



Auckland Region Community Laboratory Services Consultation Feedback Report

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Table of Acronyms

ACC: Accident Compensation Corporation

ARDHB: Auckland region District Health Boards

ADHB: Auckland District Health Board

BPAC: a New Zealand-based organisation that provides information, resources and training about patient-centred healthcare interventions and medical best-practice.

CMDHB: Counties Manukau District Health Board

CME: Continuing medical education

DHB: District Health Board

DML: Diagnostic Medlab

GP: General practitioner

HFANZ: Health Funds Association New Zealand

NDSA: Northern DHB Support Agency

PHO: Primary Health Organisation

POCT: Point of Care Testing

RFP: Request for proposal

WDHB: Waitemata District Health Board

1. Executive Summary

Introduction

Between September and November 2008, the Auckland Regional District Health Boards undertook a public and stakeholder consultation on community laboratory services. This report is about the stakeholder and public feedback to the ARDHBs community laboratory proposals.

The proposals attracted a great deal of public interest and some strong feelings from medical and laboratory personnel, organisations and service users. The range of activities undertaken to engage the public in the consultation, the amount of feedback received, the High and Appeal Courts' decisions and media attention makes this one of the most significant consultation exercises in New Zealand's health sector.

The ARDHBs asked the public for feedback on its proposals for the delivery of community laboratory services in the greater Auckland region. The proposals addressed:

- The location of collection centres
- The opening times of collection centres
- The information provided to patients about the tests and the results
- Who should pay for privately referred tests
- The collection of samples by GPs and other health professionals
- Putting initiatives in place to encourage the right test to be requested at the right time and the associated clinical practices
- Assessing how well the public felt the services were currently working
- Assessing what improvements the public would like to see
- The number of service providers should there be one, or more

Methods and analysis

The consultation canvassed the views and preferences of as many interested organisations, communities and individuals as possible. Therefore, the communications campaign and consultation process were intended to maximise awareness and participation. The consultation was designed as a non-statutory consultation process that complies with the Ministry of Health's consultation guidelines. Many stakeholders and organisations were directly invited to provide feedback and a large number of notices were circulated in newspapers and radio. Feedback channels were numerous: on-line survey, public workshops, hui, fono, focus groups, e-mail, post and telephone.

In sum, 4,425 surveys, 8,019 emails and 33 letters were received from stakeholder organisations and individuals and hundreds of people attended stakeholder and public meetings. A research company's 'panel'¹ was used as a comparator to the views of interest groups and those motivated to attend public meetings and make submissions. The panel members and people who accessed the survey through the DHBs and community laboratory project's websites completed the same questionnaire.

The feedback has been analysed qualitatively and quantitatively and is reported here according to the ARDHB's proposals as listed above. Feedback from all sources and

¹ Buzz Channel (www.buzzchannel.co.nz)

respondent groups has been drawn into the analysis in all sections of this report. Qualitatively, we gave more weight to technical feedback for technical matters and service users' points of view for the proposals that are targeted at service accessibility. Quantitatively we have only reported results that are reliable at or above the 95% confidence level. The only ethnic group with a sample size large enough to give statistically significant results was NZ European therefore no results by ethnicity have been reported.

Results and recommendations

Based upon our analysis of this material, we offer recommendations as to what the Boards should consider when deciding how the Auckland region's community laboratory services should be delivered. We encourage the ARDHBs to consider the levels of support for the DHBs' proposals alongside the discussion about the respondents' comments, which explain their response.

While some of the feedback was strongly put and conveyed upset and anger at some of the DHBs' proposals, the consultation process, the RFP process and the awarding of the contract to Labtests, other feedback was supportive.

Paying for Laboratory tests

We recommend that when the ARDHBs decide whether to introduce charges for privately-referred laboratory tests, they note that:

- Just over half of panel respondents agree that some form of payment should be required, whereas only 11% of website survey-respondents supported this proposal.
- Many strong and extensively-argued messages were received from a wide array of respondents, including the privately insured, medical associations, and professional bodies, who felt that any such charges should not be introduced. A few respondents indicated they would take action should the DHBs adopt this proposal.
- The respondents opposed to the proposal, raised economic, clinical and ethical concerns with regard to the DHBs' continued ability to spend wisely, provide quality health care to all, and maintain a positive working relationship with the private health sector should they introduce this proposal.
- Those in favour of introducing private charges, either across the board or only for some tests, see it as an effective way of encouraging efficiency and believe the public will benefit from more purposefully targeted expenditure.

Attracting and Retaining a Pathology and Laboratory Workforce

When the Boards consider how to retain and attract a pathology and laboratory workforce, we recommend they note that a strong message was delivered about low workforce morale and the region's ability to attract and retain staff. Respondents believed this will be compromised unless the factors contributing to it are rectified: provision of stability in the sector, wages comparable to those offered elsewhere, opportunities for private practice, research, and career development, workforce input into management decisions and policy direction, and reputable employers.

Collection Centre Location

We recommend that the ARDHBs note that the current distribution of collection centres poses few barriers to having a sample taken. Nevertheless, 45% of panel respondents agreed that the location of collection centres needs to be reviewed as compared to 39% of website survey respondents. Many thought there were either too many or they were not well spread

out across the region. Some of those who were opposed to the review, expressed concern that the number of centres may be reduced, which they tied to increasing barriers to care, especially for patients with limited mobility (who also tend to be the heaviest users of laboratory services). We also recommend that the Boards' note the range of factors impacting on the suitability of collection centres' locations, and the factors impacting on the centre's accessibility to workers and those who fast prior to having samples taken..

Collection Centre Hours

The feedback suggests that time factors, including the hours and days the collection centres are open, put about one-in-five people off from having a sample taken. We therefore recommend that the ARDHBs consider addressing these factors as key to making laboratory services more accessible to the public. While most panel and website survey respondents rated both the collection centres days of operation and opening hours as good or excellent, one-in-three panel members and one-in-five website survey respondents rated them as poor or fair. Common reasons for dissatisfaction were that it can be difficult to have a sample taken early in the day: too few centres are open early; and those that are open early often have long queues. More than 1000 respondents asked that collection centres be open longer, beyond regular working hours.

Point of Care Testing

When deciding whether to implement POCT more widely than it is currently practiced, we recommend that the ARDHBs note that two-thirds or more of health care professionals and non-health professionals support POCT in theory, at least in part. The proposal is supported, provided that the costs and benefits of POCT be weighed up on a case-by-case basis. The utility of POCT is dependent on a range of factors including, but not limited to, the type of test in question, the point of care's proximity to a suitable laboratory service provider, the cost of performing that test, the facilities and skill-set required to do it, quality control and storage of test results.

GPs and other health professionals collecting samples and electronic collection referral systems

We recommend that the ARDHBs note that more than two-thirds of non-health professionals, as compared to less than half of health professionals, supported more sample collection by GPs and other health professionals. Those against the proposal questioned why the DHBs would want to change the current system and noted work-load, resource and quality control issues. Those in favour thought more clinic-based sample collection would be much more convenient for patients and improve rates of compliance.

There was considerably more support for an electronic collection referral system, especially from health professionals, so long as the transfer and storage of information was secure and, with patient consent, could be easily shared.

Information about tests and test results

With regard to information about tests and test results, we recommend the ARDHBs note that nearly half of panel survey respondents and one-quarter of website survey respondents rated the information they received as poor or fair. Those who were dissatisfied with the current information sharing arrangements asked for the patient to be provided with tests results when results are normal as well as abnormal, to receive both an email record of their results from the laboratory, and to receive an explanation as to what the results mean in plain language.

Preferred number of providers

We recommend the ARDHBs consider that, firstly, there were some strong feelings attached to this aspect of the DHBs' proposal, as many respondents took it as an opportunity to express frustration and, on occasion, anger at the RFP process and the awarding of the contract to Labtests. Secondly, while just over half the website survey respondents preferred that there be one service provider, just over one third of panel respondents felt the same way. Thirdly, strong messages of support were received from health professionals and regular patients, for DML to be if not the only, then a, provider of laboratory services to the Auckland region. Fourthly, underlying the disagreement as to whether there should be one provider or more was a shared interest in the DHBs holding the provider(s) of laboratory services accountable to ensure they delivered not only efficient but also high-quality laboratory services.

Right test right time and clinical practice

There was widespread support for this aspect of the proposal. Although medical practitioners generally supported this proposal, it was noted that the investment of time and effort this additional CME training would require must deliver clear benefits. They offered their support on the condition that medical practitioners and the organisations that represent them, be closely involved in developing and implementing any further test-referral training and guidelines.

Other feedback

This section of the report presents points frequently made by public meeting attendees, survey respondents or letter writers that, while pertaining to decisions the ARDHBs have to make, do not fit under one of the proposals put to stakeholders and the wider public for consultation. A lot of respondents offered support for DML and the quality of services it provides, and argued that the ARDHBs should retain or recover its contract. There were strong messages of disapproval of the ARDHBs consultation process. Respondents felt that it was too late in the piece; there had been inadequate recognition of feedback received to date; awarding that contract to Healthscope presents unwarranted risk; and there should be a rigorous on-going assessment of the quality and efficiency of laboratory services set in place to monitor their adequacy.

Supporting information

As noted above, there was a large amount of data collected during this consultation process. More in-depth analyses of the feedback received about each of the proposals are possible, should this be required.

2. Introduction

The purpose of the consultation

Between September and December 2008, the Auckland Regional District Health Boards undertook a public and stakeholder consultation on community laboratory services. This report contains the consultation findings.

The purpose of the consultation was to inform the development of a long-term purchasing plan for the three Auckland District Health Boards (ARDHBs). The DHBs specifically undertook this consultation to find out what patients, medical professionals and different population groups in the wider community would like to see in this service and what they thought about the services currently purchased and proposed, as outlined below.

The services purchased and proposed

The community laboratory service comprises three areas: collection of samples to be tested, the testing of those samples, and specialist advice to family doctors.

The DHBs are obliged to maximise the value-for-money with regards their investments in health services and they routinely review current purchasing as to appropriateness against current standards and needs. With regard to community laboratory services, the DHBs need to ensure the service they purchase meets an appropriate level of both patients' and doctors' needs, is of an appropriate level of quality, and provides value for money.

Annual community laboratory spend across the ARDHBs is substantive. The Auckland Region DHBs spend \$73.8 million each year on community laboratory services. Historically, laboratory service expenditure has grown at a rate that exceeds growth in DHB revenue. Both the number of tests and costs have been increasing. This is driven by numerous factors including, but not exclusively:

1. Population growth
2. Aging population
3. Growth in numbers of people with chronic conditions

These factors are likely to continue to influence volume growth and consequently put pressure on growth in expenditure.

Future purchasing needs to be cognisant of these factors to enable appropriate management of expenditure. The DHBs also wish to ensure service provision is of an appropriate standard and is responsive to health need.

The Auckland Region District Health Boards believe there are a number of ways the community laboratory services could be improved, and sought public feedback on them. They are:

1. Reviewing where blood or other samples are collected. Some areas may have too many and others may not have enough. Changing where samples are collected may make it easier for more people to get their samples collected.
2. Reviewing whether the opening hours of collection centres may need to change to better meet the times the services are required.

3. Offering opportunities for primary health care workers, such as GPs or nurses, to take and test a blood sample, without the patient having to go somewhere else. This technology is known as point of care testing or near patient testing.
4. Providing improved education to family doctors on appropriate testing requirements, so that people with similar health needs get similar types and numbers of tests.
5. Reviewing whether tax payers should continue to pay for tests when people go privately to see a doctor other than a family doctor. This does not include the doctors seen at the local hospital or those providing maternity services.
6. Reviewing whether a single provider of the laboratory service (collection, testing and specialist advice) is the best option or whether different arrangements are better.
7. Looking at requirements to attract and retain specialist doctors and laboratory workers, and including these requirements in the future plans for community laboratory services.

The DHBs have also identified a number of areas that need to be further examined, and again invited feedback on them:

1. People who most need health services are less likely to get their proper share.
2. Family doctors differ on how often they ask for laboratory tests to be done.
3. When people go privately to see a doctor other than a family doctor, they do not have to pay for any testing themselves. Currently, tax payers pay for this testing.
4. Places for the collection of blood and other samples are not evenly spread across the Auckland region.
5. New Zealand, as with many countries, has a shortage of specialist doctors to run laboratories. We need to consider how to attract and retain specialist doctors to make the service both safe and able to meet the needs of patients and doctors.

Background information about the RFP process and Court action

Much of the consultation feedback makes reference to the RFP process and court hearings. This background information helps put that feedback in context.

In 2006 the three Auckland Regional DHBs conducted a RFP process for community laboratory services. A contract was awarded to LabTests, a new entrant to the market. The historical community laboratory service provider, Diagnostic MedLab, with Harbour PHO as an intervener plaintiff, applied for a judicial review.

The plaintiff's submissions involved four heads of claim. The first was based on Dr Tony Pierre's involvement with the ARDHBs and the implications of his involvement and knowledge. The second related to DML's right to be consulted during the process and its legitimate expectation as to what was involved in the RFP process. The third alleged that the ARDHBs failed to consult with the Auckland public and general practitioners. Harbour PHO also supported this claim. The fourth alleged that the ARDHB's decision was unreasonable or irrational, and relies particularly on mistakes allegedly made during the decision-making process.

At the High Court, the decision to award the contract to LabTests was deemed to be invalid. The High Court judgment said that the District Health Boards failed in meeting their

responsibilities in two areas. The first of these was that one of the Board members had interests in community laboratory services that meant he should not have been involved in the Board discussions. The other was that the DHBs failed to meet the requirements for acceptable consultation with Primary Health Organisations. The result of this was the High Court overturned the decisions the District Health Boards had made.

As a consequence of this determination, the existing contract with DML was amended. From 1 July 2007 the amended agreement guaranteed 12 months exclusive provision to DML, except where the Court of Appeal directed otherwise. DML were to be given six months notice of termination, otherwise the contract had no fixed end date. If the agreement was to extend beyond 31 December 2008 then the parties agreed to enter into a negotiation on price no later than 1 July 2008. Consequently, the DHBs negotiated a new contract with Diagnostic MedLab.

Lab Tests, however, appealed that decision to the Court of Appeal. In a judgement released on 25 September 2008, not long after the start of the consultation, the Court of Appeal unanimously overturned the High Court's judgment, including its finding that the ARDHBs had failed to meet its consultation responsibilities. The Court of Appeal reinstated the decision of the Auckland Region District Health Boards to award the contract for laboratory services in the Auckland region to Lab Tests. As a result of the decision, Lab Tests is to commence to supply services under its contract.

At the time of the consultation the community laboratory services for metropolitan Auckland were predominantly provided by Diagnostic MedLab (DML). DML had an application for leave to appeal the Court of Appeal's decision at the Supreme Court declined.

3. Methods

The consultation was designed to get the views and opinions of as many interested parties as possible. Therefore, the communications campaign and consultation process were designed to maximise awareness and participation. The consultation was designed as a non-statutory consultation process that complied with the Ministry of Health Consultation Guidelines.

Consultation started on 22 September 2008 and ran for eight weeks, ending on 14 November 2008.

Communications Plan

Media releases were scheduled at the start, middle and end of the consultation process. These were released to the general media with specifically-targeted releases for suburban newspapers (11 publications), Asian and Pacific peoples' newspapers (five publications), and radio stations (six stations).

An all-users e-mail to DHB staff promoted the on-line survey. This included a request that they forward the email widely through their personal networks.

A fax was sent to all GP practices inviting them to log their e-mail address with the DHBs so they could be notified of when the survey was up-and-running. Around 100 responded.

In addition, the following list of stakeholders was formally invited to give feedback:

- Communities. A wide range of community representatives were identified, including Maori, Pacific, other ethnic groups, and patient support groups. DHB existing community networks were approached.
- Private laboratory providers and staff.
- General practitioners and PHOs, including accident and medical centres.
- Other community health service providers e.g. Family Planning Association,
- Midwives, pharmacists, dentists.
- Private specialists.
- The medical colleges.
- Private hospitals.
- Private health insurers.
- Unions and workforce, including professional bodies.
- Senior Medical Officers, including pathologists.
- DHB laboratory managers.
- National Screening Unit

Documentation

A number of documents were developed to support the consultation. These included:

1. A consultation document that provided an introduction to community laboratory services, how to participate, and where to find additional information.
2. A series of one-to-two page background information sheets on how the community laboratory service works, along with some of information about some of the ways the District Health Boards might improve the service. These information sheets were available in English, Maori, Tongan, Samoan, Chinese, Korean and Hindi and were provided on the following areas:

- History of Community Laboratory Services in Metropolitan Auckland
- Community Laboratory Services, what are they?
- Laboratory use and costs
- Collection
- Privately referred laboratory testing
- Structures for community laboratory services
- Workforce
- Funding non government organisations
- Point of care testing
- Referral quality management
- Other readings

Website

A dedicated website was established (www.communitylabs.co.nz), which contained information about the project, the consultation times, frequently asked questions, news and updates, and the aforementioned information sheets in English, Maori, Tongan, Samoan, Chinese, Korean and Hindi. The website also had a link to an on-line survey.

O800 Number

An 0800 number was set up to allow people to verbally make a submission (these were transcribed and included in the analysis), or to request information material or to ask questions. No verbal submissions were made, but requests were received for information packs.

Web Health

The consultation was listed on the 'WebHealth' website.

Feedback channels

Feedback could be given in a number of ways.

1. The website www.communitylabs.co.nz had a direct link to an online survey/ submission form.
2. A hard copy of the submission document could be requested by either sending an e-mail to labs@ndsa.co.nz or phoning 0800 522 667.
3. Written submissions could be sent it to:
Community Laboratory Submission
C/- Project Director
NDSA
PO Box 112147
Penrose
Auckland 1642
4. Emails could be sent to labs@ndsa.co.nz
5. Feedback could be given at public meetings. These included:
 - Forum for the general public
 - Forum for various ethnic groups including: Maori, Pacific, Chinese, Korean and Indian people
 - Patient focus groups
 - Public focus groups
 - Forum for PHOs and general practitioners
 - Forum for other health professionals and provider groups

- Other forum arranged on request. Known community groups were approached to get this issue on their agendas to ensure there was widespread knowledge that consultation was occurring and how to participate.

The Panel

In addition, the general public were consulted using a research company's² 'panel' of respondents living in the Auckland region (see table 1, below). Throughout the report, the panel is referred to as the 'panel'. The panel was surveyed as a comparator to the views of interest groups and those motivated to attend public meetings and make submissions.

On-line survey

The questionnaire was designed to seek feedback on the following areas:

- The location of collection centres
- The opening times of collection centres
- Information provided to patients about the tests and the results
- Who should pay for tests?
- GPs and other professionals collecting samples
- Right test, right time, and clinical practice
- Overall - how well current services were working
- What improvements respondents would like to see
- Service providers - should there be one, or more
- Any other feedback

Each section comprised both open and closed questions. It also provided an option for respondents to skip quickly through the questionnaire sections they were not interested in or felt not well-informed enough to comment on. They could also quickly answer questions by ticking boxes, as well as provide as much commentary about each area as they wished.

In addition to the topic areas above, respondents were given opportunities to provide any other feedback they felt was relevant to the survey.

Respondents were able to answer the questionnaire in English, Maori, Tongan, Samoan, Chinese, Korean or Hindi. Of the 4,425 surveys returned, 111 (2.5% of all surveys returned) required translation (the majority required translating from the Chinese).

Responses

A large amount of feedback was received and through a wide range of channels (table 1).

Table 1: Sources and number of responses

<i>Source</i>	<i>Number</i>
Surveys	4,425
Emails	8,019
Meetings	12
Focus groups	5
Submissions	247

Survey

² Buzz Channel (www.buzzchannel.co.nz)

In all, 4,425 questionnaires were received, which either had been completed in full or in part. A series of skips and jumps allowed respondents to complete only the parts that they were interested in. A total of 3,667 respondents, or 83% of all respondents, completed the survey through to the end. The remainder, 758 surveys (17%), were partially completed. All questionnaires, whether partially or fully completed, have been analysed. Only those where there was no input whatsoever, have been excluded from analysis.

