for evidence as to the level of public costs which may accrue in the event of the withdrawal of such funding. This submission highlights the lack of such supporting evidence in both this South Island proposal and in the Wellington DHB proposal adopted last year.

4 Sound public policy reasons for public funding

- 4.1 The reality is that there are often very sound public policy reasons for funding all costs of a specific nature in a common manner. Blanket public funding occurs for a host of 'private benefits' including GP visits and prescription charges.
- 4.2 The justification for public funding is usually made on the basis of improved health outcomes as a result. Using the GP subsidy analogy, as well as improving access to GPs, it is commonly accepted that there are benefits from early attention which saves higher cost interventions down the track.
- 4.3 Thus there is an apparent initial cost, but an expectation of a long term benefit. A similar argument can be made for funding of ancillary low cost interventions such as laboratory testing and pharmaceuticals. In the case of laboratory testing, there are efficiencies from funding this in bulk through the public sector. While there is an apparent cost to this, the benefits from enhanced private provision are well documented.
- 4.4 In the last year, the health insurance industry paid claims totalling \$600 million. Around \$400 million related to elective surgery. This is \$400 million of elective surgery that does not have to be funded by DHBs in New Zealand.
- 4.5 There are complex dynamics at work, with the take up of health insurance dependent on 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.
- 4.6 To the extent that shifting lab test costs to private patients causes this demand shift to occur, it is possible that the public sector may see either a saving or an increase in resulting costs.
- 4.7 A further factor is that DHBs might expect to see an increase in the level and severity of acute presentations in the event that the imposition of patient charges deters or defers early attention and treatment.

5 The Wellington Experience

- 5.1 Wellington's two DHBs, Capital & Coast and Hutt Valley, consulted on a similar proposal in 2006 which was implemented from 1 November 2006. This has now been in place a whole year, with monitoring and evaluation of the results in progress.
- 5.2 The consultation material and process for the Wellington proposal appears substantially similar to that now adopted by the South Island DHBs. There are some valuable lessons which can be learned from the Wellington experiment, and HFANZ urges the South Island DHBs to wait for a full evaluation of the Wellington experiment and its flow-on impacts before moving to implement this policy. The particular lessons from the Wellington experiment are discussed here as they relate to the South Island proposal.

6 Cost-shifting

- 6.1 Right from the start, the proposals appear to have been all about shifting public costs off the DHB financial statements and on to patients who have opted for private treatment. There is an ideological flavour to this approach in that anything which is not on the DHB books does not appear to count.
- 6.2 In evaluating public policies, it is more common to take a 'whole of society' or general equilibrium approach, and model the 'costs' and 'benefits' to all of society.
- 6.3 Because this has not been done, the policy proposal is at its crudest level a cost-shifting device which has not been adequately assessed.
- 6.4 In this case, the proposal is potentially very harmful as the costs are not simply shifted from public sector onto patients in a dollar for dollar fashion. There is a multiplier effect, where every dollar shifted becomes two or three dollars in costs to patients.
- 6.5 These are the worst type of cost shifting policies. The privately charged tests make up a small portion of the total tests carried out by the provider, and are the only opportunity for the laboratory test provider to make money on top of the contract with the DHBs. The whole individual invoicing, record keeping, billing, administration and financial control systems are built around chasing the small percentage of patients who are being charged.
- 6.6 The South Island proposal claims that DHBs will make savings of \$3 million per annum in laboratory test costs. The reality is that, based on the Wellington experience, the cost imposition to the public is likely to be vastly greater than this, by a factor of two or three times. This is discussed further below with reference to the observed impact on health inflation in Wellington.