The questionnaires from the panel and those from the website have been analysed separately. Panel respondents were selected from a panel of Aucklanders who had previously expressed an interest in completing surveys about any topic, in return for a small gratuity. Website respondents were self-selected and more likely to have a specific interest in the laboratory services. The views of these groups have been analysed and reported separately and their views compared. Where the views are statistically different ($p < .05$), these have been reported.

Table 2: Demographic profile of the on-line survey respondents³

<i>Respondent category</i>	<i>Panel</i>		<i>Website</i>	
	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>
Male	39.5	587	50.2	809
Female	59.6	886	47.9	772
Prefer not to answer	0.9	13	2.0	32
<i>Total n</i>	<i>100.0</i>	<i>1,487</i>	<i>100.1</i>	<i>1,611</i>
Member of public	93.2	1399	73.0	1487
Health Professionals	3.8	57	18.9	385
Laboratory workers	0.2	3	5.3	108
Representative of group or organisation	0.7	11	1.1	22
Prefer not to answer	2.1	32	1.7	35
<i>Total n</i>	<i>100.0</i>	<i>1,502</i>	<i>100.0</i>	<i>2,037</i>
Used collection centres once or not at all in last 12 months	31.6	467	19.2	304
Used collection centres twice or more in last 12 months	68.4	1010	80.8	1277
<i>Total n</i>	<i>100.0</i>	<i>1,477</i>	<i>100.0</i>	<i>1,581</i>
WDHB	37.4		36.2	
ADHB	28.5		44.3	
CMDHB	34.1		19.6	
<i>Total n</i>	<i>100.0</i>	<i>1,445</i>	<i>100.0</i>	<i>1,548</i>
NZ European	75.3	1,114	83.2	1323
Maori	7.1	105	2.6	41
Pasifika	5.2	77	0.9	14
Asian	9.5	140	6.7	106
Middle Eastern, Latin	0.9	13	0.9	14
Other	5.9	87	5.6	89
<i>Total n</i>	<i>103.9</i>	<i>1,479</i>	<i>99.9</i>	<i>1,587</i>

³ **Note:** The number of respondents differs between the set of demographic categories because every respondent did not provide an answer to every question. The number of responses from the panel to the ethnicity question adds up to more than 100% of the sample because the respondents could indicate membership of more than one ethnic group.

The profile of the panel respondents differed from those that entered the survey from the website. The panel respondents were more likely to be female, a member of the public and less likely to be NZ European or to have a job as a health professional or laboratory worker.

The panel cannot be taken as representative of the views of all population groups of Aucklanders. To be a member of the panel requires computer access and self-selection. Furthermore, the views of Maori, Pasifika, Asian and low-income households are under-represented and have therefore been sought through alternative media, such as hui, fono, focus groups and workshops.

Emails

Over eight thousand emails (n= 8,019) in opposition to the introduction of private charges were received following notices prepared and circulated by Southern Cross Healthcare by newspaper and email. The notices encouraged people to let the DHBs know they were opposed to private charges.

Meetings and focus groups

During the consultation period the following meetings and groups were organised

- 12 public meetings
- 12 ethnic-specific meetings
- Five focus groups

See Appendix 1 for the places and dates of these meetings.

Public meetings

The 12 public meetings were held at the locations noted in Appendix 1. The meetings were publicised on radio stations, in community newspapers, by email to ADHB staff (which encouraged the message be forward through the recipients personal networks) and on the community laboratories project website.

There was wide-ranging interest in the public and stakeholder meetings. There were no or only a few people at some (e.g. at Lincoln Green), and more than 100 at others (e.g. one of the GP meetings).

At the public meetings and ethnic-specific meetings, a representative from the DHBs facilitated the discussion, addressing each of the proposals and issues being considered (as noted in the introduction section of this report) and asked for feedback in response to each item. There was at least one other DHB representative taking notes about the feedback received, making an effort to be as accurate and thorough as possible.

Ethnic-specific meetings

These 12 meetings consisted of:

- Three Fono (Pacific) held at Counties Manukau, Lincoln Green and Takapuna
- Six Hui (Maori)
- Three public meetings with people from Chinese, Korean and Indian communities.

Written letters and submissions

A total of 33 stakeholder organisations and individuals sent letters hard-copy and 247 hard-copy submissions were received. They were analysed manually, adopting the same principles for analysis as explained below.

Analysis

The data from all feedback sources have been analysed, but due to the considerable amount of feedback and timeframe for reporting to the Boards, this report contains key results only. The data can be analysed in more depth should the DHBs require (see 'Further information' section below). Once the amount of feedback to be analysed was clear, additional staff were brought in to help; even so, more work can be done.

Comment, qualitative data

The survey responses were organised and coded on Excel spreadsheets. The analyst reviewed the topic(s) each respondent raised in reply to each question and gave the response a suitable label (code). This highlighted the similarities and differences of response within, and between, respondent groups in response to each question. The workshop reports, emails and stakeholder letters were coded in the same way.

In some sections of the report, we highlighted feedback from certain stakeholder groups according to the nature of the proposal being addressed. For instance, where the proposal addressed clinical practice (for example, putting initiatives in place to encourage the right test to be requested at the right time and the associated clinical practices) the feedback from health professionals and the medical colleges has been given more emphasis than the feedback from service users. And where a proposal addressed the provision of laboratory services to patients (for example, the location of collection centres and their opening times) the feedback from service users was given comparatively more emphasis than the feedback from health professionals and lab workers.

Numerical, quantitative data

The fixed-response questions give a 'summary' or 'overview' and comparison of the respondents' views.

The closed-ended questions have been analysed using SPSS (Statistical Package for the Social Sciences). All missing data has been excluded from the analysis. As respondents were able to select the questions that they wished to answer, there is considerable variation in the number that have answered each question, hence the total number of respondents has been reported in each table.

Several categories of the data, such as the number of times respondents had used the laboratory services in the past year, were grouped or recoded to allow comparisons between low-frequency and high-frequency users to be explored. We have reported only results that are reliable at or above the 95% confidence level. The only ethnic group with a sample size large enough to give statistically significant results was NZ European therefore no results by ethnicity have been reported.

Note that as some questions allowed for more than one response, percentages may not add up to 100 percent.

Results from the panel and website have been reported separately using frequency tables. Cross tabulations (two and three-way tables) were used to enable trends to be explored in more depth and those differences that are statistically significant ($p < .05$) have been reported.

The questions were cross-tabulated by:

- Whether they are health professionals, laboratory workers or members of the general public
- Whether they have not used labs services or only used them once in the past 12 months or whether they have used them twice or more
- The DHB area in which the respondent lives
- Whether respondents were health professionals, people involved in the delivery of laboratory services or member of the public
- Ethnicity.

Further information

As noted above, there was a large amount of data collected during this consultation process. More in-depth analyses of the feedback received about each of the proposals are possible, should this be required.

For instance, we could further examine:

1. The degree of support for the proposals and level of satisfaction with laboratory services by respondent group (such as health professionals, high frequency service users, age group etc)
2. The service needs of different population groups, including but not limited to, laboratory services
3. What the public feel the role of the DHB should be and how it should operate in an environment where both public and private/commercial interests are at stake

An in-depth examination of each of point 1 and 2 could help establish appropriate community laboratory service requirements and standards.

An examination of point 3 would provide the DHBs with a greater understanding of the stakeholders' and public's response to the proposals and RFP and consultation process.

Each of these analyses could be undertaken within one month (three months for all), and could be largely conducted in-house but would require additional resource.

Structure of the Report

The report has been structured to ensure that it can be read at a number of levels. In addition to the executive summary, each chapter contains a summary, background about the issue, an overview of the quantitative results, and an explanation of the open-ended feedback themes.

Summary

The summary contains an overview of the background, the on-line survey results and the main themes and issues raised by those making submissions. It also contains a boxed section highlighting the main points the ARDHBs may wish to take into account when considering the issues. It can be used by those who would like a brief overview of the material contained in the chapter.

Background

The background section provides a brief discussion about each issue, the ARDHBs position on the issue, where appropriate, and key points from the information sheets and

consultation material that was distributed. It also raises key questions the ARDHBs wanted to seek feedback on.

Quantitative results

This section highlights results from the on-line survey (closed questions only) and explores some of the differences between groups, such as the general public, those working in medical occupations and laboratory services, and between the DHBs.

Feedback Themes

These sections report on the feedback from the on-line survey (open-ended questions), submissions, meetings, workshops, focus groups and emails. In general, the sections define or describe themes and use verbatim quotes to illustrate the themes.

It is noted that quotes have been used extensively in the reports. This is to ensure that the voices of those that provided feedback are well represented and that the mood and tone of the feedback are more readily captured.

4. Paying for Laboratory tests

Summary

Currently, community laboratory tests that are requested by medical practitioners working in private practice are publicly funded. The ARDHBs are considering whether private patients (or their insurers) should pay for their laboratory tests.

This proposal received more comment from stakeholders and the public than any other topic put to the respondents for feedback. Most of the comment was in adamant opposition to the removal of public funding for private patients.

There were considerable and significant differences between the views of panel members and website respondents as to whether private patients, or their insurers, should pay for lab tests. Over half (52%) of panel respondents agreed that some form of payment, either payment for some tests, a contribution towards costs, or full payment, should be required, whereas only 11% of website survey respondents supported this proposal. The majority of website respondents (86.0%) opposed payment.

Eight thousand emails were received arguing that all tests should be publicly funded. Nearly all of these emails drew on the following statement prepared by Southern Cross Healthcare:

I strongly oppose the move to charge patients privately referred by specialists for lab tests. Private patients that take responsibility for their health care will pay twice under this policy. Privately insured people are tax payers too and should be treated fairly.

The respondents who opposed the proposal considered it to be in both the DHBs' and public's interest to make laboratory tests uniformly accessible. To do otherwise, they contended, would create barriers to care which would have negative health and economic outcomes.

Similarly, the large majority of medical colleges and associations argued that all tests should be publicly funded, regardless of whether they were requested publicly or privately. They believe:

- Removing this funding will increase barriers to care, especially for those less well off or with chronic health needs;
- Waiting lists in the public sector may grow;
- Private funding will complicate the relationship between the public and private health sectors;
- People with health insurance already contribute to their health care through their taxes;
- There is little evidence to suggest that the anticipated savings will eventuate.

The respondents opposed to the proposal raised economic, clinical and ethical concerns with regard to the DHBs' continued ability to spend wisely, provide quality health care to all, and maintain a positive working relationship with the private health sector if this proposal was to be introduced.

Those who supported the idea of private payment for laboratory tests (at least in part, or for some tests) felt that it would encourage efficiency in the sector, require people to take personal responsibility for their health, and discourage tests that have little or no health benefit.

Recommendation

We recommend that, when considering whether private patients (or their insurers) should pay for their laboratory tests, the ARDHBs note that:

- Just over half of panel respondents agree that some form of payment should be required, whereas only 11% of website survey respondents supported this proposal.
- many strong, and extensively-argued, messages were received from a wide array of respondents, including the privately insured, medical associations and professional bodies, who felt that any such charges should not be introduced. A few respondents indicated they would take action should the DHBs adopt this proposal.
- The respondents opposed to the proposal raised economic, clinical and ethical concerns with regard to the DHBs' continued ability to spend wisely, provide quality health care to all, and maintain a positive working relationship with the private health sector should they introduce this proposal.
- Those in favour of introducing private charges, either across the board or only for some tests, see it as an effective way of encouraging efficiency. They believe the public will benefit from more purposefully-targeted expenditure.

Background

Patients in Auckland do not pay any charges for community laboratory tests. Currently, whether people go to a doctor, specialist or midwife, laboratory tests are free. In some areas of New Zealand people seeing a specialist doctor in private practice either have to pay themselves or get their health insurance to pay.

The cost of each laboratory test is different. Costs range from several dollars to hundreds of dollars. As a result we are not able to provide accurate information on what costs consumers would face if the public funding of tests requested by private specialists was removed. The costs would be set by the laboratory provider. Recent experience in Wellington, where public funding has been removed, indicates an average cost of \$16.51 for each test requested.

If the ARDHBs were to introduce this in Auckland, around 8% of tests would be paid for privately and the ARDHBs could save up to \$5 million. This \$5 million could then be used to pay the increasing demand for community laboratory services or to pay for other health services.

The ARDHBs asked whether private patients (or their insurers) should pay for laboratory tests.

Quantitative results⁴

There were considerable and significant differences between the views of panel members and website respondents as to whether private patients, or their insurers, should pay for lab tests.

More than half (52%) of panel respondents agreed that some form of payment should be required (table 1), whereas only 11.9% of website survey respondents supported this proposal (table 2). The majority of website respondents (86.0%) opposed private payment.

Those panel respondents who had used collection centres twice or more in the past 12 months were more likely to oppose payment than those who had used the centres once or not at all (table 1).

Amongst panel survey respondents who felt private patients or their insurers should pay for their tests, there was considerably more support for either a contribution towards costs or keeping some tests free than there was for private patients paying in full.

Table 1: Should private patients (or their insurers) pay for their tests, panel

<i>Panel survey respondents</i>	<i>Yes -</i>	<i>Yes - but some tests should remain free</i>	<i>Yes - they should pay part of the cost</i>	<i>Not sure</i>	<i>No</i>	<i>Number</i>
<i>(Note that many of the respondents are in more than one category).</i>	%	%	%	%	%	n
Used collection centres once or not at all in last 12 months	8.1	28.7	19.9	9.3	34.0	397
Used collection centres twice or more in last 12 months	9.9	23.7	15.2	10.3	40.0	893
Total Panel respondents	9.6	25.9	16.5	10.0	38.1	1,485

Table 2: Should private patients (or their insurers) pay for their tests, Website respondents

<i>Website survey respondents</i>	<i>Yes -</i>	<i>Yes - but some tests should remain free</i>	<i>Yes - they should pay part of the cost</i>	<i>Not sure</i>	<i>No</i>	<i>Number</i>
<i>(Note that many of the respondents are in more than one category).</i>	%	%	%	%	%	n
Total Website respondents	2.5	5.9	3.5	2.0	86.0	2,171

⁴ Note that differences between DHBs are not statistically significant. Differences between involvement in health amongst panel respondents (i.e. whether the respondents are members of the public, health care professionals or those involved in the provision of laboratory services) are not statistically significant, nor are differences between website respondents who have used collection sections once or not at all in the last 12 months, and twice or more in the last 12 months.

Feedback themes

All tests should be publicly funded

As noted above, most survey respondents felt that all laboratory tests should be publicly funded, at least in part. In addition, there were more than over eight thousand emails (n= 8,019) in opposition to the introduction of private charges. These were received following notices prepared by Southern Cross Healthcare for circulation by newspaper and email. The notices encouraged people to let the DHBs know they were opposed to private charges. The vast majority of emails received repeated verbatim or built upon this message:

I strongly oppose the move to charge patients privately referred by specialists for lab tests. Private patients that take responsibility for their health care will pay twice under this policy. Privately insured people are tax payers too and should be treated fairly.

Many of those who built upon this message expressed strong views against the proposal:

Whoever thought up this idea?? IT IS MOST UNFAIR. My husband is 78 and I am 73 and we struggle to pay the premiums for our private health care, but we still choose to be responsible for this and thus be less of a drain on the national health system. BUT TO ALSO BE EXPECTED TO PAY FOR ANY LAB TESTS WE MIGHT NEED IS VERY UNFAIR. We have to live on our pension and would probably not be able to afford these extra charges and therefore could be risking our health by not having any tests done. We strongly oppose the move to charge patients privately referred by specialists for lab tests. (received by email)

Two email submitters noted that they intend to take further action should the DHBs proceed with this proposal:

Privately insured people are tax payers too and should be treated fairly. I believe this is a human rights issue and will take it to the Commission if this policy is introduced. (email 6011)

I see this as blatant discrimination based on my income and will look to take legal action against the members of the Council who support this in the event this proceeds and I will go well beyond the call of duty to ensure they are held individually accountable for their decisions. (email 4779)

There was also widespread dissatisfaction among survey respondents, including panel members, who felt that by paying private charges for laboratory tests, private patients would be charged twice for their care, whereas those without health care insurance would be paying once. A little over 500 survey respondents commented on this and most of the stakeholder organisations were similarly dissatisfied with this proposal.

... we pay taxes for healthcare - why should we have to pay twice - once in our taxes and again to the healthcare insurer. I feel very strongly that the government should pay for tests. (Panel member)

The large majority of medical colleges and associations that responded also argued that all tests should be publicly funded, regardless of whether they were requested publicly or privately. This stakeholder, for example, submitted that:

The College strongly supports using public health funding for laboratory tests for all patients regardless of whether they are in the public or private health system. Specifically (the College) considers that charging private patients for their tests:

- *Is out of step with the Primary Health Care Strategy which is focused on improving access to services by reducing fees*
- *Creates a barrier to care*
- *Is unfair, as it charges one set of patients*
- *Will increase pressure on the public system*
- *Disregards the complexities of the public/private interface*
- *May result in insurance premium increases*
- *Will produce inequities between regions. (received by letter)*

It was felt that people seeking private care were already subsidising the DHB and should not be further penalised, charged or discouraged from seeking health care in the private sector.

Some people seek private care because of 'waiting lists'. They should not be penalised for saving the DHBs time and money. (public survey respondent)

Furthermore, some medical professionals and organisations considered that specialists were already saving the DHBs money as the tests that they ordered were more likely to be cost efficient and justified.

... when reflecting upon my personal circumstances (ex NZ Navy), injured whilst serving in a conflict zone, afflicted with radiation related health problems for years – you name it I've had it – and with a partner who has given over forty years of her life to nursing (RNZN) and is no suffering health problems you don't want to know about – we would like to think we are going to be fairly treated in our old age. Unfortunately, this latest initiative of yours doesn't inspire much confidence. (received by letter)

Because the tests are ordered by specialists rather than by more junior or inexperienced staff, the testing is more likely to be more appropriate than if the tests were ordered by junior staff in the public system. (received by letter)

Often specialists are much better at ordering justified tests. (public survey respondent)

All patients should be allowed right of access to specialists because with some difficult cases, the general practitioners cannot cope with the

complexity of the investigation and, accordingly, order an excessive number of blood tests, which may have no relevance at all to the actual problem. It would then be expected that the patient would have to pay for further blood tests, even though excess dollars had been spent by the general practitioner in investigating the problem. It should be remembered that specialists are experts in their field and are therefore more discriminatory with regards to blood tests, and hence provide more cost-efficient investigations, which ultimately benefits the patients in terms of having their problems treated. (received by letter)

The proposal to make private patients pay for lab tests was seen by many to be “unjust”, “discriminatory” and/or “inequitable”:

all NZs pay tax people with private insurance pay double it will unjust to make them pay even higher if you withdraw service to them (panel respondent)

Why put insurers on there? It can only be the patients that pay - The insurers will simply raise their fees - I find this whole thing REALLY inequitable (public survey respondent)

the question is discriminatory - all taxpayers have already paid for their healthcare costs - the dnb is saving already, so pay the lab costs and be grateful for the savings achieved in not providing the medical care! (public survey respondent)

The equity issues apparent to patients with exactly the same conditions but dependent upon the decision made by the referring or receiving specialist render this proposed policy change unworkable and inequitable. (public survey respondent)

Affordability of charges for tests

More than 100 of those that support the introduction of charges felt that people who seek private health care, or have private health insurance, are wealthy and can afford to pay for their tests.

Anyone who pays into health insurance can afford to pay for tests and collect back from their insurance co. (panel member)

However, a few stakeholders and many survey respondents noted that people who seek private care are not necessarily wealthy; instead, they seek private care for a wide variety of reasons, such as being in a position where they are unable to wait for treatment or cannot source the required expertise in the public sector.

... about half of all patients who are referred from general practice are self-funding as they carry no health insurance, either because of choice, non-affordability, or ineligibility ... (received by letter)

... My 7 month old daughter has recently been diagnosed with multiple food allergies and is at risk of a severe reaction. This diagnosis was reached following RAST tests referred by our GP (so the tests were publicly funded). She has been referred to see a paediatrician at Wellington Hospital, but the hospital has advised that there is a 7 month waiting list, so my daughter will not get to see the specialist until April 2009. This wait is intolerable when we are worried about what else she may be allergic to, worried about how to avoid an anaphylactic reaction ... Therefore, we have decided to see the specialist privately. ... We pay our taxes and have made very few demands on the public health system, yet the public health system is failing our daughter and the delay in getting treatment is potentially putting her life at risk. It is grossly unfair that we personally will also have to meet the full costs of any tests ordered by the specialist. I do not want to see any other people (Auckland patients or other regions) put in this position. (public survey respondent)

There was also concern that introducing charges would deter people from having the screening, diagnostic and monitoring tests that they required.

... let the government pay for it. It may otherwise lead to low-(socio) economic groups not going for tests. (panel survey respondent)

A concern common to many stakeholders, and one noted by more than 200 survey respondents, was that introducing charges would create a barrier to care, particularly for those who cannot afford to pay for tests. This was seen to most likely lead to a decrease in the number of precautionary, monitoring and screening tests undertaken, which would in turn lead to more serious health problems that require more expensive care, or develop into conditions that are no longer curable, or at worst are and/or fatal.

I am a Psychiatrist in Private Practice, and have a number of patients who are very vulnerable and who do not have significant financial resources; and who ... would find it much more difficult to get access to blood tests that they need for medications I prescribe... It would be very difficult to treat such patients and make certain that the medications are not causing side-effects for them unless regular blood monitoring can be done ... It would be very complicated and potentially unsafe for them not to have access to regular blood tests. (received by letter)

Ophthalmology is in fact a primary care service in that patients generally come directly from the community rather than being referred through a general practitioner. Patients who visit ophthalmologists reflect the makeup of the community at large; they are not necessarily rich or have private health insurance. ... ophthalmologists often treat skin cancer ... We are deeply concerned that if patients are now required to pay a significant amount for the laboratory tests required, the further cost may lead to them deciding either to not have the analysis done, risking potentially fatal consequences, or to shift to the public system which at present is not coping with the skin cancer load. (received by letter)

if fees are charged those who can least afford to see a doctor will refrain from doing so, I suspect that the number of people needing medical treatment is proportionately greater among those in the lower socio-economic part of society than among those who are more easily able to afford to pay, but it would be disproportionately expensive & difficult to apply means testing to the provision of medical services (and politically suicidal). (public survey respondent)

More than 50 survey respondents and some public workshop attendees felt that introducing charges for private patients would not necessarily make economic sense, as tests can be critical to formulating appropriate early, less-expensive interventions.

... tests are for the overall long term health of the patient and help determine the most cost-effective treatment therefore they should be free to all. (panel survey respondent)

[If adopted, this proposal] may result in “inappropriate” savings – people’s health may suffer because of it. (WDHB public meeting)

Literally thousands of respondents questioned the implications this proposal has for health insurance. They doubted that health insurance premiums would remain at the current level and predicted reduced affordability, and hence coverage, leading to further drain on the public system and/or poorer health outcomes.

I have worked all my adult life and the only thing I have had is the pension at the end of it. I now struggle to pay my medical insurance so I can have the treatment I need when I need it. Should I be charged for all my lab tests I would have to give up my insurance and would be another drain on the health system which is unable to cope now and I am sure I won’t be the only one. (received by email)

the insurance companies are currently not covering for the laboratory fees whether gp or specialist. the lab fees can be very expensive. it will not be covered by insurance or the insurance companies will have to markedly increase their premiums. in this case, patient will ended up:1. raising dbt to pay for the fees, 2. do not seek earlier treatment and go back to the public system. you need to know that at the end of the day, the population will get sicker and the public will get burdened and the patient will be more sick. this is false economy. you 'save' a bite in lab fees, but you will have to pay dearly in the public. at the end of the day, the dhb will have to get more money from the government who then can turn around and says that you have manage the money wrongly. (public survey respondent)

A respondent questioned the assumption that insurance companies would pick up the charges for laboratory tests.

That insurers will continue to pay for lab tests is uncertain, and if they do continue to pay, premiums will increase leading to a reduction in the number of people who can afford medical insurance (received by letter)

Tests should be privately funded

Of those who felt that private patients, or their insurers, should pay for test, some supported payment for tests because they felt that it would encourage efficiency.

[I] would be happy to part of the cost to ensure system is not overused unnecessarily (panel survey respondent)

... if tests had to be paid for, there might be a tendency to do only the essential tests, saving on costs and thus making other services available ... (panel survey respondent)

If you are seeing a specialist and getting it paid by your insurance company, I don't see why laboratory tests could not be included. This would require the insurance companies to include them in their schedule. When going private, you pay for all your other services including dressings, etc. so why should lab. tests be different. (public survey respondent)

It was suggested that patients 'jump the queue' by accessing private care and should therefore pay the costs associated with doing so.

... if you are escalated through the healthcare system because you pay a premium for health insurance you should also pay for the same escalation through testing. (panel survey respondent)

Among those who supported this proposal, there were some who felt that a limited introduction of private charges would be most appropriate, in the interests of not limiting access to care.

if you go private you are intending to bump yourself up the priority list for healthcare and to get a better level of service and expertise - and you are making this happen by paying for it because you have the \$\$\$\$. ... if you are willing to do this, i think you can also pay for your tests. ...it would be a terrible thing if we went the way of America where people are turned away because of inability to pay. (panel survey respondent)

A stakeholder considered this proposal to be positive if savings could be redirected toward addressing the needs of Maori and high-needs patients.

There has to be a re-focus and emphasis on addressing the gap in equity for Maori and high-needs patients, and if by making private patients or their insurers pay for laboratory tests this frees up money ... for this to happen. (received by letter)

Subsidise some private tests

There was support from 5.9% of website survey respondents (5.9%) and one-in-four panel respondents (25.9%) for private sector patients paying for some lab tests.

Although they are going private, they should still have at least some subsidy because they are taking pressure off the public health system. (panel survey respondent)

Some payment should be made to discourage abuse of services. Therefore a subsidised service is most appropriate. (panel survey respondent)

If you make the tests affordable for everyone then everyone should pay something ... (panel survey respondent)

Several survey respondents and stakeholder organisations suggested a schedule of tests could be introduced.

Schedule a set of publicly-funded tests that everyone is entitled to, such as tests expected as part of best-practice, regardless of whether or not the test is ordered by a public provider. (received by letter)

Most 'normal' tests should be publicly funded ... (public survey respondent)

Those who identified types of tests unsuitable for public funding often singled out tests associated with elective procedures and cosmetic surgery.

I would have ethical problems with someone who for example had elected to have unnecessary cosmetic surgery having free tests but in all other situations i think there should be no charge for this service... (panel survey respondent)

In addition, it was often suggested that tests requested by the patient and/or deemed unnecessary, should be paid for by the patient.

Any blood tests requested by patient but not deemed necessary by doctor should be paid for by patient. Any tests requested by insurance companies or for residency applications etc should be paid by [patient]. (public survey respondent)

Subsidise some patient groups

A little over 30 respondents suggested that certain population groups should receive subsidised tests. Some of these respondents said:

Elderly and young children should be free, also including some people on the benefits (panel survey respondent)

Others suggested that tests for those who are least able to afford them should be either subsidised or paid in full.

... those who can afford to pay for their tests should, but there should be a service like the community services card that enables lower income patients to access the same healthcare services as the wealthy ... (panel survey respondent)

There was concern that those not entitled to free tests are currently accessing free services, as they are unidentifiable from the forms.

New immigrants are heavy users of the lab services but many are not eligible for free tests. How do we get GPs to identify these people? An identifier should be on the form (ADHB public meeting)

if people are not entitled to free tests they shouldn't get NHI numbers (WDHB public meeting)

Patient load shifting to the public sector

Almost 130 survey respondents and many stakeholders warned that because private care would become more expensive to the patient, the costs may shift back to the DHBs.

The service of our group would be severely compromised ... The DHB will then have a new flow of consultation costs, as well as the laboratory costs associated with them, and increased waiting lists. (received by letter)

At present a large number of patients pay for private health insurance and utilise their policies to seek both consultation and endoscopy in the private sector. If such patients are expected to pay for their laboratory investigations as well, I predict that many (even most) are likely to elect not to be investigated are treated privately, and instead come on to the public waiting lists. At [an Auckland] DHB we are already struggling to keep up with the demand for endoscopy in particular, and waiting lists are growing. I do not think we are in a position to cope with the extra workload that would inevitably come our way ... (received by letter)

We are deeply concerned that if patients are now required to pay a significant amount for the laboratory tests required, the further cost may lead them to decide either to not to have the analysis done, risking potentially fatal consequences subsequently, or to shift to the public system which at present is not coping with the skin cancer load (received by letter)

If the proposed changes are introduced, there will be:

- *A drop off in laboratory tests undertaken as a number of people find they can no longer afford such tests to be undertaken privately.*

- *An increase in pressure on public hospital waiting lists.*
- *A decrease in private specialist treatment activities including surgery which will not be able to be compensated by the public system with a consequent drop in the quality of life and increased suffering for those affected. (received by letter)*

Regional variation, experience and central government policy

Several hundred survey respondents, in particular health professionals and those representing organisations and medical associations, and a few stakeholder organisations, believed that there should be a nationally-consistent approach.

[the stakeholder] strongly opposes the proposal to withdraw DHB funding for privately referred laboratory tests ... It asks that the ARDHBs retain the status quo until nationally consistent options have been developed. (received by letter)

This issue of who should pay for lab tests requested by private specialists should be decided upon nationally with the same outcome for all DHBs in the country. (public survey respondent)

What ever happens regarding the public/private split it needs to be a nationally consistent approach. (ADHB public meeting)

With a change of central government, several stakeholders and respondents are expecting a concomitant change of policy direction.

HFANZ suggests the DHBs give serious consideration to the implications of the change in Government, in particular the National Party's pledge to impose a moratorium on DHBs withdrawing funding. (HFANZ)

Many of these respondents expressed concern that regional variation would lead to inequitable access to services.

Wellington and Hutt Valley DHBs have not funded privately requested lab tests for 12 months which has seen the costs to patients accessing private sector rise significantly. This proposal would contribute to regional variation in practice, contrary to the MoH ambition of equality and equity. (received by letter)

It has been [the stakeholder's] long standing position that policy of this type which affects the population as a whole needs to be established at a national level by central government [so that] "post code" access to key services can be avoided. (received by letter)

A stakeholder felt that the introduction of this proposal in Wellington had not worked well, and that the ARDHBs needed to take note of this and reject the proposal.

The proposal does not demonstrate learning from the evidenced opposition to both the Southland and Wellington experience ... [the stakeholder'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. Implementation in the Auckland region by DHBs can be expected to lead to:

- *The imposition of \$2-3 in costs to patients for every \$1 saved from 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*
- *At least an extra \$5 million per annum in patient charges paid by Auckland patients referred by specialists for laboratory tests*
- *Charges averaging \$42 per patient visit, up to \$2000 for some testing (received by letter)*

In contrast to the above, another respondent contends that as yet there is not adequate data about the Wellington and Hutt Valley initiative to be sure that the ARDHB's proposal will improve health services. Nevertheless, they suggest that introducing private charges for laboratory tests may lead to poor outcomes:

We are aware of a review that was commissioned by Capital Coast following the introduction of a similar initiative in recent time. Our opinion, from reviewing that document, is that there is inadequate information to draw conclusions that this does not have a negative impact upon services (received by letter).

Administering accountability, payment and entitlement

More than 100 respondents noted that introducing these charges would require careful management of patient's demands, test referral and follow-up.

... patients may pressure specialists to reroute laboratory tests through their general practitioner. This in turn may lead to increased pressure on General practitioners and confusion as to responsibility where a General practitioner orders and receives an abnormal test on the "recommendation" of the specialist. (NZMA)

Indeed, this survey respondent said

I would make sure my GP ordered tests or I would seek public hospital care rather than private treatment. (public survey respondent)

Questioning what would happen when a practitioner was managing the care of patients for the same condition in different sectors, a survey respondent said

if a patient would receive the same test free via a dhb, it should be free in private. charging outside this parameter will lead to ... more paperwork for dhb clinicians who will be asked by gps/private specialists to 'arrange tests' as the patient cannot/will not pay. (public survey respondent)

Around 30 respondents questioned the proposal's efficiency on the basis that administering the entitlement and payment system could be too complicated and expensive.

all this does is create another layer of bureaucracy. a system has to be developed to manage the accountancy system required to manage this process - staff will need to be employed databases developed etc ... there will be increased costs for insurance companies as they need to modify their systems and the policy costs will increase for the consumer. (public survey respondent)

... it costs to collect money, a good example of this is when another ridiculous 'money saving' venture was imposed on the NZ public - Crown Health Enterprises - who attempted to charge, those who could afford to pay, for their public hospital out-patient clinic visits. This was an unmitigated disaster costing more to manage than the monies collected (public survey respondent)

And this respondent, among around 20 others, questioned how a patient's care could be managed should they refuse to pay for a test:

what will happen with people who refuse/are unable to pay. will they be refused further tests, in the future, then maybe what will happen will they will get really sick and end up in secondary services - which is exceedingly expensive to run. (public survey respondent)

5. Attracting and Retaining a Pathology and Laboratory Workforce

Summary

There is a worldwide shortage of pathologists and the real level of pathologists in New Zealand is declining. The ARDHBs have asked for feedback on how to attract and retain a pathology and laboratory workforce. Specifically, the ARDHBs has requested feedback on:

- How the ARDHBs can retain and attract pathologists to the Auckland region, and
- What issues are facing the laboratory scientist and technician workforce?

A considerable amount of feedback was received from health care professionals (n = 442), people involved in the delivery of laboratory services (n = 110), and in meetings. This issue generated considerable anger, and the feedback, particularly in meetings, was heated.

Overall, there was strong and clear feedback that workforce morale is currently low and that there are a range of issues to be addressed to attract and retain a pathology and laboratory workforce.

Skilled pathologists and laboratory workers are internationally mobile and can secure higher wages overseas. Respondents noted that while it is difficult for New Zealand to compete on wages, we can compete on lifestyle and environment. Aside from pay, the working environment, opportunities for private practice, professional development and the ability to influence management and policy decisions, reputation of prospective employers, the quality of laboratory services and collegiality are all considered when the workforce considers for whom they would like to work.

Many of the respondents felt that the uncertainty caused by the tender process had made laboratory medicine in New Zealand less attractive and therefore asked that the employment matters and the laboratory contract be settled promptly. Respondents noted DML's ability to attract quality workers and many questioned whether Lab Tests would be equally attractive to highly skilled pathologists and technicians.

Securing our workforce was considered an urgent matter as it was noted that Australia offers more attractive pay and conditions and is actively recruiting New Zealand workers. Some respondents observed that there is an opportunity to raise the profile of pathology and laboratory medicine in medical school. Others suggested that more could be done to ease the path of immigrant workers into the pathology and laboratory workforce.

Recommendation

When the Boards consider how to retain and attract a pathology and laboratory workforce, we recommend they note that: a strong message was delivered that workforce morale is low; and the region's ability to attract and retain staff will be compromised unless the factors contributing to it are rectified. These include provision of stability in the sector; wages comparable to those offered elsewhere; opportunities for private practice, research and career development; workforce input into management decisions and policy direction, and reputable employers.

Background

A report by the Royal College of Pathologists Australia suggests that there is a worldwide shortage of pathologists. The New Zealand Committee of Pathologists also states that the real level of pathologists in New Zealand has declined by 7% over the last five years. The ARDHBs have asked for feedback on how to attract and retain a pathology and laboratory workforce.

The ARDHBs are also interested in finding out more about the laboratory workforce of scientists and technicians who run the testing within the laboratory and the issues facing this workforce.

Specifically, the ARDHBs has requested feedback on:

- How the ARDHBs can retain and attract pathologists to the Auckland region, and
- What the issues are facing the laboratory scientist and technician workforce?

Feedback themes

The global setting

More than 40 survey respondents and many stakeholders observed that the Auckland region's pathologists and laboratory technicians operate within a global environment, which has implications for recruitment and retention.

The laboratory workforce is relatively mobile with pay being higher in many competing OECD countries. Reputation, quality and collegiality are all important factors when professionals choose their workplace. The uncertainty caused by the tendering process has increased unattractiveness of laboratory medicine in New Zealand for some pathologists and scientists. (stakeholder letter)

Opportunities for employment in Australia are not only available but are very attractive including opportunities to practice on one's own account. Making New Zealand an attractive place for pathology workers is paramount. To retain key personnel in New Zealand the contract structure must allow professionals to establish their own business where practical. (stakeholder letter)

The local setting

A stakeholder highlighted workforce morale and training and development opportunities as key workforce issues with not only local but national implications.

The Auckland region plays a strategic role in the provision of training and ongoing development of the pathology workforce for the whole of New Zealand.

Numerous risks exist to the future quality, viability and sustainability of community laboratory services in Auckland depending on the manner and skill in which the tendering process proceeds and the outcomes are implemented. These risks include the further undermining of:

- *Workforce morale and security*
- *Training and development capability and sustainability; and*
- *The exacerbation of existing Auckland region and New Zealand wide workforce recruitment and retention challenges. (stakeholder letter)*

It was noted that this dissatisfaction and uncertainty was occurring at a time when overseas operations were vigorously recruiting New Zealand workers.

You will be lucky if anybody stays and doesn't leave for Australia. Look at Sth Australia's search for workers here that is happening at the moment. More \$ as well. (public survey respondent)

Attract school leavers and graduates

Almost all the respondents considered the recruitment and retention of both pathologists and laboratory workers to be problematic.

Recruitment is a serious problem. Every year only a handful of people qualify. Of 3 or 4 graduates we may get 1 or 2. This instability [the regional laboratory service tendering process] is not helping as they do not know if this lab service will exist in a few years time. We are not in position to compete on terms and conditions with other countries. We can compete on lifestyle and environment – and the ability to be part of a world-class service with a great reputation but this instability is driving them away. (ADHB Public meeting)

Some respondents offered solutions to the recruitment and retention problem. It was suggested that pathology is actively promoted as a career opportunity.

Promote pathology to medical graduates as a medical career, it has certain appeals (eg less on call after hours load) and is overlooked by many graduates (public survey respondent)

Find out what puts the students off from training and becoming a Pathologist. Does anyone go out to the schools to enthuse the students on this career? I have never heard anything in the schools I've been associated with. (public survey respondent)

It was suggested that student loan incentives should be offered to encourage people into the workforce

Government support. Student loan write-offs if they remain working in the Auckland region for a certain amount of time. (panel survey respondent)

If they stay in NZ for 8 years after their training wipe their student debt, which means they don't pay a cent. if they leave NZ to work they have to pay it back (panel survey respondent)

Immigrant workforce

Several respondents suggested making practicing in New Zealand more accessible to the overseas workforce.

Encourage the people who have experience and coming from outside out the country. (panel survey respondent)

get some immigrating to do it, especially once they come over to NZ as doctors. [Currently some] can not work as doctors because they need to study again. [Allow] them to do both at the same time like NHS in the UK. (panel survey respondent)

Remuneration and incentives

A large majority of the laboratory workers who responded to the survey expressed dissatisfaction with their pay and conditions, and felt that the uncertainty that they felt only exacerbated these feelings.

very low pay... many left for better wages overseas or are unsatisfied with their position ... (public survey respondent)

The lab workforce is aging and it's already hard to recruit QUALITY staff. Wages are now low relative to the training required so any reduction in quality of the environment will further exacerbate the problem. Many of the new graduates go overseas ... (public survey respondent)

Higher salaries or wages were usually seen as the trump solution most likely to appeal to pathologists. Many respondents noted that local wages are not as high as they could be and not as high as those earned offshore.

Give them decent and comparable salaries with overseas (panel survey respondent)

Conditions of employment other than wages

More than 140 respondents who identified as health professionals or as involved in the laboratory sector, noted that conditions of employment, other than wages and incentives, need to be taken into account when considering how to attract and retain the workforce.

Several respondents raised laboratory infrastructure, the quality of its management, and workforce satisfaction, as factors that affect how attractive a laboratory is to a prospective employee.

Provide a highly skilled and organised laboratory from which they can work from and be happy to represent. Many pathologists do not wish to be responsible for a team of laboratory workers that are over worked and stressed by conditions in which they can make mistakes like a budget or understaffed lab, they would prefer to leave the country. (public survey respondent)

Some noted the need to have better research programmes and facilities for pathologists.