7 Equity issues

- 7.1 An issue raised in the Wellington consultation was the resulting inequity in the impact of the proposed policy on similar tests ordered by GPs as opposed to being ordered by specialists. Consider the following example:
- 7.2 Two patients using the same private specialist and requiring the same tests. Patient 'A' has their tests ordered by their GP, while patient 'B' has their tests ordered by their specialist.
- 7.3 In this scenario, they would be treated differently, with patient 'A' receiving the testing for free, ie- funded by the DHB, and patient 'B' receiving an invoice from the lab test provider. This is despite the patients being in a virtually identical situation.
- 7.4 The problem was recognised as an issue by the Wellington DHBs although efforts to resolve it have been largely unsuccessful. The Wellington DHBs focused on what they perceived as avoidance of the fees by re-routing of tests through GPs instead of specialists. They factored in a percentage of tests which it would be anticipated might be re-routed through GPs, and devoted some time

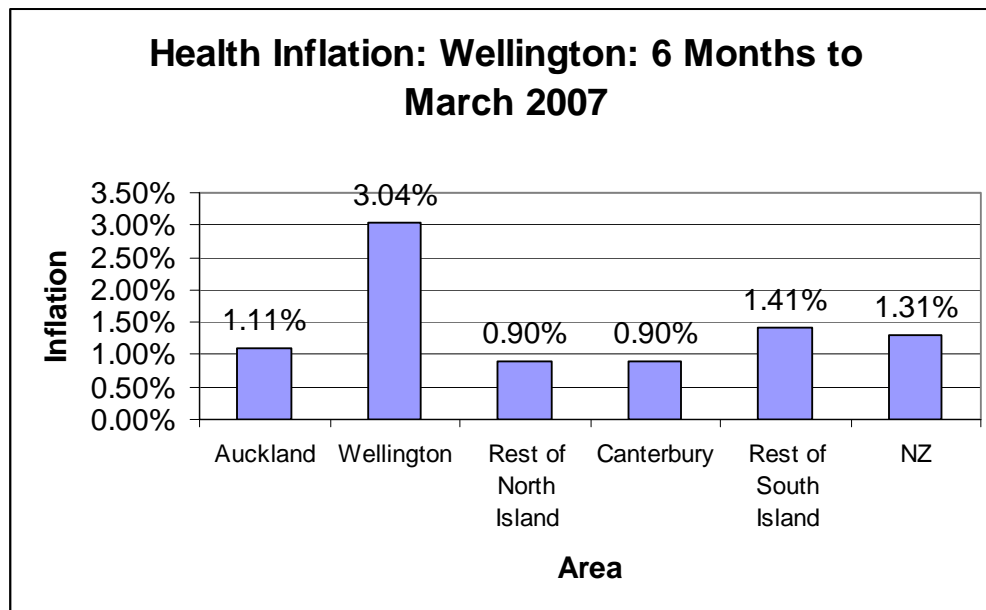
and energy into clamping down on this practice, while admitting there was fundamentally no way to avoid it in many instances.

- 7.5 The result is that there are fundamental equity issues which remain unaddressed. The reality is that some patients will be in a position to avoid it by going through a GP, while others will not, because of the nature of the testing. For example, testing carried out in conjunction with a specific surgical procedure rather than testing requested prior to any procedure being undertaken.

8 Impact on health sector inflation

- 8.1 The imposition of laboratory testing charges has increased health costs in Wellington. Statistics New Zealand figures for the six months to March 2007 show Wellington health inflation of 3.04%. This is three times the increase experienced elsewhere in New Zealand.
- 8.2 What has happened is that all the little extras, the cost of the new computers, the paperwork, the stationary, the invoices, the administration staff, the office space and everything else is loaded on top of Wellington health costs, plus the lab's profit margin.
- 8.3 The net result observed was a 2% loading on health costs for the Wellington region.

Fig 1: Consumer Health Inflation in NZ Regions over Period where Lab Test Charges Introduced in Wellington



Source: Statistics New Zealand

- 8.4 Total consumer health spending in New Zealand for the last year is some \$3.46 billion¹. If the patient charges are rolled out nationwide, the additional 2% impost equates to approximately \$69 million. This is the additional cost impost on

¹ Statistics New Zealand 2007 estimate

patients which would occur if all DHBs in New Zealand chose to exclude funding for specialist referred laboratory tests.