By having pathologists involved in public, private and university based activities, instead of the segregation that now exists. There needs to be a massive strengthening of University based Surgical Pathology with a focus on research in the most prevalent disease in our community and support and assistance with research projects by practicing Surgical Pathologists. (public survey respondent)

Offer equipment funding for ergonomic microscopes and labs etc. Include digital camera and software for better storage and retrieval of images. (public survey respondent)

And a dozen felt that there was insufficient career progression, for laboratory workers in particular.

They must not feel they are just a cog in some endless belt. They need to be recognised adequately and given time off, paid for up-skilling and doing peer approved research projects. (public survey respondent)

It strikes me as an industry with few career prospects. once a technician, always a technician - unless you can attain the giddy heights of senior technician after 10 years. (panel respondent)

The feedback, from and about pathologists in particular, suggests that they feel they do not get enough recognition and respect for their work in New Zealand, that they are undervalued, and are not properly consulted with.

You could offer financial incentives but if you show that you appreciate them, accord them some respect and stop managers from bullying them, you might

actually be able to stop losing them to private/Australia/elsewhere! (public survey respondent)

At the level of policy-making, pathologists feel that they are not being given due recognition

... the NZ Committee remains concerned that pathologists continue to be ignored when new relevant policy initiatives are established. ... the [stakeholder organisations] will continue to correspond with you and others, until the New Zealand health system effectively interacts with us to provide New Zealanders with a relevant, efficient sustainable and cost effective laboratory service. (stakeholder letter)

The labs tendering process

More than 110 survey respondents and some stakeholders who responded by letter felt that the impact on both the laboratory and pathology workforce had already been significant and that restoring a secure employment environment was a critical workforce issue.

The impact of the tendering process on the laboratory workforce in New Zealand particularly in Auckland has been significant. These impacts have included reduction in morale, and the loss of skilled workers, both medical scientists and pathologists. Many of our new Fellows are leaving for Australia and overseas, partly due to the uncertainties brought about by the recent tendering processes. (stakeholder letter)

I am a pathologist at DML and what you are doing now is the exactly what you should not be doing. Status quo with fine tuning would be a much better option. Long term uncertainty MUST be avoided. Pathologists are not just threatening to leave community (public survey respondent)

Do I have a job? There's no certainty or security of employment. Staff feel that redundancies and reemployment will corrupt the service (WDHB public meeting)

Certainly the long-term affects on the morale of the medical workforce (which is already under considerable strain) has not been properly considered. Most working in the private specialist health system have skills which are in demand in Australia and overseas. This change [the proposal to introduce private charges for lab services] would encourage them to go rather than remain where their skills are perceived not to be valued. (stakeholder letter)

... while it is understood that DHBs need to reduce their overheads, the constant targeting of laboratory funding as an area where the spend can be reduced is in turn threatening to ultimately undermine both quality and safety. Pathologists need to feel valued in the system and know that the contribution they make is understood. (stakeholder letter)

The uncertainty associated with replacing DML with a new provider was considered to be problematic, but avoidable by contracting more than one provider.

The problem with the recent RFP tendering process and decision to award the contract to an entirely new company was of course that it has destabilised the current pathology workforce who are uncertain whether they have a future position, what the terms and conditions would be and whether or not they wish to work for the new company. The effects of this process however could have been substantially ameliorated if the DHBs final decision allowed for more than one provider of laboratory services. (stakeholder letter)

Transition arrangements

There was widespread concern about the transition arrangements and how smoothly the transition will progress if there is a change in the provider.

A range of issues were foreseen by the respondents should DML be disestablished and Lab Tests deliver the region's community laboratory services. The primary issues pertained to the transition arrangements for staff, in particular the legal issues raised by the union, and the strong feelings expressed by some pathologists and DML staff that they had no desire to work for the other provider.

Was a practical thought given to the workforce issues if they don't want to work for the new provider? No security in this field of work if you keep changing the provider. I have not been convinced by Lab Tests that they provide quality so I would rather leave than work for them (ADHB Public meeting).

Retaining staff will be a challenge for the new provider. We need to retain staff, particularly the older, experienced staff (WDHB public meeting).

The future of the lab workforce at DML hangs in the balance. There are Pathologists at DML who on principle will not work for the new provider if Labtests are eventually successful, they will go elsewhere, i.e. out of NZ. (public survey respondent)

6. Location of Collection Centres

Summary

The ARDHBs noted that it appears some areas have too many collection centres and others not enough. The Boards suggested that reviewing where samples are collected would help identify how to make collecting samples more efficient, equitable and accessible, and noted the review could lead to the closure of some centres.

Respondents were asked whether they agreed that the location of collection centres needed to be reviewed. Just under half the panel respondents (45%) agreed that the location of collection centres need to be reviewed as compared to 39% of respondents from other the website (table 1). There was considerable regional variation, with more respondents from the CMDHB area than other areas, agreeing that locations need to be reviewed, than respondents from the other areas.

Those who think they should be reviewed, suggest the placement of collection centres could better reflect the local population's health needs, population density, places of work, GP clinics, pharmacies and public and private transport corridors. Whereas some respondents highlighted historical and current patterns, others noted the Auckland region's dynamism and suggested more attention should be paid to forecasting population densities, demographic characteristics, health needs and urban forms. Respondents noted that there needs to be particular measures in place to address the sample collection needs of the rural areas. They also noted a comparative lack of collection centres in the CMDHB area.

While only a small number of respondents identified that travel to a collection centre may pose a barrier to having a sample collected, many respondents called for longer hours at strategically-located centres to make collection centres more accessible for workers. Hence, much of the feedback about the collection centres hours and location was tied together – many respondents didn't see them as separate matters. Therefore, the feedback about collection centre hours and location should be considered together.

Recommendation

We recommend that the ARDHB's note that the current distribution of collection centres poses few barriers to having a sample taken. Nevertheless, 45% of panel respondents agreed that the location of collection centres needs to be reviewed as compared to 39% of respondents from other sources. Many thought there were either too many or they were not well spread out across the region. Some of those who were opposed to the review expressed concern that the number of centres may be reduced, which they tied to increasing barriers to care, especially for patients with limited mobility (who also tend to be the heaviest users of laboratory services). We also recommend that the Boards' note the range of factors impacting on the suitability of collection centres' locations, and the factors impacting on the centre's accessibility to fasters and workers in particular.

Background

The ARDHBs noted that it appears as if some areas have too many collection centres and others not enough. The Boards suggested that reviewing where samples are collected would identify how to make collecting samples more efficient, equitable and accessible. The DHBs noted that the review could lead to the closure of some centres.

The feedback about collection centres' hours were tied by many respondents to the centres' location. Therefore, the feedback about collection centre hours and location has been considered together.

Respondents were asked whether they agreed that the location of collection centres needed to be reviewed. Respondents could view a map showing the location of current collection centres within each city council area.

Quantitative results

Survey respondents were asked if they agreed that the collection centres locations should be reviewed. In posing this question, the DHBs noted that a review could lead to a reduction in the number of collection centres in some areas.

Just fewer than half the panel (45%) respondents agreed, compared to 39% of people who responded through the website (see tables 1 and 2). There were significant differences between the DHBs with both panel and website respondents from CMDHB more likely to agree that the locations need to be reviewed.

Table 1: Should the location of collection centres be reviewed – Panel respondents

<i>Panel survey respondents</i>	<i>Strongly disagree</i>	<i>Disagree</i>	<i>Neither</i>	<i>Agree</i>	<i>Strongly agree</i>	<i>Number</i>
	%	%	%	%	%	<i>n</i>
Used collection centres once or not at all in last 12 months	3.8	15.4	33.8	39.3	7.7	364
Used collection centres twice or more in last 12 months	8.0	19.7	28.0	38.1	6.1	863
WDHB	7.5	22.3	31.0	34.7	4.5	467
ADHB	6.8	18.6	27.5	42.3	4.7	338
CMDHB	5.0	14.3	30.2	39.7	10.8	398
Total Buzz Panel	6.5	17.8	30.2	38.3	7.1	1,500

Table 2: Should the location of collection centres be reviewed – Website respondents

<i>Website survey respondents</i>	<i>Strongly disagree</i>	<i>Disagree</i>	<i>Neither</i>	<i>Agree</i>	<i>Strongly agree</i>	<i>Number</i>
	%	%	%	%	%	<i>n</i>
Used collection centres once or not at all in last 12 months	12.4	26.4	21.5	36.4	3.3	121
Used collection centres twice or more in last 12 months	23.4	25.4	13.8	33.1	4.2	875
WDHB	25.6	31.3	13.5	25.9	3.7	355
ADHB	19.7	24.9	14.5	37.8	3.1	421
CMDHB	22.2	16.7	15.8	38.4	6.9	203
Total Website respondents	20.7	23.8	16.5	34.1	4.9	1,683

The survey respondents were also asked if there was anything that put them off or stopped them from having a sample taken. Around half of those surveyed indicated that there was nothing that they thought put people off having samples collected. Website respondents were more likely to feel this way than panel respondents.

For one in five respondents, the times that the collection centres were open and the waiting times for tests were factors that stopped or put people having tests.

Table 3: Factors stopping or putting people off having a sample taken

<i>Survey respondents</i>	<i>Panel</i>	<i>Website</i>
	%	%
Nothing	48.2	59.8
The collection centres are not open at the right time	20.7	20.3
The waiting times to get a test	20.4	17.7
Afraid of having blood taken	19.2	6.8
I cannot take time off from work	17.7	14.8
Too far to travel	5.2	8.5
A lack of public transport from home to the collection centre	5.2	6.8
Other	4.4	5.7

Feedback themes

Satisfied with status-quo

The respondents who were generally satisfied with the current distribution of collection centres, felt that the system currently worked well and therefore no review and/or changes were necessary.

The current system works...it is not broken so why change it by closing some collection centres? (panel survey respondent)

Some respondents noted that that they were satisfied with the current network of collection centres because they had collection centres close at hand, whether they were at work, at home, or at the doctor's.

... around my area is not a problem as collection areas are so accessible ... one is walking distance and one is accessible by bus so if in case the other one is not available in some point i could walk or take a bus. (panel survey respondent)

Whether I'm at work in Onehunga or at my doctors in Ponsonby or at home in Te Atatu south, there is a med lab close by. (panel survey respondent)

I find the current distribution in the eastern suburbs is near ideal with collection centres near to both my home and my place of work. as the tests i take often involve 12 hour fasting the ability to take the test locally and then return home to have breakfast is a real benefit. (public survey respondent)

A review, and some closures, have merit

As noted, just under half of the panel respondents and just over one-third of the website respondents agreed that a review had merit. Many noted that they were also comfortable with the possibility that this could lead to a reduction in the number of collection centres in some areas.

Several collection centres have already closed in my area and I have not had problems with this. If further centres need to be closed or moved that would be fine by me. (public survey respondent)

It is clear from comments made earlier, that some areas already have too many collection centres and others not enough. I would imagine from this information something could be done fairly swiftly regarding spreading out these locations without further ado. (panel survey respondent)

Many respondents noted the uneven distribution of centres, that some had too many and others not enough.

Auckland city (central) has way too many and some of them are so close to each other, north shore has a good even spread however southern Auckland ... just doesn't sound right!!! (public survey respondent)

More than 20 respondents explained that they were in favour of a review but not a reduction in the number of collection centres.

There should be more available if there aren't enough or if some people have to travel further than others (panel survey respondent)

I suspect a review will result in a reduction in the number of collection points would be detrimental to public service. If anything they could increase in the newer and less serviced area. (public survey respondent)

The DHBs and other organisations' role in the review

A few stakeholders questioned the extent to which the DHBs should be involved in making decisions about the network of collection centres.

The DHB has no need to start a micro-management process with a provider to dictate how many or the location of collection facilities. That is a process that can be managed by the laboratory and the PHOs. (received by letter)

One PHO said that they would want to be actively involved in the planning or any review.

[A stakeholder] requests that all considerations regarding the location and number of service rooms to be shared with us, not consultation, but active planning. The PHO may be able to offer a cost effective collection and transport service and some medical centres may wish to take samples. (received by letter)

“Principles” for a review

Some respondents expressed concern that business, rather than patients needs or clinical practice, would drive the review of collection centres.

Thank you gentlemen for coming to explain to that what you are doing is good business practice. My concern is the reduction of sample collection points. (WDHB public meeting)

We have 150 patient collects a day and about 6000 people. We're located in the CBD. [A Labtests representative] said we're not moving in to your area because you're not big enough. But our patients want to get 95% of their health care with us. He says there will be a peripheral depot for collection. That won't suit our patients. (ADHB public meeting)

Some respondents felt that if there was to be a review, the needs of service users needed to be kept as the primary driver.

Remember it is the sick and infirm who need these labs the most, and driving or getting to a lab when you are so unwell is a nightmare for many. (public survey respondent)

We would like to ensure that a review of collection operations should be “demand-focused”, ie what are patients and other healthcare providers looking for, rather than solely “supply-focused”. That is, what is costs the laboratory to run the collection point without regard to the alternatives available to patients. (received by letter)

At a stakeholder meeting the attendees felt that the principles that a review should be built upon:

- *An increased risk that tests will not get done*
- *High risk patients potentially disadvantaged due to reduced access*
- *More peripheral collections there are then more responsive the collection service will be*
- *Need to limit travel for patients. (ADHB public meeting)*

Barriers for patients

Many respondents, workshop participants, and stakeholders, felt that the review's outcome was as clear as writing on the wall - it would lead to an inadequate network of collection centres.

Labtests are going to cut collection centre numbers by half – we're not happy about this (WDHB public meeting)

Healthscope [Labtests parent company] said there will only be 43 collection centres versus 80. We need these collection centres. (ADHB public meeting)

Others pointed to negative clinical implications should patients encounter barriers to sample collection.

Proximity to patients is important. I know many people who would not be able to have regular blood collections done for their diseases if they were not near a laboratory. I also see the results of those who are too far away currently. Reducing the number of collection centres as was proposed by Bierre et al would make the situation far worse. Warfarin monitoring is one of the most critical in this area, and although the risk for stroke from Atrial Fibrillation, and the risk of clots from DVT is reduced when a patient is on warfarin, this is only while the patient is in the therapeutic range. Only 40% of patients stay in the therapeutic range, and this is mostly due to infrequent blood testing, because they can't get to labs. How many more people will suffer when you reduce both the collection centre numbers, and the direct house collection that LabPlus intended? (public survey respondent)

The more difficult it is to access rooms the greater the likelihood of patients delaying getting their tests performed or not getting tests done at all. It also creates particular problems for patients who need regular blood tests as part of ongoing disease monitoring if access is difficult ... Surely the important thing is that all patients have good access to collection facilities. (public survey respondent)

A more sparse distribution of clinics is expected to impact more on vulnerable populations:

There are too few collection centres now that so many have been closed to cut costs. Elderly, disabled, and people without easy transport or with dependants have problems getting to one. (public survey respondent)

I suffer from cranial arthritis and have done for about 9 years. As a consequence I have to have frequent blood tests. The lab in Hillsborough Rd is very convenient and the phlebotomists there (one of whom has worked there for many years) is very efficient and friendly. I do not want to have to travel further and wait longer. I am nearly 76. (received by letter)

Transport corridors

More than 360 respondents asked that collection centres be located along public and private transport corridors.

Should be located with easy access to public transport and parking. (public survey respondent)

At the moment I am temping across Auckland. I need blood tests every 12 weeks and it is brilliant that I never need to take time off work, because Diagnostic Medlab have collection centres everywhere. If there were fewer I would have to take unpaid leave to get my blood tests done which is unacceptable. I also have a friend who is almost 80 years old and can get to centres at the moment. It causes me concern that she would have to travel distances on public transport if centre numbers were reduced. (panel survey respondent)

A stakeholder wished that, “in particular, accessibility close to public transport and or adequate parking are considered a priority” (received by letter). Many survey respondents agreed:

There needs to be enough locations for it to be convenient for people - the elderly & families, people who use public transport - to get to easily. (public survey respondent)

A stakeholder suggested that there be more centres in locations where comparatively large numbers of people are reliant on public transport.

There needs to be an increased density of collection facilities in areas of the city with greater proportions of people reliant on public transport. (received by letter)

Parking

Nearly 100 respondents requested that collection centres have dedicated, or be close to, adequate parking.

Collection rooms should be located near public transport, but also with good parking. Most people are taken to the Doctor by someone if unable to drive themselves. Good parking is essential (public survey respondent)

Many suggested having centres ideally located at shopping malls for easy access to free and ample parking.

Being handy to shopping centres and easy parking are advantages. Some tests require doing at a particular time - not always at the same time one has a GP appointment. (public survey respondent)

Services should ... be located with access to public transport, plenty of available parking and located close to local shopping centres (public survey respondent)

Proximity to other services and facilities

Many respondents noted that collection centres located close to medical centres or doctors surgeries, shopping malls, and other facilities and services, improves accessibility and saves time on travel.

Good idea to review locations. Best locations are adjacent to medical centres/doctor's surgeries, and/or near supermarkets in shopping centres which people have to visit anyway, and generally are also accessible to public transport. (public survey respondent)

Almost 90 respondents indicated that collection centres should be close to GP clinics or be part of them to make visits to the centres more convenient and accessible.

There needs to be a location centre near or in every medical centre that contains doctors' rooms so that you don't have to travel to a collection centre. (public survey respondent)

Having medical and collection services co-located means patients do not have to make two trips – one to the GP and another to have a sample taken. (public survey respondent)

It is important, I think, to have collection areas near to GP services so that those who have difficulty with transport aren't having to organise travel to another location. (panel survey respondent)

The collection centre is close to the Kelston GP and Pharmacy. Its good to have that relationship (WDHB public meeting)

Centres of activity, especially shopping, were noted as suitable sites for collection centres.

Malls will be a good place to have collection sites (WDHB public meeting)

... collection centres should be near shopping centres as most people visit shopping centres often. need parking space and/or easy to access public transport (panel survey respondent)

From the public meeting held at Northcote, feedback was to,

Have some collection centres on Marae, especially the bigger ones (WDHB public meeting)

Health, demographic and socio-economic profile

Nearly 80 respondents argued that population health profiles should determine the distribution of collection centres.

The College supports the notion of ensuring equity of access to sample collection for all consumers. Equity of access can be achieved by ensuring an adequate number of, and adequate opening hours for, sample collection points that align with the demographics and health status of different communities (received by letter)

More than 30 respondents suggested that socio-economic deprivation overlaps with health status sufficiently well to serve as an indicator of an area's need for collection centres. Stakeholders such as the Women's Health Action Trust and a PHO, for example, were concerned at the current spread and felt that collection centres needed to be in areas of socioeconomic disadvantage.

... We are concerned that areas with higher socio-economic disadvantage in the greater auckland region have lower laboratory coverage. This should be the inverse if anything, given the transport challenges and health needs faced by those who experience socio-economic disadvantage. (public survey respondent)

... the locations of the current DML collection sites are unevenly spread through the DHBs (33 in WDHB, 29 in ADHB and only 20 in CMDHB areas) and areas of need. Of the 20 in the CMDHB area, only 10 are in the areas of highest deprivation (index score 8-10). ... A redistribution of laboratory collection points with an emphasis on areas of need will improve access and completion of tests ordered in the hardest to reach populations. (received by letter)

Several suggested that the age profile of populations should impact upon the distribution of centres:

In areas where there are large numbers of elderly people and families, they need labs within walking distance. (public survey respondent)

Forecasting population growth, density and demand

More than 100 respondents said that future trends in population growth and demand for health services, need to be accounted for when deciding how the collection centres should be distributed.

Collection centres need to reflect population and demand ... The re-distribution of collection centres needs to allow for further growth and demand. (public survey respondent)

The Hobsonville peninsula and Massey are growing. There will need to be collection rooms there. Collection centres need to be decided in concert with projected growth (WDHB public meeting).

Some respondents felt that areas with dense populations should have the most collection centres.

... the location of collection centres is governed by demand. Population density varies from time to time according to housing development. Therefore demand will change and review of centre placement should be made. (public survey respondent)

A respondent noted that urban and rural collection centre distribution might be managed and accessed differently.

I think it should be fair to all in cities [to have] centres reduced if they have too many. Rural people expect to travel a little more for all their facilities but there still should be access in main centres where they come to town to do shopping etc. (panel survey respondent)

Probably could do with more in the rural areas, or a mobile unit to service these areas at least once a week. This would be over and above the areas covered by the current Diagnostic Medlab (current providers) in their cars. (public survey respondent)

Home and mobile service

The mobile and home collection service received very positive feedback. The risk that this service might be disestablished concerned some respondents.

At present a visiting service provides an excellent service to needy transport limited patients. We wish this to be maintained. (received by letter)

Home visits very welcome when my husband had a stroke. (WDHB public meeting)

In addition to servicing patients with limited mobility, the mobile collection service was valued by people who live and work far from collection rooms:

Home visits are fabulous, (CMDHB public meeting)

The mobile service is good for small communities such as Parakai and Kaukapakapa (WDHB public meeting)

While the large majority of comments about the home service were very positive, a small number had recommendations as to how the service could be improved:

The mobile unit outside a home is a “stigma and reason for gossip” – its better to go to a centre. (WDHB public meeting)

Mobile ones are great but more advertising is needed as to where and when they will be located. (panel survey respondent)

7. Collection Centre Hours

Summary

The ARDHBs want to make sure that collection centres are open at times that are convenient. Respondents were asked to comment on current opening times and identify convenient times.

Overall, most panel and website survey respondents rated both the collections centres' days of operation and the opening hours as good or excellent. However, one-in-three panel members and one-in-five public survey respondents were dissatisfied with these factors, rating them as poor or fair.

There were calls for longer hours during the working week and a weekend service, at least at strategically-located centres, so as to make collection centres more accessible for workers. There were also calls for the centres to be open earlier to make the collection service more accessible to workers and those who fast prior to having samples taken.

It appears that time factors – opening hours and waiting times – have more impact on the centres' accessibility than location. Some respondents note that they will travel a considerable distance to have their sample taken at a collection centre that is open early in the day. This can lead to congestion and long waiting times at those centres. It was also noted that some collection centres did not keep the same hours as nearby GP clinics. This can cause considerable inconvenience for some patients, especially for the very unwell, elderly and disabled, because a further outing/journey is required.

Once again, it is important to note that the feedback about collection centres hours was tied by many respondents to the centres' location. Therefore, the feedback about collection centre hours and location should be considered together.

Recommendation

The feedback suggests that time factors, including the hours and days the collection centres are open, put about one-in-five people off from having a sample taken. We therefore recommend that the ARDHBs consider addressing these factors as key to making laboratory services more accessible to the public. While most panel and website survey respondents rated both the collections centres' days of operation and opening hours as good or excellent, one-in-three panel members and one-in-five website survey respondents rated them as poor or fair. Common reasons for dissatisfaction were that it can be difficult to have a sample taken early in the day; too few centres are open early; and those that are open early often have long queues. Over 1000 respondents asked that collection centres be open longer, beyond regular working hours.

Background

The ARDHBs want to make sure that collection centres are open at times that are convenient. Respondents were asked to comment on current opening times and identify the times that are convenient.

Quantitative results⁵

Levels of satisfaction with days and hours of operation

Overall, most panel and website survey respondents thought that the number of days the centres were open, the opening hours, and the time spent waiting for samples to be collected, were good or excellent (see tables 1 and 2).

However, more panel members than website survey respondents gave these factors a poor or fair rating. Around one-third of the panel respondents felt that the days the collection centre were open (29.0%), the opening hours of the collection centres (38.6%), and the waiting times to get samples collected (34.9%), were poor or fair (see table 1).

Table 1: How would you rate the following, panel respondents

<i>Panel survey respondents</i>	<i>Days open</i>		<i>Hours</i>		<i>Waiting time</i>	
	Poor or Fair %	Good or Excellent %	Poor or Fair %	Good or Excellent %	Poor or Fair %	Good or Excellent %
Used collection centres once or not at all in last 12 months	27.7	54.1	39.5	45.6	33.9	51.8
Used collection centres twice or more in last 12 months	28.6	64.3	37.8	57.0	34.5	60.3
Total Panel	29.0	60.6	38.6	53.3	34.9	57.2

Note that the percentages do not add to 100 percent, as the remainder stated that they did not know.

Table 2: How would you rate the following, Website survey respondents

<i>Website survey respondents</i>	<i>Days open</i>		<i>Hours</i>		<i>Waiting time</i>	
	Poor or Fair %	Good or Excellent %	Poor or Fair %	Good or Excellent %	Poor or Fair %	Good or Excellent %
Used collection centres once or not at all in last 12 months	25.4	18.6	36.9	58.2	29.5	64.8
Used collection centres twice or more in last 12 months	66.4	79.6	23.3	76.1	23.9	71.9
Total Website respondents	18.2	70.2	22.5	76.0	21.7	73.9

⁵ Note that differences between DHBs are not statistically significant. Differences between involvement in health amongst Buzz panel respondents (i.e. whether the respondents are members of the public, health care professionals or those involved in the provision of laboratory services), are not statistically significant.

Time-barriers to sample collection

Respondents were asked if there was anything that put them off or stopped them from having sample taken. Table 2 notes the results pertaining to time.

Time factors, including the hours and days the collection centres are open, put about one-in-five people off from having a sample taken. Around one-fifth of respondents felt that the collection centres are not open at the right time. Similarly, around one-fifth of panel respondents considered the waiting times to get a test posed a barrier.

Some respondents (around one in six) indicated that getting time off work was a barrier to getting samples taken, and around 19% identified waiting times as another barrier.

Table 3: Factors stopping or putting people off having a sample taken

Survey respondents	Panel	Website
	%	%
The collection centres are not open at the right time	20.7	20.3
The waiting times to get a test	20.4	17.7
I cannot take time off from work	17.7	14.8

Feedback themes

Opening times - generally satisfied

Around one-third of respondents commented that they were satisfied with the current collection centres opening hours and that they did not expect the centres hours to be extended. A higher proportion of retired people than workers felt this way.

I dont have any problems with the times that are already located @ the collection centres, they do a good job and are very helpful (panel survey respondent)

The current times suit my family. We are both superannuitants, the rest of my family manage as things are as they know the importance of having tests done (panel survey respondent)

Some of respondents in this group, although generally satisfied, felt that minor adjustments needed to be made to the opening hours to improve the service.

Opening times are sufficient at the Mangere collections centre but perhaps opening earlier would help with the 'fasting' test rush! (public survey respondent)

The current opening times of the Devonport collection centre suit me, although it would be good to have an extra centre open after hours on the North Shore (eg, for fertility patients). (public survey respondent)

Maybe they could open a little earlier for those that have to do fasting prior to blood tests but overall find the current opening hours very convenient (public survey respondent)

More open with longer hours

More than half of the respondents to the question about opening hours (2,200 in total) suggested that the centres should have a wider range of hours, beyond 8am-5pm.

Workers asked for centres to be open early in the day and later at night.

It can be difficult to get to them outside work hours (panel survey respondent)

Currently it is really difficult to get there in time, and when I do everyone else is trying to get in before or after work as well so it makes it really busy. (panel survey respondent)

As this respondent noted, for people with chronic conditions, having samples collected can lead to having a considerable amount of time off work and early starts.

From personal experience (diagnosed [with Diabetes] type 1 Mar 07) constant visits involves much time off work as the hours are not "worker-friendly". Fasting overnight for tests involves not eating for 10-12 hours and going really early to ensure a place in the queue. Also arranging transport in case you are "low" pre-breakfast. (public survey respondent)

Just over half said the collection centres should open at or before 7am and remain open until 6 or 7pm. Some noted that extended hours such as this will not only make sample collection more convenient for workers, but also for those at home.

Centres that are close to home are not open at convenient times - even though I don't work I need to arrange childcare so have to wait til my husband is home from work (panel survey respondent)

Rural respondents, including those at a meeting in Pukekohe, noted that longer hours are also needed by people who live and/or work in rural areas.

The opening hours are not long enough. Sometimes it is hard to take time off work especially in the Franklin District when work can be quite a long distance from the collection centre. (panel survey respondent)

More than 160 respondents suggested that more collection centres should be open during the weekend:

... unfortunately the few centres open on Saturday mornings are overcrowded (public survey respondent)

A stakeholder organisation that facilitated a focus group of its members found that while the present hours are very good for older people, they would like collection centres to be open during the weekend because family tended to be available to help with transport at that time.

The cost of extending hours

There was an acknowledgement that extending clinic hours was costly. Some suggested that extending hours at strategically-located centres would be a suitable way of utilising scarce resources.

It would be good if more strategically placed centres were open on Saturday mornings. I use the Ascot Hospital lab centre several times a year on Saturday mornings and there are often queues and long waits. (public survey respondent)

There should be several, strategically situated throughout the greater Ak area, that are open 24/7, the rest in sync with general commercial and medical practice opening times. (public survey respondent)

We suggest – strategically located laboratories, fewer in number, larger (based on immediate population) with sufficient staff to minimise waiting time, with adequate parking, and preferably on a bus route. (received by letter).

It was noted by one stakeholder, that extending collection centre hours would require more costly sample storage.

...although evening blood collection points may seem logical, this may dramatically increase costs because of the need to separate samples or freeze samples for subsequent testing the next day (received by letter)

Alignment with clinic hours

Nearly 30 patients noted that aligning collection centres with clinics would make the collection of samples considerably easier.

Currently the hours tend to be different to the hours of the adjacent GP clinic, either operate the same hours or allow the clinic to take samples if the collection room are closed (public survey respondent)

Many medlabs appear to close at 4pm, and this could be extended to a bit later - eg 6pm, as many gps see patients and require tests for looming acute illness in the late afternoon/early evening (public survey respondent)

Aligning clinic and collection room hours will prevent patients having to make two trips – one to the GP and another to have a sample taken. (public survey respondent)

Waiting times

The waiting times before work and Saturdays appear to be most problematic.

There is always a queue at the branch I go to before 8am so it would be better to open earlier since everyone seems to be in a hurry to get to work etc (panel survey respondent)

Often quite a queue at opening time. many older retired folk waiting interspersed with frustrated 'currently' working folk. (panel survey respondent)

Not early enough or not staffed enough to avoid waiting times sometimes. So long that it's not possible to have a blood test before going to work. (panel survey respondent)

As an insulin dependant diabetic i find it difficult doing fasting tests. i need to go early in the morning before i take my morning insulin and find there is often a long waiting time at that time of day. (panel survey respondent)

Saturday isn't open long enough and then it is the queue for the wait that puts you off (panel survey respondent)

Nearly 40 respondents suggested that more staff should be allocated to reduce waiting times, thereby making the busy collection centres more convenient and accessible.

Some open at 7:30 with 10 people in the waiting room. More staff arrive at 8:00 and the waiting time reduces. It would be better to have more staff at opening time, as this is when more people are wanting blood collected. (public survey respondent)

8: Point of Care Testing

Summary

Point of care testing (POCT) allows for practitioners to take and test samples, either at their practice or in the patient's home. However, POCT is more expensive than centralised testing because of the loss of economies of scale. Submitters were asked whether they saw POCT as useful.

Of the total number of people who responded to questions about POCT, most said that they supported POCT, at least in part (see table 1). Once again there were clear divisions between respondent groups. Panel members were much more likely to support POCT than respondents from other sources. Amongst website respondents, health professionals and people involved in the delivery of laboratory services supported POCT, at least in part. The principal benefits respondents identified were timeliness, patient convenience and ensuring tests get done, particularly in locations on the outskirts of Auckland and when test results are required quickly to inform clinical decisions.

Some respondents observed that POCT is already practiced in some clinics in certain instances and that there are some benefits extending this practice in some cases. A broad-scale introduction of POCT raised concerns about costs, training and workload, quality control, managing and sharing information, and test duplication.

Many respondents tied some of the issues, impacts and benefits of POCT to GPs and nurses collecting samples. Therefore, the sections about POCT and GPs and nurses collecting samples should be considered together.

Recommendation

When deciding whether to implement POCT more widely than it is currently practiced, we recommend that the ARDHBs note that two-thirds or more of both health professionals and non-health professionals support POCT in theory, at least in part. The proposal is supported, provided that the costs and benefits of POCT be weighed up on a case-by-case basis. The utility of POCT is dependent on a range of factors including, but not limited to, the type of test in question, the point of care's proximity to a suitable laboratory service provider, the cost of performing that test, the facilities and skill-set required to do it, quality control and storage of test results.

Background

Point of care testing (POCT) allows for practitioners to take and test samples either at their practice or in the patient's home. There are three clinical scenarios where POCT has relevance:

- Where the result can support patients who find it difficult to manage their diseases;
- Where the result can support patients who find it difficult to manage their diseases and they require monitoring and support to keep them on track;

- To make an early diagnosis of chronic conditions for patients who find it difficult to go to a collection facility.

However, POCT is more expensive than testing through a central laboratory, because of the loss of economies of scale. Submitters were asked, in general whether they saw POCT as useful.

Quantitative results

Overall, there was support for POCT, and again there were clear divisions between groups. Panel members (80.8%) were much more likely to support POCT, at least in part, than non-panel members (64.9%) (see tables 1 and 2).

Amongst website respondents, laboratory workers (25.6%) and health professionals (21.0%) were more likely to oppose POCT than the general public (15.3%).

It is important to note, however, that there were differences in the degree and kinds of support from both healthcare professionals and those involved in lab services for POCT (see table 2 and feedback themes). Although only 11.6% of those involved in delivering lab services supported it fully, a further 55.8% supported it in part. Similarly, while only one-quarter (23.6%) of healthcare professionals supported it fully, a further 38.7% supported it in part.

Table 1. In general, do you see POCT as useful – Panel survey respondents

<i>Panel survey respondents</i>	<i>Yes</i>	<i>In part</i>	<i>Not sure</i>	<i>No</i>	<i>Number</i>
	%	%	%	%	n
Total Panel	52.4	28.4	14.3	4.9	750

Table 2. In general, do you see POCT as useful – Website survey respondents

<i>Website survey respondents</i>	<i>Yes</i>	<i>In part</i>	<i>Not sure</i>	<i>No</i>	<i>Number</i>
	%	%	%	%	n
Member of public	34.8	31.8	18.1	15.3	431
Health Professionals	23.6	38.7	16.7	21.0	305
Laboratory workers	11.6	55.8	7.0	25.6	86
Used collection centres once or not at all in last 12 months	46.7	33.3	13.3	6.7	60
Used collection centres twice or more in last 12 months	31.8	32.3	19.3	16.6	446
Total Website respondents	28.2	36.7	16.6	18.5	1,006

Feedback themes

Balancing the benefits and costs of POCT

A stakeholder organisation is of the opinion that “while POCT is clearly convenient and quick, there are many issues that moving to greater POCT raises”. Along with two other stakeholder organisations, they noted the following issues (submissions received by letter):

- *Device costs and maintenance*
- *Training*
- *Quality control, operating standards and accreditation issues*
- *Staff time required for sample collection, testing and associated administration*
- *Payment to practices for undertaking these activities*
- *Medico-legal responsibility for incorrect results/actions taken on the basis of these results*
- *Information management, sharing and access*

Similarly, while another stakeholder considers there to be some clear benefits of POCT, they are unconvinced by the overall economy of its widespread adoption.

Each application of POCT needs to put a price on convenience and truancy and take into consideration how to ensure quality and transfer and translation of results. We support POCT for diabetic monitoring and high dependency units as examples but, along with the authors cited [in the consultation document], have yet to be convinced on the overall economy of other forms of POCT. (received by letter)

Some queried why further POCT was being considered

You have stated this would cost even more to POCT - so why change from existing when you're trying to save money in the first place? (public survey respondent)

Some stakeholders, and more than 80 online survey respondents, felt that on balance POCT was suitable for some purposes, but that its utility had to be assessed on a case by case basis:

The main utility of point of care testing is for tests where a rapid turnaround time is of value (e.g. troponins) or for patient self monitoring (e.g. diabetes) where frequent testing is required. Point of care testing is expensive, however, and only a limited number of tests are available. Quality control, limited sample numbers, recording of results and training of users all create significant extra costs and so broad statements cannot be made about the utility of point of care testing in general. Generally the costs and benefits of individual point of care tests have to be evaluated on a test by test basis

before an informed decision can be made about their utility. (public survey respondent)

It depends on the time taken to do the test, the reliability and how often that test is clinically indicated - and for chronic care conditions depends on the test being able to be done & the results manage, by the patient with appropriate training & support (public survey respondent)

POCT can be very valuable in some situations, particularly in the High Dependency Unit. It can also be valuable to general practice and has potential advantages in rural after hours care. It allows for the early diagnosis of some acute conditions (e.g. strep throat). While the test kit is more expensive (although at the moment patient pays the cost) the advantage of POCT is that it allows diagnosis and treatment up to 24-48 hours earlier than a conventional swab and at a similar cost. Not all tests however are suitable to POCT (e.g. finger prick lipid testing) and should continue to be done at the laboratory. (received by letter)

Supported introduction of point-of-care and near-patient testing, particularly for those areas on the outskirts of Auckland, would enhance medical practice because of the timeliness of results in relation to making diagnosis. (received by letter)

Good for emergency testing, good for outlying areas of NZ. Glucose monitoring good. However most POCT is more expensive than current testing in the lab. No QC. Are results recorded to be available later to other health professionals? (public survey respondent)

Some stakeholders noted they would like to discuss further implementation of POCT.

We request we have the opportunity to discuss and implement some POCT for clinical situations where this is cost effective, confers a clinical advantage and where an immediate result supports better care. (received by letter)

Patient convenience and compliance

A principle benefit of POCT identified by respondents — both clinicians and the general public — was that it is convenient for the patient and will enhance compliance.

It allows the client to have one stop with respect to testing and discussion of the result - and it could be combined with e.g. a consultation or supply of medication. It also means the client is a 'captive audience' for discussion of results! (public survey respondent)

A key benefit seen in POCT was that it reduced a patient's need to travel.

... it is not always practical for someone to travel beyond their GP, or their home. (panel survey respondent)

This is better for the patient. Making them try to get to a clinic is sometimes stressful for older people. (public survey respondent)

This would be useful for those who aren't particularly mobile (i.e. the elderly and very sick) but would use up our human resources at the surgery. (public survey respondent)

Very convenient for really sick patients who find the trip a hardship. One trip out to a GP would be better for them. (panel survey respondent)

Timeliness

Respondents considered timeliness to be the other major benefit of POCT. More than 240 respondents noted that it would lead to faster results, which would be of benefit to both the patient and the medical professional.

Lessens need to travel, and waiting time for tests to be taken if a practitioner is already at a patients bedside (panel survey respondent)

Aside from waiting times or time to travel, some noted that getting a test done and the results back in the weekend, would enable treatment to get underway.

over the weekend a GP may be able to start treatment in a more timely manner so pt does not end up in hospital (panel survey respondent)

Not all respondents agreed with these benefits. A few respondents, for example, argued that because the laboratory delivers test results quickly, one of the principle benefits of POCT is diminished:

Current turn around times don't warrant POC testing. I can have a blood test in the morning and if it is put through by my GP as priority, he is phoning m is phoning me that same afternoon with the results. Therefore there is no delay in treatment. I would prefer to keep it the way it is, at least then I know it is accurate ... It is more expensive. Quality control - how can accuracy of results be guaranteed? Who would pay? (public survey respondent)

Costs and resources

The costs and resources required to broaden the scope of POCT were discussed by more than 430 survey respondents. There was some debate as to cost benefits of POCT, particularly as the accuracy was questioned. Some indicated that they did not approve of added costs going to the patient or being carried by GPs.

Would be easier and simpler rather than having to go off and find a diagnostic lab etc, but some concerns regarding the integrity of the samples and GPs charging extra for this service. (panel survey respondent)

At several public workshops, attendees were largely against significantly broadening the scope of current POCT practice, largely due to the anticipation that the costs will outweigh the benefits.