- 8.5 Apportioning of this on the basis of the South Island population share suggests if all the South Island's DHBs implement the policy on laboratory test charges, that South Island patients paying the charges will likely have to find an additional \$15-16 million each year. If the implementation was limited to those five DHBs currently consulting on the proposal, the additional cost on South Island patients will be correspondingly lower, in the order of \$13-14 million. This is well in excess of the claimed savings to DHBs.
- 8.6 Review of more recent cpi data from Statistics New Zealand for the full year ending September 2007 shows the Wellington area with health inflation of 1.5% compared to other regions averaging a reduction of 0.2%, largely due to the impact of increased GP subsidies. (*South Island -0.4%; Auckland -0.5%; Wellington +1.5%; rest of North Island +0.2%*). Thus the approximate 2% margin has persisted, with the different age profile of populations in each area having little impact on the observed results as the full GP subsidy roll out was completed.

9 Variation in fees at top end

- 9.1 The consultation material uses the same figures on costs as the Wellington DHB consultation, citing average costs of \$10. There is actually solid data available from Wellington and Hutt Valley DHBs which show the true extent of fees charged over the last year.
- 9.2 Between 1 November 2006 and 30 September 2007, Hutt Valley DHB advises that charges were applied to a total of 42,267 patient visits referred from private specialists. The total charged was \$1.495 million, giving an average charge of \$35.37.
- 9.3 In addition, there are a number of charges which amount to significantly higher amounts, particularly those where regular testing is required over a protracted period, such as in the event of cardiac bypass surgery. Analysis of the patient charging in Wellington over the last year shows the top ten charges all relate to testing accompanying cardiac procedures.

Table: Top ten patient invoices for lab tests issued since cessation of payment by DHBs for private specialist referred testing in Wellington: (Source: Hutt Valley DHB).

Amount	Reason
\$1660.94	Pre operative, intra operative and post operative tests for cardiac surgery.
\$1662.09	Pre operative, intra operative and post operative tests for cardiac surgery.
\$1604.90	Pre operative, intra operative and post operative tests for cardiac surgery.
\$1488.01	Pre operative, intra operative and post operative tests for cardiac surgery.
\$1437.56	Pre operative, intra operative and post operative tests for cardiac bypass.
\$1422.82	Pre operative, intra operative and post operative tests for cardiac surgery.
\$1375.22	Pre operative, intra operative and post operative tests for cardiac bypass
\$1362.80	Pre operative, intra operative and post operative tests for cardiac surgery.
\$1362.66	Pre operative, intra operative and post operative tests for cardiac surgery.
\$1356.13	Intra operative and post operative tests for cardiac bypass surgery.

9.4 Other specialist testing has charges well in excess of the \$10 average cited in consultation material. These include testing relating to breast cancer and testing relating to fertility treatments, with the Wellington lab test provider advising as follows:

- *A woman needing investigation of a breast lump could expect to be directly charged \$261.15 upon presentation for testing*
- *People self-funding fertility treatment (only one cycle is publicly funded) would be charged \$210 and \$133 for each cycle*

10 Potential for monopolistic behaviour

10.1 In the Wellington contract, the successful laboratory test provider was required to cap laboratory test charges in line with a schedule based on historical cost, for a period of 12 months. After that, increases are restricted to the rate of cpi inflation. This recognised that the successful laboratory test provider would have an effective monopoly. With over 90% of the tests carried out as part of the DHB contract and privately referred or charged tests making up just a small percentage of tests, effective competition is not feasible.

10.2 It is not clear that the South Island DHBs' proposal involves any restriction or 'capping' of fees that test providers may charge patients. This presents a clear opportunity for a successful provider to engage in monopolistic behaviour in the South Island laboratory test market. Because there will be total market dominance, effective competition is not feasible. This will likely see charges for tests significantly exceeding the reasonable costs involved in carrying out those tests. To the extent that any contracts permitted this, the resultant impact on health inflation would be expected to be worse than experienced in Wellington where fees were capped.

10.3 Even with a schedule of charges, there is little guarantee that the prices properly reflect the costs of carrying out testing. The Wellington charges appear to be largely based on historic schedules. The ability to rebalance to reflect true costs will be hampered by the cpi limit on increases. The resulting impact being that the maximum increase will likely become the minimum increase. In other words, this is simply an inflation-adjusted revenue stream offered to the successful bidder in return for a lower contract price to the DHBs.