There is not a real need for POCT. It is more expensive than sending it to the lab. Who will pay? The cost is shifted or picked up by the DHB. If there is testing at the coal face, will be charged a doctor's fee. If we go to the lab it costs nothing. If it starts to cost, this will be passed on to the patient. (ADHB public meeting)

It costs 3 times the price. (ADHB and WDHB public meetings)

POCT would be fine if it was free but it would be difficult to get it into GP practices. That it's free and accessible is key. (CMDHB Pukekohe meeting)

Logistics of setting it up would cost patients. (WDHB Takapuna public meeting)

Many respondents (140) felt that the resources required to test accurately made it unrealistic without a large investment of funds.

Funding to compensate for the time and extra resources (public survey respondent)

... the cost of point of care testing can often outweigh its usefulness ... Remembering that every point of care device needs maintaining and quality control who would do this? What would the cost of this be? (public survey respondent)

Equipment would need to be owned, serviced and accredited by/through the laboratory service provider. GPs and midwives would need to be trained to use the equipment including certification and recertification processes. (public survey respondent)

A smaller number questioned how the appropriate use of POCT could be ensured because the process could be open to abuse from people who did not want to visit a collection centre.

If it is more expensive than lab testing then it would have to be limited to certain cases. I could see that it would be open to abuse - people who don't want to travel to the labs saying they can't manage their illnesses etc (panel survey respondent)

Close monitoring of not just patient need but also of GP prescription frequency as to necessity for this care may be needed. (public survey respondent)

It could be open to 'abuse' and be 'overused' - means the GP has to decide who should receive this - on what basis do they make this decision? What if 'I' want it and can't get it? On what basis would it be funded? (panel survey respondent)

Alongside costs and resources, many respondents noted quality issues.

POCT testing is very expensive. Per test costs far exceed bulk testing done on larger laboratory analysers. More tests are often performed unnecessarily due to poor technique and easy access. (public survey respondent)

Workforce and training

About one-third of respondents' comments on the workforce and training issues relating to POCT. In particular, they highlighted the additional responsibility that would be borne by the primary care workforce, the number of staff, skill-sets and scope of practice, and training that would be required.

Increased workload for doctors and medical professionals, longer waiting times for patients to be seen by doctors, nurses for dressing etc, instead of them concentrating on their profession. The cost of time and labour is being shifted to the GPs (public survey respondent)

Training of staff will require a lot of buy-in and significant outlay of expense - may negate any savings made in the Lab area. (public survey respondent)

Unless point of care systems were simplified, it is likely that further stress would be placed on doctors' daily activities. (public survey respondent)

INCREASED COST FOR TRAINING AND MAINTENANCE OF STANDARDS FOR WHAT IS A RELATIVELY SPECIALISED SERVICE. Basic dipstick glucose and urine testing is currently available. (public survey respondent)

Attendance at training and refresher courses was expected not only to be a significant commitment, but a requirement, if POCT was to work effectively.

Training of the end user and regular controls being done and monitored to ensure that the result being given is reliable and meaningful. These are big issues because if not used correctly the results are meaningless and incorrect treatment could occur (public survey respondent)

Very good training for practice nurses and government sponsored regular up-skilling programmes. Also some kind of regular testing of these nurses to ensure they are up to scratch. (panel survey respondent)

Quality control

All stakeholders and more than one-in-ten survey respondents indicated that POCT could compromise the accuracy, efficiency and quality of results. There were widespread concerns that to maintain quality service there would have to be significant investment in quality control.

I would be a little hesitant about the effectiveness in testing for some things in a home etc & the delays in getting the samples to a lab for testing. Would the sample be as accurate? Would need more information on how it was to be achieved. (panel survey respondent)

... maintenance of equipment. Records and documentation of maintenance, servicing and repairs, Electrical compliance. Quality control, calibration and reference ranges. Annual accreditation of process, procedures, staffing. Continuing education, maintaining competencies. (public survey respondent)

Some public meeting participants questioned whether the exactitude of training and supervision currently in place for laboratories would and could be extended to POCT practice.

Look at the level of training and degree of supervision over collection. There is a stringent programme to become a qualified technician. Will this continue? (ADHB public meeting)

It should be made clear that the samples are a 'test' and independent testing is needed to confirm the results (panel survey respondent)

Some respondents felt uncomfortable with POCT not being able to deliver the same reliability and accuracy as laboratory testing processes.

Quality control is an issue and registered health professionals are needed. Even so, testing is not that accurate. (WDHB public meeting)

Test quality amongst different providers. Current labs will have quality systems appropriate to a medical lab but it would be hard and expensive for all locations performing Point of Care Testing to meet the same standard (public survey respondent)

It is the most costly way of doing tests. Quality is inferior to lab tests. Only works in special settings and for some tests (e.g. remote areas). Who will be accountable if something goes wrong? (public survey respondent)

The accuracy and standardisation of the test results would have to be addressed. Currently far too many of the point of care devices lack accuracy and reproducibility (public survey respondent)

Information management

Many raised the issue of how test results would be recorded and shared.

It has limited usefulness. It could give simple information but I have reservations about quality and recording and sharing of information. (public survey respondent)

... who will ensure all results are entered, and entered correctly into the IT system? Will clinics link to a central IT system so that the patients' results will be available to another surgery in case the patient visits a different surgery the next week?... (public survey respondent)

... How would the results get into Testsafe? How would the data be managed? ... (public survey respondent)

9: GPs and other health professionals collecting samples and electronic collection referral systems

Summary

The ARDHBs are interested in whether, rather than sending patients to collection centres, health professionals such as GPs, primary care nurses and midwives could take more samples at the clinic. Submitters were asked if they support this.

Panel members (79%) were much more likely to support this, at least in part, than website respondents (48%). Of the website survey respondents, health professionals (55.3%) and laboratory workers (52%) were much more likely to oppose health professionals taking samples at the clinic than the public.

Those against the proposal questioned why the DHBs would want to change the current system and noted work-load, resource and quality control issues. Those in favour thought more clinic-based sample collection would be much more convenient for patients and improve rates of compliance.

Submitters were also asked whether information systems should be modified to enable general practitioners and other health professionals to order laboratory referrals electronically directly to the laboratory provider. Two-thirds agreed (see table 2). Responses regarding the electronic referrals were largely positive. Electronic referrals were seen to be convenient and efficient, for both patients and practitioners, enabling common access to patient information and sample tracking, should patient consent be given. Respondents considered the current paper-based system to operate efficiently, but most nevertheless saw benefit in moving to an electronic system.

Note that this section is based on a preliminary analysis only. It is based on an analysis of all stakeholder letters and workshop notes, and 630 of the 1800 responses due to time constraints.

Some issues raised in the section about Point of Care Testing apply to GPs and other health professionals collecting samples. Therefore these sections of the report should be considered together.

Recommendation

We recommend that the ARDHBs note that more than two-thirds of non-health professionals as compared to less than half of health professionals supported more sample collection by GPs and other health professionals. Those against the proposal questioned why the DHBs would want to change the current system and noted work-load, resource and quality control issues. Those in favour thought more clinic-based sample collection would be much more convenient for patients and improve rates of compliance.

There was considerably more support for an electronic collection referral system, especially from health professionals, so long as the transfer and storage of information is secure and, with patient consent, it can be easily shared.

Background

The community laboratory service comprises three areas: collection of samples to be tested, the testing of those samples, and specialist advice to family doctors. The provision of these three sets of services could be unbundled.

ARDHBs are interested in whether health professionals such as GPs, primary care nurses and midwives could take more samples at the clinic, rather than send patients to collection centres. Submitters were asked if they support this.

Quantitative Results

Health professionals collecting samples at the clinic

Many of the respondents were in favour of health professional taking more samples at the clinic, at least in part.

Again there were clear divisions between groups. Panel members (79%) were much more likely to support this, at least in part, than website respondents (48%) (see tables 1 and 2).

Of the website survey respondents, health professionals (55%) and laboratory workers (52%) were much more likely to oppose health professionals taking samples at the clinic than the public. It is noted, however, that there was still some support for this proposal from these groups with 44% of lab workers and 40% health professionals supporting this proposal, at least in part.

Table 1: Would you support health professionals take more samples at the clinic – Panel respondents

<i>Panel survey respondents</i>	<i>Yes</i>	<i>In part</i>	<i>Not sure</i>	<i>No</i>	<i>Number</i>
	%	%	%	%	n
Used collection centres once or not at all in last 12 months	62.5	17.7	11.5	8.3	192
Used collection centres twice or more in last 12 months	52.6	26.7	6.2	14.5	498
Total Panel respondents	55.8	23.2	8.4	12.7	837

Table 2: Would you support health professionals take more samples at the clinic – Website respondents

<i>Website survey respondents</i>	<i>Yes</i>	<i>In part</i>	<i>Not sure</i>	<i>No</i>	<i>Number</i>
	%	%	%	%	n
Member of public	29.6	25.9	8.0	36.4	486
Health Professionals	14.6	25.2	4.9	55.3	349
Laboratory workers	8.6	35.5	4.3	51.6	93
Total Website respondents	22.6	25.8	7.6	44.2	1,191

Electronic referral

Submitters were also asked whether information systems should be modified to enable general practitioners and other health professionals to order laboratory referrals electronically directly to the laboratory provider. Most of the panel and website respondents agreed (see table 3).

Table 3: Should information systems be modified?

<i>Agree</i>	<i>Panel</i>	<i>Panel</i>	<i>Website</i>	<i>Website</i>
	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>
Yes	69.2	571	61.1	698
Not sure	26.7	220	28.3	323
No	4.1	34	10.7	122
Total	100.0	825	100.1	1,143

Feedback themes

Current collection services work well

More than 40 respondents expressed satisfaction with the current sample collection system. They did not see any need to either alter it or for GPs to take on more sample collection.

I think the present set up of collection units nearby GP clinics works pretty well already. (public survey respondent)

The Govt and DHB have continually loaded GP Nursing staff up with more and more Primary Health care duties as it is. I want to see Medlab or equivalent continue as is thank you. It aint broke so dont fix it. (public survey respondent)

Point of care sample collection will save time and money

More than 330 respondents supported further sample collection at the point-of-care, because they considered that it would save time and money. One-in-ten of these respondents were health professionals.

Save time and money on running separate centres and also patients don't have to run from one place to the other. This will be effective and cost saving on both sides. (public survey respondent)

Workload

More than 360 survey respondents, a high proportion of whom were health professionals, said that primary care practitioners were already collecting an appropriate amount and range of samples at the clinic. Further, they said that they should not be taking on any more samples.

The health professionals are already under pressure to cope with their workload. Leave the collections to the specialist specimen takers. (public survey respondent)

This will take more time from GP to see other patient. And they have to administer this collection which mean more cost to GP. Leave all collection to collection centres. (public survey respondent)

The current system seems to be working well. As a doctor I have limited time to take blood. I often do not have the correct tubes and find it difficult and frustrating remembering which tubes go with which test. I think that my energies are better spent with other responsibilities and think that the current service is excellent. (public survey respondent)

Some of these respondents indicated that the costs associated with GP clinics taking more samples might be passed on to the patient. They also noted that the time taken to collect samples might add to the patients' waiting times.

GP's are busy enough without having more to do - they need less bureaucracy and paper work so they can spend more time with patients (public survey respondent)

this would add a delay and possibly more cost (panel survey respondent)

A waste of highly trained staff time. likely to make their services cost more (public survey respondent)

A stakeholder organisation cautioned against moving to greater collection at the point of care given the current capacity, kinds of expertise, and level of resources available in the primary care sector.

We are aware that laboratories experience more errors in relation to samples collected in surgeries and there is an additional hidden cost in following these up. As the laboratory may process up to 10,000 patients per day and approx 40,000 tests per day the percentage does not need to be high to make this a real problem. There is a potentially serious logistical problem should most or all patients choose to attend surgeries to have blood tests in that the volume of patients would overwhelm surgeries. One option would be a roving laboratory staff member who attends private practise in the area. (received by letter)

Some survey respondents suggested that when practices get too busy, collection could be left to the collection centre.

depends on where people go and what the tests. For GPs I feel that some tests should be done with collection centres at times clinics can get busy... (panel survey respondent)

Funding

Many of the survey respondents who commented on workload issues also commented on how primary care practices would be funded to cover sample collection costs.

While on the one hand a few suggested that sample collection did not make good primary care sense from a business point of view:

*Admin/management issues for provider to collect – does not add value
(CMDHB public meeting, Pukekohe)*

On the other hand two stakeholder organisations note that many providers currently collect samples and some are willing to collect more than they currently do so long as they are supported to do so.

There is considerable variation among medical practices in their ability to take more samples at their clinic. Around the country some practices (who are appropriately reimbursed for their services) already take up to 90% of all samples at the clinic while in other areas resource constraints mean that they take relatively few. There are significant costs in running this service and if the Auckland DHBs want more practices to take samples at their clinics then they will need to provide funding. Where DHBs have accepted the need to do so and have provided a fee commensurate with the service then the uptake of practices taking samples at their clinic has been good. (received by letter)

...there should be consideration of a scaled fee for Primary Healthcare doctors collecting blood in rooms. Again, with an emphasis on a higher payment for clinics located in higher deprivation areas. There is no better time to complete tests while the patient is present, especially in a population that is in general highly mobile and hard to contact. The experience with other aspects of health delivery such as cervical smears and childhood immunisations is testament to that (received by letter).

At a consultation meeting with GPs, some suggested that the prospect of providing a greater array of collection services on site will be quite different for large and small practices.

The people who want a one stop shop approach to their health go to a big provider and have their blood collection done on site. There's a lab depot on site. But for smaller practices the taking of a blood sample will be like immunization - we'll do it as a charity. It will be the same thing – offering a service but not getting sufficient funding to cover the true cost (Combined DHBs stakeholder meeting, Auckland city)

We're a small service and we couldn't do it for the cost that been suggested. We need another room, we need a nurse, we need to cover that nurse if they're off, all extra staff for a small practice. There no economics of scale so it rules us out (Combined DHBs stakeholder meeting, Auckland city)

A general practitioner suggested that if this went ahead GPs would be put in a very difficult position because it was unclear who would carry the costs of this service.

Labtests will tell us we can have 50 cents for the blood collection. Will DHBs arbitrate with the provider re the cost of taking blood? Will there be any ruling regarding the GPs' ability to charge patients for collection - maybe in those areas where Labtests is not contracted to deliver a service? The patient will ask us and we have to do it. Maybe they can pay us to do it. Labtests haven't indicated that they compensate us for taking that test. The collection of blood by GPs needs to make a profit or we won't survive. (Combined DHBs stakeholder meeting, Auckland city)

Patients' convenience and compliance

More than 420 respondents commented that health professionals taking samples at the point of care would be convenient for patients and help ensure that tests would get done.

Some suggested that GP collection might be most appropriate in places where collection samples are not close at hand.

Taking samples as well as being a GP is too much work. Too long to wait to get to see busy doctors anyway. In rural places it might be good for GPs to take tests (WDHB public meeting, Northcote)

Convenience. In our modern society people have less free time, so the quicker we can get things done the better. (panel survey respondent)

If blood is not taken on site, then it doesn't happen. Hospital tests do get done. GPs should take blood before patient leaves surgery. (WDHB public meeting, Lincoln Green)

Most of those who said it would be convenient were members of the public, although some health professionals saw this as a benefit.

It would be convenient for patients, and GPs would ensure that really important tests would be done on the spot (patients don't always go on to the lab when requested to do so) But GP practice is already too busy at times, and this would be another task. Advantage with having Nurse collect is that can grab person while at practice. (public survey respondent)

More than 50 respondents felt that clinic-based sample collection was of most benefit to patients with limited mobility – the very ill, elderly and disabled.

Convenience, especially for elderly or those who have difficulty getting where they need to (panel survey respondent)

Sample collection skills and quality control

More than 200 respondents said that having samples taken at dedicated collection centres was preferable from a number of points of view.

From the patient's point of view:

I prefer to go to a collection centre as there are less problems with collecting blood, they are more experienced than the GP (CMDHB public meeting, Pukekohe)

Doctors pass you to nurses to take blood – often newly qualified who experiment on me. This must be happening to others. (WDHB public meeting, Kelston)

Some service-users at a workshop agreed that, in theory, blood collection at the point of care is a good idea. They noted, however, that if blood is not collected by a trained phlebotomist, the service can be poor.

It was almost like torture. The patient is now scared to return for any similar procedure. (WDHB public meeting, Takapuna)

We see lots of patients arms that have been stuffed up by people at GP clinics etc that cant find blood. They don't have time for this – the patient is in and out in 5 minutes. (ADHB public meeting, Alexandra Park)

Several attendees at the Waitakere public meeting noted conditional support for introducing further sample collection at primary care practices:

I strongly advocate for the availability of blood collection at doctors' surgeries. But from a patients point of view - I need to have an experienced person taking blood. (WDHB public meeting, Waitakare)

Some survey respondents also provided conditional support – noting that they would be happy with for primary care practitioners to collect specimens so long as staff were adequately trained.

Only if they are trained and qualified to do this (public survey respondent)

From a testing point of view, many noted they would be concerned about the quality of samples collected.

The most important part of the test is a correctly collected specimen. For this you need a specialised trained phlebotomist whose ONLY concern is correct collection, labelling, and delivery of specimen. The samples already collected by GPs are often incorrectly labelled, illegible or inappropriate for the test requested (public survey respondent)

I work in a lab – GPs don't really know the requirements of a lab and mix-up tests etc – test quality is not guaranteed. There needs to be some investment in the up-skilling of GPs and the resourcing of their practices in terms of equipment. (WDHB public meeting, Waitakere)

The College supports the notion of ensuring equity of access to sample collection for all consumers ... However, the College stresses that ensuring equity of access must not become overly burdensome on the sample collectors. ... While general practitioners and nurses are either trained, or can be trained, to take blood and other samples, consideration needs to be given to the environment they operate in and whether this is conducive to safe sample collection. For example, general practitioners may not have adequate facilities in which to take samples and appropriately store them. Busy practices may not have the time to incorporate sample collection into their services. (received by letter)

Some respondents noted that the more complicated collections could be left to more specialised staff or dedicated collection services.

There are some tests where it would be quicker for the doctor to do them. Other more complex tests should be done at a specialist collection centre (public survey respondent)

I worked at a GP practice and was up-skilled to phlebotomist. High value to the GP practice. I would refer to lab if any specialised skills were need. (WDHB public meeting, Waitakere).

Electronic referral

A stakeholder organisation provided an extensive commentary on the benefits and points to be considered before and during implementation of an electronic referral system:

We see electronic ordering as a potential advance now that electronic reporting is well accepted. There are positives as well as negatives to this change. There is no call for reverting to non-electronic means of result reporting. Like everything related laboratories it is a development that must be done well with attention to detail. Under any e-ordering system the patient is still likely to need a piece of paper if only to introduce him/her to the laboratory collector. The advantages are that it should ensure that the right tests are done as the request goes directly to the laboratory information system and the request cannot be modified by the patient; it provides a record system for truancy and the data would be accessible for to further enhance review of test ordering patterns. It provides the opportunity for 'smart ordering' so that repeat tests are not undertaken inappropriately and can alert the requestor to the fact that the particular test has been recently performed. It can help with diagnostic algorithms etc.

But while there are these advantages it is essential that the existing paper system remain in place as a transition precaution and for those health providers without access to any e-system.

From the laboratory perspective there is the issue of patient identification and how accurate contemporary practice records are on new NHIs etc. There are many issues around patients using different names/dates of birth and this can result in problems with accumulation of results etc. Again with a

*large number of transactions involved even minor discrepancies can create major problems but these are all potentially solvable. Key issues to resolve if this is to progress are around funding and medico-legal responsibility.
(received by letter)*

Common access to patient information and sample tracking

One of the major benefits of an electronic referral system identified by both health professionals and members of the public was the promise of common access. Common access was seen to make collection and test referral more convenient for both patient and practitioner and help reduce duplication.

Results should be available to anybody with the patients permission (panel survey respondent)

Common access via nhi is essential (public survey respondent)

*We fully support electronic ordering and see Auckland as an important potential pilot for New Zealand following the development of TestSafe.
(received by letter)*

Current paper-based system works well

Electronically referring patients for sample collection and testing raised largely positive comment from health professionals and members of the public.

Of the survey respondents who were either unsure or opposed to moving to an electronic system, seven noted the efficiency of the paper-based referral and therefore questioned the need to change.

I have been required to supply samples regularly for the past 15 years and i have no problem with dealing with the current laboratories and their sampling process. the results are always available for my gp when i visit after i have had samples taken. (panel survey respondent)

Not sure how electronic referrals would work - do you have to decide right then at the clinic which collection clinic to go to? with paper one you can go to any of them, whichever is most convenient at the time. (panel survey respondent)

why change the system we have. it is not broken so why mend it. (panel survey respondent)

Efficiency of an electronic system

Almost 20 respondents noted that a benefit of moving to an electronic referral system would be greater time and cost efficiency.

It would be a big help if we could electronically send lab test forms. it would cut down on surgery traffic and save receptionist time (public survey respondent)

I believe that we should make the most of decision support and demand management rules that can be implemented in the Auckland regional TestSafe repository to reduce unnecessary duplicate testing. This would require broadband access at the point of order and a little integration between GP PMS systems and the TestSafe repository to make it a seamless process. This in itself could save the DHBs money without reducing service levels or changing providers for real obvious reason. (public survey respondent)

Convenience of electronic referral to patients and practitioners

Almost 30 respondents considered that both patients' and health professionals' convenience would be well-served by electronic referrals.

I guess it would be advantageous to have a system where the GP could look up the status of the test and/or results in real time. This would help them field inquiries from the patient. (panel survey respondent)

... it would be useful for data collection re who is ordering what, when and how often which i have no issues with. (public survey respondent)

Consent and confidentiality

Six respondents, some of whom were in favour of electronic referral, noted that there were some issues to be addressed before adopting an electronic method to ensure the security of patients' information and test requests.

Any modified electronic system must ensure complete patient confidentiality or don't change it. any chance of information being corrupted/interfered/alterd by internet abusers should be considered carefully prior to any changes. (panel survey respondent)

Patient consent/fully informed about the process and an absolute 100% guarantee of confidentiality is non-negotiable (public survey respondent)

10: Information about tests and test results

Summary

The ARDHBs asked how satisfied people were with the information they received about tests and test results and whether better information could be provided.

Although there is general satisfaction with the information received in relation to test results, only half (54%) of the respondents from the panel rated the information they received about results as good or excellent compared with three-quarters (75%) of website respondents.

It seems the area of greatest dissatisfaction for patients is that as a matter of course they do not receive information about test outcomes when the results are normal. Hearing nothing is not a comfort for some patients – it makes them anxious. And while no quantitative information was collected about timeliness of results to the patient, it seems that may explain why non-health professionals are considerably less satisfied with information provision than health professionals. Most respondents would like an email record to come from the laboratory and an explanation from the GP in plain language.

Some patients asked that tests be explained to them in plain language. This included information about how they should prepare for tests, what the results mean and what the implications are for both their GP-managed, and self-managed, care.

Because many fixed-choice responses were collected in this section of the survey, the quantitative and open-ended feedback is presented together.

Recommendation

With regard to information about tests and test results, we recommend the ARDHBs note that nearly half of panel survey respondents and one-quarter of website survey respondents rated the information they received as poor or fair. Those who were dissatisfied with the current information-sharing arrangements asked for the patient to be provided with tests results when results are normal as well as abnormal, that the patient receive an email record of their results from the laboratory, and that the patient receive an explanation as to what the results mean in plain language.

Feedback themes

Satisfaction with test results

Half (54%) of the respondents from the panel rated the information they received about results as good or excellent compared with three-quarters (75%) of website respondents (see tables 1 and 2). Respondents from the panel and website who had used the service twice or more in the past 12 months rated the information about test results more highly than those who had used it less frequently.

Table 1: Overall satisfaction with information about test results, Panel

<i>Panel survey</i>	<i>Poor</i>	<i>Fair</i>	<i>Good</i>	<i>Excellent</i>	<i>Don't know</i>	<i>Number (n)</i>
	%	%	%	%		
Used collection centres once or not at all in last 12 months	10.5	29.9	42.2	7.6	9.9	344
Used collection centres twice or more in last 12 months	14.6	26.9	37.3	19.4	1.9	837
Total Panel	14.1	27.9	37.9	15.7	4.3	1,268

Amongst website respondents, laboratory workers (83%) and health professionals (86%) were more likely to rate their satisfaction with the information on test results as good or excellent than members of the public (72%) (see table 2). The more frequently patients use the laboratory services the more satisfied they are with the information they receive.

Table 2: Overall satisfaction with information about test results, Website respondents

<i>Website survey</i>	<i>Poor</i>	<i>Fair</i>	<i>Good</i>	<i>Excellent</i>	<i>Don't know</i>	<i>Number (n)</i>
	%	%	%	%		
Member of public	10.6	16.1	34.2	37.3	1.8	931
Health Professionals	4.3	7.6	24.8	61.2	2.1	327
Laboratory workers	4.3	8.6	30.1	52.7	4.3	93
Used collection centres once or not at all in last 12 months	16.9	23.4	36.3	20.2	3.2	124
Used collection centres twice or more in last 12 months	10.1	15.5	32.5	40.2	1.7	895
Total Website respondents	9.1	14.1	30.8	43.7	2.4	1,512

Information about normal test results

Respondents were asked how satisfied they (or those they cared for or represented) were with the information they received about the results of the tests when they were normal.

There were comparatively high levels of dissatisfaction: one-quarter of panel respondents (24.8%) and 16% of website respondents indicating that they were dissatisfied with the information that they received (see table 3).

Table 3: Satisfaction with information about the test results when they are normal

	<i>Panel</i> %	<i>Panel</i> <i>n</i>	<i>Website</i> <i>Respondents %</i>	<i>Website</i> <i>respondents</i> <i>n</i>
Dissatisfied	24.8	357	16.0	241
Neutral	31.6	454	18.7	281
Satisfied	43.5	626	65.2	981
Total	99.9	1,438	99.9	1,505

The feedback shows that a key reason for respondents dissatisfaction is that not getting information about normal tests results can lead to anxiety about their condition and wondering if their sample and/or test-request has been lost. Forty respondents commented on this.

You never get results when they are all clear, but this knowledge will save a lot of anxiety and worry. (public survey respondent)

I would like to be told about test results even if they are normal, then you know that they have definitely happened and haven't got lost in the process. (public survey respondent)

Information about test results when there is an issue

Respondents were asked how satisfied they (or those they cared for or represented) were with the information they received about results when an issue required attention. Most respondents were satisfied. Those from the panel were less likely to be satisfied with the results than those from the website.

Table 4: Satisfaction with information about test results when there is an issue

	<i>Panel</i> %	<i>Panel</i> <i>n</i>	<i>Website</i> <i>respondents %</i>	<i>Website</i> <i>respondents</i> <i>n</i>
Dissatisfied	14.5	209	11.3	171
Neutral	33.8	486	17.3	262
Satisfied	51.7	744	71.4	1082
Total	100.0	1,439	100.0	1,516

There were relatively high levels of dissatisfaction on this matter and the comments show that a key reason for people's dissatisfaction might be the explanations that accompany the results. Over 70 people comment on this.

How test results would like to be received

Respondents were asked whether they (or those they cared for or represented) would like to have access to the results of the tests. The majority indicated they would like access to the results of their tests. Three-quarters of panel respondents (75%) said that they would like to receive their results by email.

Table 5: How you would like to receive test results

	<i>Panel</i>	<i>Website</i>
Mail	52.6	40.5
Email	75.0	71.0
Text	13.6	9.6
No	2.4	10.6
Not sure	5.6	5.5
Total n	1,440	1,512

Email was a popular choice because it was seen to be fast and convenient and would enable people to keep a record of their test results.

Who respondents would like to receive test results from

The respondents could select more than one preference when responding to this question. Most respondents said that they would prefer to get their lab results from their GP and around half said that they would prefer to get the result directly from the laboratory.

Table 6: Who you would like to get your test results from

	<i>Panel</i>	<i>Website</i>
My GP	78.9	82.2
A nurse	30.9	33.1
A health worker	10.2	8.6
Directly from the laboratory	54.0	48.1
Other	4.7	10.3
Total	1,438	1,528

More than 30 respondents noted that it was important to have your results relayed by a health professional (preferably a GP or Nurse) to ensure that patients understood and interpreted the results correctly.

I want to know the specific results even if they are normal but I believe it is important a medical professional who knows my medical history provides interpretation or comment at the same time. (public survey respondent)

Some of these respondents said they had to ring their doctor to get their results. They were unhappy that they had to do this and that they were not given copies of their results.

Sometimes it takes more than a week to get results. We ring the Doctor, but again the results have not been sent after two days. (public survey respondent)

I often find that the GP doesn't explain the tests very well. I also have to ring up to find out what the results were which is irritating - especially if the medical issues is worrying me. (panel survey respondent)

Those who commented on getting a copy of test results directly from the lab, suggested that a patient should be get results from the lab as a matter of course or be able to elect to have the lab send results to them. Some of these respondents felt that giving the patients their own results would enable them to monitor their own health more closely and save them having to rely on, or wait to hear from, their GP.

I believe all patients should be able to elect to have lab results sent directly to them, especially if they have the same test on a regular basis. (public survey respondent)

information about tests relevant to the patient should be available to the public as it is for the doctors (public survey respondent)

On occasion when I have requested to have copies of test results to be sent to me, I have been told this is not possible as the required form is not there for me to sign. As a patient working in the health industry myself I find this very frustrating (panel survey respondent)

Information about the reason for tests

Respondents were asked how satisfied they (or those they cared for or represented) were with the information they received about the reasons for the tests. Many were satisfied with the information given on the reason for the test, although more website respondents (79%) were more likely to be satisfied than panel members (63%). Satisfaction increased as frequency of service-use increased.

Table 7: Satisfaction with information about the reason for the tests

	<i>Panel</i> %	<i>Panel</i> <i>n</i>	<i>Website</i> %	<i>Website</i> <i>n</i>
Dissatisfied	9.2	131	6.6	97
Neutral	28.8	409	14.8	218
Satisfied	62.0	880	78.6	1159
Total	100.0	1,420	100.0	1475

Information about how test relates to patient care

Survey respondents were asked how satisfied they (or those they cared for or represented) were with the information they received about how the tests relates to patient care. Again, there were high levels of satisfaction with how the test relates to patient care.

Table 8: Satisfaction with information about how the test relates to patient care

	<i>Panel</i> %	<i>Panel</i> <i>n</i>	<i>Website</i> %	<i>Website</i> <i>n</i>
Dissatisfied	10.4	149	7.3	109
Neutral	41.2	589	21.7	323
Satisfied	48.4	692	70.9	1054
Total	100.0	1,429	99.9	1,487

The level of dissatisfaction was slightly higher amongst panel members (10%) than non-panel members (7%).

Some of those who were dissatisfied with this aspect of information sharing wanted to be more empowered to partake in their own health care.

I would like the test results to be better explained so i can be more involved in my well being which will help me make better decisions for treatment and further prevention. Often the results come straight from the lab with no explanation, although that responsibility is as much the professional who requested the test as the labs. (public survey respondent)

Information about the tests being done

Respondents were asked how satisfied they (or those they cared for or represented) were with the information they received about the tests they (or the patient) is getting.

Although most respondents were satisfied with the information they were given about the reasons for the tests, those from the panel were less likely to be satisfied than those from the website.

GP's often do not give enough information to their patients about why they are having tests done or what is required to prepare for the tests. (public survey respondent)

Table 9: Satisfaction with information about the tests you (or the patient) are getting

	Panel %	Panel n	Website %	Website n
Dissatisfied	12.1	173	6.7	100
Neutral	32.3	462	18.0	269
Satisfied	55.6	796	75.3	1124
Total	100.0	1,431	100.0	1,493

Use plain language and more thorough explanations

A theme that emerged from the open-ended comments – but was not raised by the DHBs as a matter for public feedback – was that health professionals should make more of an effort to use plain, everyday language when providing explanations about test results to patients. This will help more patients understand what their test results mean and what the implications are for their health and health care. More than 70 respondents commented on this matter directly. For instance,

Make sure they are in language which the layperson understands (public survey respondent)

as a patient, more explanation of data would be appreciated (e.g. even the simple cholesterol test: who can remember the 'good' type from the 'bad'?) (panel respondent)

Patients should be encourage to understand the results of the tests and how they are used to assist in the management of their health (public survey respondent)

An example of how more through information can be delivered – while using plain language – was provided at a public meeting, where an attendee noted:

The Dr sends me to the lab and tells me you are only allowed to drink. But I didn't understand because they didn't tell me that I can only drink water (WDHB public meeting, Kelston).

Making such efforts could directly improve the quality of samples, test results, and patient's health outcomes.

Provide results promptly to the patient

A further theme to emerge from the responses was about unsatisfactory delays in getting test results. More than 30 respondents directly commented on this.

GPs don't seem to explain the results to you and don't get the results to you in a timely manner. (public survey respondent)

My dad gets very anxious waiting for test results. It can take time to wait for the GP to pass on the results (WDHB public meeting, Northcote)

11: Preferred number of providers

Summary

The ARDHBs need to make sure that they are getting the best service that they can afford and the best value for money that they can. The ARDHBs invited feedback on the possibility of moving from a single provider of laboratory services to more than one service provider.

This generated considerable, and in some cases, heated, feedback. The responses to this question tended to focus more on the question of who the provider should be, rather than on the preferred structure of the service and whether competition should be introduced. Many respondents, particularly those who attended GP and public meetings, expressed strong opposition to there being more than one service provider, and a strong preference for that service provider to be DML.

Many of those who supported one provider, appeared to only support that provider if it were the incumbent. It is unclear from their responses whether they would be as enthusiastic for a single provider if it were an alternative provider.

Panel respondents were fairly evenly divided over whether they preferred the option of one or more services providers. They were, however, more likely to prefer more than one provider than website respondents. Differences between respondents from the DHB areas were not significant.

Submitters were asked how likely they would be to support introducing competition to all of or parts of the service, to manage costs. Just under half (45%) of those from the Panel said that they would be likely to support competition if costs could be better managed compared with one-third (33%) of website respondents. Differences between respondents from the DHB areas were not significant.

The respondents who see benefit in reintroducing competition consider doing so will encourage efficiency and quality. However, some respondents made the point that competition need not be introduced for this to occur; the DHB could take a firmer hand in holding a provider or providers of community laboratory services accountable against clear efficiency and quality criteria.

Some of those who preferred that there be multiple providers suggested that they operate in a free-market environment. The majority, however, preferred that the market be carefully regulated to ensure that competing for efficiency and market share does not compromise the quality of service.

Recommendation

We recommend the ARDHBs consider that, firstly, there were some strong feelings attached to this aspect of the DHBs' proposal as many respondents took it as an opportunity to express frustration and on occasion anger at the RFP process and awarding of the contract to Labtests. Secondly, while just over half the website survey respondents preferred that there be one service provider, just over one third of panel respondents felt the same way. Thirdly, there were strong messages of support received from health professionals and regular patients for DML to be if not the, then a, provider of laboratory services to the Auckland region. Fourthly, underlying the disagreement as to whether there should be one provider or more was a shared interest in the DHBs holding the provider(s) of laboratory services accountable to ensure they delivered not only efficient but also high-quality laboratory services.

Background

There is one company that collects samples, tests them, reports the results to the doctor and provides the doctor with specialist advice.

Relying on one company has advantages and disadvantages.

- Accountability - one organisation means that we know which organisation is responsible for the service
- The prospect of greater efficiency as services, equipment etc. are not 'doubled up' or duplicated.

However, there are disadvantages. Sometimes competition can be used to help control costs. The DHBs wish to hear stakeholder and public views on the possibility of moving from a single provider to multiple providers. Respondents were asked whether they would prefer the option of:

- One service provider
- More than one service provider
- Not sure
- No preference
- Another option.

Respondents were then asked if costs could be managed by introducing competition. If different organisations were involved in providing the service, or parts of the service, how likely they would be to support this change?

Quantitative results

Preferred number of providers

Panel respondents were fairly evenly divided over whether they preferred the option of one or more services providers (table 1). They were, however, more likely to prefer more than one provider (36.7%) than website respondents (29.8%), and those from the panel were

more likely to be unsure or have no preference than website respondents (compare tables 1 and 2).

More respondents who had used collection centres once or not at all in the past 12 months were more likely to support the option of one provider than those who had used the centres more frequently (table 1).⁶

Table 1: Options for number of service providers, panel

	<i>One service provider</i>	<i>More than one service provider</i>	<i>Not sure</i>	<i>No preference</i>	<i>Number</i>
	%	%	%	%	n
Used collection centres once or not at all in last 12 months	30.7	43.0	14.1	11.9	277
Used collection centres twice or more in last 12 months	38.7	33.7	15.5	12.0	664
Total Respondents	36.5	36.7	14.7	12.1	1,000

Table 2: Options for number of service providers, Website respondents

	<i>One service provider</i>	<i>More than one service provider</i>	<i>Not sure</i>	<i>No preference</i>	<i>Number</i>
	%	%	%	%	n
Used collection centres once or not at all in last 12 months	38.5	43.1	11.0	7.3	109
Used collection centres twice or more in last 12 months	55.6	29.2	7.7	7.4	712
Total Website respondents	55.4	29.8	8.2	6.6	1,241

Managing costs through competition

Submitters were asked how likely they would be to support introducing competition to either the entire service, or parts of the service, to manage costs.

The feedback shows that competition was principally seen as a way of maximising efficiency. When the DHBs suggested that competition be introduced as a way of managing costs, the proportion of respondents in favour of having more than one provider, and hence competition, increased to just under half of panel respondents and one-third of website respondents (compare tables 1 through 4).

Just under half (45.1%) of those from the panel said that they would be likely to support competition if costs could be better managed, compared with one-third (32.5%) of website respondents (compare tables 3 and 4). Both panel and website respondents who had used

⁶ Differences between respondents who are not involved in health and those who are (i.e. whether the respondents are members of the public, health care professionals or those involved in the provision of laboratory services) are not statistically significant. Differences between DHBs are not statistically significant.

the service once or not at all in the past 12 months were more likely to support managing the costs through competition, than more frequent users.⁷

Table 3: Managing costs through competition, panel respondents

	Likely	Not sure	Not likely	Number (n)
	%	%	%	
Used collection centres once or not at all in last 12 months	54.9	31.3	13.9	288
Used collection centres twice or more in last 12 months	41.4	32.4	26.2	710
Total panel	45.1	32.0	22.9	1,060

Table 4: Managing costs through competition, Website respondents

	Likely	Not sure	Not likely	Number (n)
	%	%	%	
Used collection centres once or not at all in last 12 months	48.2	25.2	26.4	110
Used collection centres twice or more in last 12 months	31.9	23.0	45.1	758
Total website respondents	32.5	23.7	43.8	1,306

Feedback themes

Competition

Around a third of all survey respondents indicated a preference for ‘more than one provider’. Those who did prefer more than one provider saw a range of benefits resulting from “competition”.

More competition, professional progress, efficiency awareness, reduced risk of failure by single provider. sharing of expertise. (panel survey respondent)

Competition was also seen as offering customers choice.

To keep them honest and to keep the costs down but not stupidly so. also if one provider goes bust then the other can do their best till new arrangements are made. and the patients will have a choice. (-panel survey respondent)

A healthy competition will benefit tax payers, bring the investment in lab and new technology. This will improve the testing and DHBS will have more options to choose (public survey respondent)

Competition was seen as a way to encourage continual quality improvement.

⁷ Once again, the differences between DHBS are not statistically significant. Neither are differences between members of the public, health care professionals or those involved in the provision of laboratory services.

More than one provider would help with competition and avoid them resting on their laurels. (-panel survey respondent)

Competition keeps costs down. a single provider becomes complacent about service delivery and systems. (public survey respondent)

Never good to just have one provider - as standards can slip - always best to have competition - keeps people on their toes (-panel survey respondent)

I think only having one provider is a problem. If we have competition they will prioritise the needs of the patient (WDHB public meeting)

A stakeholder considered that competition would provide greater employment opportunities for pathologists and a back-up should one provider falter.

It is infinitely more preferable to have more than one provider of laboratory services. Not only is this better for the pathologists concerned in that they are assured a measure of job security, but also for patients who will still be assured of having services provided regardless that one service provider might subsequently falter. (received by letter)

A respondent who supported competition felt that the contracting cycle did not work in favour of competition.