11 Induced patient transfer to public sector

11.1 With the impact of additional laboratory testing charges resulting in significant increases in the cost of some procedures, it is logical to expect some transfer of demand from private fee-paying patients across to the public sector. This puts an additional financial strain on public sector resources.

11.2 In the Wellington proposal, the DHB modelling wrongly assumed nobody would shift to the public waiting lists because of the extra patient charges forcing up the cost of specialist treatment. It is not clear that the proposal by the South Island DHBs has made any attempt to model this impact.

- 11.3 In Wellington, as the cost of private treatments increases with extra lab test charges and daily fees, some patients change their mind and decide to wait to have their operation done publicly. They are trading off the extra cost with the time they are forced to wait for public operations.
- 11.4 Good policymaking is built on sound modelling. HFANZ believes there is a duty to model this impact. It either increases costs on the DHB or forces up the thresholds for qualifying for elective services. Either way, there are adverse health consequences and these need to be quantified and factored in to the analysis.
- 11.5 While it may be the case that not many patients change their behaviour over a \$10 charge, there is a cumulative impact which needs to be modelled. Some of the individual laboratory testing bills in Wellington have been well in excess of \$1,000 and these can be clearly considered as potentially behaviour-changing.
- 11.6 In the event that health insurance funds laboratory testing, there will be an impact on premiums. Increases in premiums will likely have a negative demand response at the margin which could see health insurance coverage reduced. Any reduction in coverage will be most visible for those groups who are most price-sensitive, particularly those aged 65 and over, where premiums are higher than average and incomes lower.

12 Adverse health impacts

- 12.1 The combination of demand shift factors has the potential to result in adverse health outcomes. The factors described above could be expected to result in an increase in demand for publicly provided elective surgery (as a result of reduced insurance coverage and higher charges deterring fee-paying patients).
- 12.2 A further factor is that DHBs might expect to see an increase in the level and severity of acute presentations in the event that the imposition of patient charges deters or defers early attention and treatment.
- 12.3 DHBs are financially limited in terms of options for responding to increased demand for elective surgery. Typically, there will be funding set for a specified number of procedures, so increased demand will result in a need for tighter rationing of treatment. Rather than responding with increased funding, a more likely response is therefore to review upwards the thresholds for qualifying for elective surgery. Effectively, this means a patient's condition must deteriorate to a worse level than previously in order to qualify for surgery.
- 12.4 The most likely outcomes are therefore longer waiting lists, with people required to wait longer times and deteriorate in condition to a worse extent, before being considered for elective surgery.
- 12.5 There are well-documented adverse health impacts from such deferral of treatment. The magnitude of these likely adverse health outcomes needs to be better understood and modelled before the proposed policy is taken any further.

13 Conclusions and recommendations

13.1 HFANZ's analysis of the Wellington experience shows that the withdrawal of DHB subsidies fails the test for good public policy, and amounts to an expensive exercise in cost-shifting with adverse and unmeasured health outcomes.

13.2 Implementation in the South Island by DHBs can be expected to lead to:

- The imposition of \$2-3 in costs to patients for every \$1 saved from the DHB budgets;
- A one-off health inflation hit of up to 2% upon implementation;
- An un-modelled increase in demand for public services from DHBs as patients transfer from private to public;
- Around \$15-16 million per annum in patient charges paid by South Island patients referred by specialists for laboratory tests;
- Charges averaging \$35 per patient visit, up to \$1600 for some testing.

13.2 HFANZ urges the DHBs to either:

- (c) Reject the proposed withdrawal of payments for privately referred laboratory tests; or
- (d) Defer consideration of the proposal for 12 months to allow for a full evaluation of the Wellington experiment, with better information and data on which to make an informed decision.

Roger Styles
Executive Director

Appendix 1: HFANZ Members

HFANZ FULL MEMBERS

- American International Assurance
- ING Life (NZ) Ltd
- EBS Health Care
- Accuro Ltd
- Manchester Unity Friendly Society
- Police Health Plan Ltd
- Southern Cross Healthcare
- Sovereign Assurance Company Limited
- TOWER Health & Life Ltd
- Union Medical Benefits Society Ltd (Unimed)

HFANZ ASSOCIATE MEMBERS

- Medilink Limited