... the eight yearly contracting round [Firstly] in effect excludes competition and makes the ARDHBs vulnerable to price demands of a single provider. The size of the contract, in practice, excludes New Zealand owner participation because of the capital commitment required. Secondly, the lack of competition results in the provider not taking advantage of technology changes. Thirdly, a single provider is competing with the Australian laboratory services for human resources. All laboratory staff and pathologists especially have no choice but to work for public services or the incumbent in Auckland. ... The contract structure must allow professionals to establish their own businesses where practical. (received by letter)

Competition unlikely to reduce costs

In addition to support for DML, these respondents generally thought that having one provider in Auckland was preferable, because, as noted above, the Auckland region was too small to accommodate more.

One supplier will be more efficient and be more economical because of volume of service. (panel survey respondent)

Economy of scale. Consistency and quality of lab results. (panel survey respondent)

Speaking against the DHBs' reasoning for introducing competition, two people – a survey respondent and a public meeting attendee – thought that the DHBs considering introducing competition to manage cost was unnecessary, even mistaken.

if the reason for this is to save money - that is a non-sense as the price paid for the testing is not set by the labs it is set by dhb/moh (public survey respondent)

You don't get a real 'monopoly' with the single provider because the govt fixes the price. The 'monopoly' doesn't mean you can crank up the prices unreasonably. Single provider should continue. (WDHB public meeting)

Insufficient reason and too much risk to change from one and the current provider

Nearly 380 respondents explained their opposition to having more than one provider in terms of there being insufficient reason to change from the current arrangement or that the likelihood of improving upon the current arrangement was slim.

Many respondents did not see sufficient reason to change provider as DML runs an efficient, highly-regarded, world-class, service.

- *It its not broken why fix it?*
- *The present service is working very efficiently*
- *Break the system as it is you get an increase in general errors-loses-increased costs*
- *Maintain the service as it is*
- *Present system us totally adequate – keep it simple*
- *We wish the current diagnostic laboratory to be retained (received by letter)*

... the widely held view amongst our member practices is that the current Community Laboratory Service is of an exceptional standard. It would be a folly to purely focus on fiscal costs when evaluating a possible change in provider. There are very important unseen benefits of remaining with a trusted and well-respected service provider who has a proven track record of having served the Auckland community exceptionally well for many years (received by letter)

In our view, the current consultation document fails to reflect the need for any new Lab Contract to take these factors into account. (received by letter).

Other stakeholders at public meetings conveyed similar sentiments:

Not broken, don't fix it. Service works incredibly well., wonderful service, very pleasant, couldn't ask for more (WDHB public meeting)

The system is superb (WDHB public meeting)

System that is in place now works well (CMDHB public meeting)

I'm 86 years of age. I used to be a laboratory technician. They have built up an excellent service. I cannot understand why the contract has not returned to DML (applause) (WDHB public meeting)

Many of those at stakeholder and public meetings thought that moving ahead with large-scale change was too much of a risk.

I think one of the biggest risks is the transition. So that services are not affected, what happens if it all turns to custard? (WDHB community meeting)

Cannot afford to test if Healthscope can get a service up and running. The consequences of them failing are too great (ADHB GPs meeting)

Are there clauses relating to failure? What happens if it all falls to pieces after it kicks off – then what happens? 8 years is a long time and there will be no other service to pick things up. This is a huge risk. (ADHB Public meeting)

What are the contingency plans? My wife has bone-marrow cancer and has blood taken daily. I need to reassure her the service will continue (WDHB community meeting)

If I can so say – with all due respect – you are taking a flying leap into the unknown. If you end up with a poor service, what then? You are taking a risk at our expense and at the expense of the public. Our service is exemplified as a world-class service. (ADHB public meeting)

You say that you have three criteria – value for money, quality for money and that the population needs are being met – yet you are giving the service to a lab that doesn't exist and you are expecting them to deliver instead of giving them to an existing lab which performs well and is accurate. (ADHB public meeting)

Much of the feedback that falls under this theme was as much about support for DML as it was in favour of there being one provider. It conveyed satisfaction not only with the current arrangement – a sole provider – but also with DML. These stakeholders' comments convey the flavour of many of the 120 who were in favour of retaining the incumbent as the provider.

Diagnostic Medlab provide an excellent service. Their premises are well located and their staff are well trained, experienced and courteous. They have the latest technology available. There is no need for another provider. (public survey respondent)

I would like to see the monopoly continue. We've had competition and it didn't work. The key is maintaining the quality. Should achieve quality using one provider. DML, as one provider with a long track record, is preferable. The 'competition will make this better' doesn't always work. See what's

happened internationally here. ACC another case in point (ADHB GPs meeting)

I have always had excellent service from Diagnostic Medlab staff, who have been very helpful and supportive with my son when he needed a series of tests at a very young age. (panel survey respondent)

... the current provider Diagnostic Medlab has provided a very high [standard of] service over a prolonged period of years with specialist led testing facilities. If changes to service delivery are necessary it would seem sensible to address these at the time of contract negotiations rather than dismantling the service and replacing it with an unproven service. There is some risk in having a sole provider for anything in business and it may instead be more sensible to have two private providers to avoid the risk of monopoly provision and hone the negotiating skills of the DHBs, which have hitherto, been lacking. (received by letter)

Splitting services

Several stakeholders and survey respondents commented on the proposal to split the collection of specimens from the testing.

A few stakeholders were in favour, such as this respondent:

Observation leads [the stakeholder] to suggest that the current “single provider” approach in diagnostics is not working. It drives a cost-focused, winner takes all approach that inhibits innovation (which might lower costs in the overall health system) and can lead to lower patient service. However, within the current funding model for NZ public health it is difficult to see what alternatives are available without significant changes across the system – such as co-pay arrangements for all patients as seen in other health systems overseas. (received by letter)

Most were against splitting services.

You have talked about the possibility of separating out the collection services – this would be a disaster (general agreement in room). The quality of the specimen is paramount to the end result. Poor collection means poor results. This is from a lab point of view – a scientific point of view. There will be lots of issues if you separate out the service (ADHB public meeting)

Evidence in other areas of life show that multiple providers adds to multiple confusion, frustration and additional cost for all parties (in this case - dhbs, praticioners, clinics and patients). more calls tracking down where the hold ups are. more staff answering calls and searching. (panel survey respondent)

A stakeholder considered that the various aspects of the community laboratory had to be well coordinated if a high quality service was to be provided.

The college believes it is important that providers of sample collection, laboratory testing and specialist pathology services have good working relationships and close co-ordination to ensure a high quality, consistent and timely service. (received by letter)

Likewise, integration across the sector was most important for this respondent:

whatever option, integration and communication across a level playing field is crucial to the flow of information for clinical practice. (public survey respondent)

Provider relationships

GPs and health professionals pointed out that GPs, laboratory staff and pathologists had developed trusting and strong relationships that are highly-valued and contribute positively to morale, cohesion across the sector, timely patient care and cost-savings.

GPs want to talk to people that they know and they want the service to be available. There's trust with the pathologists. The DHB has underestimated the trust we have with pathologists, we can ring up anytime. It saves money having a direct link and it saves hospital visits. (ADHB GPs meeting)

When I've call the hospital laboratory you never get a person. There's about a 50% hit rate and the English spoken is often not good. Or you get the after-hours number and three minutes of automated messaging. It time-consuming getting hospital information. On the other hand DML fix everything. Immediately. The issues so far are ease of access, rapid return of results, notification of out of range tests. Out of hours help, they even ring us at home. That's really valuable. We can talk to competent pathologists. We can ring someone with special areas of expertise (ADHB GPs meeting)

Relationships are considered by some to be a foundation block of the current lab services – a factor that a new provider will have to develop.

DML delivers a quality of service that is a result of relationships built over many years. How will DHB ensure such a relationship with new providers?. (ADHB GPs meeting)

I have a few concerns as a user of the health service – I have no knowledge of the new company and credibility – so maybe people like me will not follow up on blood tests. It will be unfamiliar for many Maori who have built up a relationship with one lab technician (WDHB community meeting)

This survey respondent believes a new supplier will not benefit from the strong relationships currently in place between clinicians and DML's technicians and pathologists.

[A new supplier] could help with spreading the load, but could disadvantage patients because of lack of communication between the companies. (panel survey respondent)

Provider quality

More than 260 survey respondents either explained that they were against competition because they were concerned it may have a negative impact on the quality of service, or supported competition as long as quality was assured.

Competition will not only ensure costs are kept under control, but also tends to raise service levels – [but] one provider tendering purely on price will tend to result in poorer service standards. (public survey respondent)

I'd support competition as long as standards are maintained (public survey respondent)

Assuming quality/reliability of the test is a given, no problem with competition for blood tests, microbiology. (public survey respondent)

I find a question of change frightening and stressful. Fear of the unknown quality of service (public survey respondent).

Several respondents cautioned the DHBs' that their interest in managing cost, meant that they risked quality and safety.

The DHBs have used cost as their major reason for awarding contracts over issues such as the sustainability of the workforce, appropriateness of laboratory services, quality, consistency and future laboratory requirements/technologies. Lowest price contracting threatens quality and, at some point, safety. (received by letter)

We have spent a lot of time teaching [Medlab phlebotomists] about phobic people regarding needles, etc. To date I have questioned many people and all want to stay with Medlab. I realise this is not an in-depth assessment. Medlab may cost a little more than a new service, however, keep referring back to quality and experience. (received by e-mail)

Others noted that costs could be managed in such a way that ensured high-quality services were delivered.

Competition can save costs, however strict measures must be in place to ensure that the savings are not by sub standard or unqualified work. (panel survey respondent)

The DHBs' role

Several respondents thought the DHBs' role in the design and delivery of laboratory services needed to be reconsidered when deciding how the community laboratory services should be contracted and delivered.

*We have demonstrated over the last 10 years that competition is not the only way to ensure service and quality is maintained. In addition we support other structural models such as closer relationships with DHB laboratories ...
(received by letter)*

Community labs should not be privately run, as the private model provides no incentive to reduce the amount of lab testing. The more tests the private lab does, the more profit they make. I favour a nationalised model similar to the NHS laboratory service (public survey respondent)

A few others contended that PHOs should have a more prominent role in the design and contracting of laboratory services:

The only rational choice is for PHOs and laboratories to contract laboratory services with the PHOs holding the budget as well as having a budget expectation from the DHBs (received by letter)

*The need for closer working relationships with community labs and PHOs as well as systems to report back relevant and useable information is need for PHOs to manage Laboratory expenditure and address inequalities in access ...
We believe the Auckland region DHBs need to be very prescriptive in any new contract to ensure the needs of Maori and other high needs groups are met
(received by letter)*

Divest budgets to PHOs. Divest choice of how service is applied (ADHB GPs meeting)

At a public meeting, the attendees questioned whether the DHBs could not peg back the scale of change being proposed in favour of taking a firmer hand in determining the conditions of the laboratory services contract.

Why don't the DHBs' service specifications become more specific? (ADHB GPs meeting)

12: Right test right time and clinical practice

Summary

There is considerable variation in referral practices between doctors. Some people may be getting fewer tests than they need, while others are being tested more frequently than they require.

The ARDHBs are considering offering practitioner training and feedback on individual test referral practices. Submitters were asked whether this would be useful.

Overall, the majority of survey respondents thought this would be useful in general or in part (see table 1). Stakeholder groups, health professionals and those involved in the delivery of lab services were more likely than other respondents to see this as at least as partly useful. Two-thirds or more of all respondents (table 2) thought that practitioner training would lead, or contribute to, a range of positive outcomes sought by the ARDHBs.

There was concern, particularly from medical practitioners and medical organisations, that the issues around variation in referral practices amongst Auckland practitioners, were not well understood, and until these were more clearly understood, they would be difficult to address effectively.

Some felt there was no issue with current test-referral practices, suggesting that current testing levels and broad testing were necessary as it was 'better to be safe than sorry'. These respondents considered the current CME, test referral guidelines and feedback to be sufficient or in need of modest attention only.

However, many more comments were received in support of further development of practitioner education and individual feedback mechanisms, although there were questions about what, exactly, should be addressed, and how. Those who agreed that training and feedback should be targeted at GPs asked that GPs and the organisations that represent them have considerable input into the design and delivery of any training and feedback process.

There were also suggestions, though not particularly widespread, that interventions other than training and feedback training should be considered, such as incentives and disincentives, to encourage more efficient use of laboratory tests.

Note that of the 1,827 responses to this proposal, there were still around 600 left to code at the time of writing due to time restrictions. Note that section is based on a preliminary analysis only. It is based on an analysis of all stakeholder letters and workshop notes, and 630 of the 1800 responses due to time constraints. To be sure that the preliminary analysis gave a fair view of the entire range of responses, the coding continued until there was only repetition emerging across the main respondent groupings (health professionals and members of the public) before writing up the results.

Recommendation

We recommend that the ARDHBs consider that there was widespread support for offering practitioner training and feedback on individual practice. Although medical practitioners generally supported this proposal, it was noted that the investment of time and effort this additional CME would require must deliver clear benefits. They offered their support on the condition that medical practitioners and the organisations that represent them be closely involved in developing and implementing any further test referral training and guidelines.

Background

There is considerable variation in referral practices between doctors. It appears that not all parts of the population have equal access to laboratory services. Some people may be getting fewer tests than they need while others may be being tested more than they really need.

The literature suggests that referral levels for laboratory testing are higher than necessary. The ARDHBs are seeking ways to reduce any unnecessary testing and make access to laboratory services more equitable.

Respondents were asked whether they had any comments about this, in particular how test referrals could be improved. They were also asked whether practitioner training and individual feedback would be useful, and whether any of the following could be achieved by training and feedback:

- A reduction in the differences between health practitioners in testing level
- Improved health outcomes
- Improvements in the quality of requests
- The management of growth rates and the management of costs to DHBs

Quantitative results**Levels of support for practitioner training and feedback**

There was widespread support for practitioner training and individual feedback.

Overall the majority of respondents thought that training and feedback for practitioners would be useful, in general (panel 62.6%, Website 56.5%), or in part (panel 16.8%, Website 20.2%) (see table 1). Just over 84% of healthcare professionals and those involved in the delivery of lab services who responded through the website considered practitioner training and feedback would be useful, at least in part.

Table 1. Would practitioner training and feedback useful?⁸

	<i>Panel</i> %	<i>Panel</i> <i>n</i>	<i>Website</i> %	<i>Website</i> <i>n</i>
Yes	62.6	422	56.5	539
In part	16.8	113	20.2	193
Not sure	17.2	116	14.8	141
No	3.4	23	8.5	81
Total	100.0	674	100.0	954

Expected benefits of practitioner training and feedback

Two-thirds or more of both panel and website respondents (table 2) thought that practitioner training would lead, or contribute to, a range of positive outcomes sought by the ARDHBs:

- A reduction in the differences between health practitioners in testing levels (panel 74.5%, website 74.0%)
- Improved health outcomes (panel 78.1%, website 66.7%)
- Improvements in the quality of requests (panel 79.3%, website 77.0%)
- The management of growth rates and the management of costs to the DHBs (panel 66.5%, website 64.8%)

Table 2: Will the following be achieved by practitioner training and feedback?⁹

<i>Outcome</i>	<i>Sample source</i>	<i>Yes</i> %	<i>In part</i> %	<i>Not sure</i> %	<i>No</i> %	<i>Total</i> <i>n</i>
A reduction in the differences between health practitioners in testing levels	Panel	43.2	31.3	22.1	3.4	655
	Website	41.7	32.3	15.9	10.0	878
Improved health outcomes	Panel	47.9	30.2	18.0	3.9	660
	Website	39.1	27.6	19.3	14.0	902
Improvements in the quality of requests	Panel	50.8	28.5	17.8	2.9	663
	Website	49.2	27.8	12.3	10.7	913
The management of growth rates and the management of costs to the DHBs	Panel	33.5	33.0	28.7	4.8	666
	Website	33.2	31.6	21.4	13.8	919

Feedback themes

Evidence of Variation in Referrals

While there were strong levels of support for practitioner training and feedback from health professionals, several practitioners, academics and medical organisations questioned the evidence-base showing variations in referral rates and/or access to laboratory services.

⁸ Differences between respondents who are not involved in health and those who are (i.e. whether the respondents are members of the public, health care professionals or those involved in the provision of laboratory services) are not statistically significant.

⁹ These results haven't been broken down into respondent groups because there is widespread support across the board. (P<.05)

The College is interested in the evidence you have collected which shows inconsistent or inappropriate testing practices amongst doctors, as suggested in your consultation document ... as this would assist with appropriately targeting any required education (stakeholder letter)

We believe that some inappropriate ordering occurs in Auckland as it does elsewhere but, similar to the overseas studies cited, have no robust data to present on this. We detail some examples of over-ordering and under-ordering [elsewhere in their letter] and do, and will, support appropriate testing. (stakeholder letter)

They asked that the actual issues that the DHBs wants to address be well defined and understood before any measures to address inappropriate testing are developed.

Education is required

The majority of those who provided comment, however, felt that education was a suitable way of ensuring appropriate test referral practices. They felt that the most suitable way for this to take place was through professional development.

In my opinion, this is really up to the doctor in question. I guess the only way to minimize unnecessary testing would be to improve education of the doctors. (panel survey respondent)

Medical professionals and medical organisations were most likely to support education.

Clearly education of test requesters for more appropriate and efficient use of tests is important... (stakeholder letter)

More effort put into continuing education programmes, targeted to avoid unnecessary laboratory tests in primary care, would be a sensible initiative likely to lead to real savings (stakeholder letter)

This is currently being done around the country, and has been for the last 15 years. It is very useful, particularly when undertaken in a peer group/cell group situation. We would be very happy to see more of this if the end result is that patients are better cared for. While we do not believe that saving money should be the goal, if further training meant that the same health outcome is achieved by spending less money then this in our view would be a win/win situation. (stakeholder letter)

How should training be organised?

Some respondents (30) recommended ways in which test referral education could be delivered.

A stakeholder group noted, for example, that they are the appropriate organisation to consult concerning general practitioner training and feedback.

... the College is the appropriate body to be consulted over decision regarding the need for further education related to indications for laboratory testing for general practitioners. Further, it is inappropriate for other groups to determine the education requirements within the specialist scope of practice for general practitioners. (stakeholder letter)

Others within this group suggested the delivery of training through BPAC or through GP CME meetings.

Support GP education although reservations about how it may be done but it should be bottom up, eg BPAC (ADHB GPs meeting)

GP education takes place in a variety of ways vizz: via the College; via BPAC; via other CME put on by either the PHO or the DHB. What GPs don't need is additional 'education' by another agency. Additionally it assumes the GP needs educating and that is a dangerous and unsupported assumption. Pathologists currently give educational information at GP CME meetings. (stakeholder letter)

Nearly 70 respondents noted that any training, to be effective, would have to be done in consultation with the GPs. It was observed that GPs must be willing participants and open to changing laboratory referrals to make any intervention worthwhile.

You would have to work hard to ensure practitioner backing I believe. (panel survey respondent)

The willingness of practitioners to be involved. As I have said before. Most medical practices are too busy now to take on any extra workload. (public survey respondent)

It was also noted (by 40) that to engage GPs, they would have to be able to see that the training was specific and relevant to their needs and practice.

The training would have to be very specific and relevant. If it is not carefully planned it would be a very large expenditure for no return. Practitioners must also be willing to receive the training. (panel survey respondent)

[training should focus on] specific review of patient cases and what was reflected in the tests requests (public survey respondent)

Many of the respondents (90) felt that from a practitioner's point of view, training needs have to be balanced against costs to the practitioner, such as time and money. To address this, some felt that training costs should be covered.

Suggest that practitioners are reimbursed for their time and commitment to ongoing education (public survey respondent)

More than 20 respondents suggested, however, that incentivising or reimbursing attendance should not happen; instead, attendance should be compulsory.

Compulsory attendance and completion, the programs merits would be lost if doctors and/or medical professions could elect not to attend. (panel survey respondent)

One stakeholder, however, questioned whether the target of education should be a group of practitioners, such as GPs, or a clinical practice, such as test referrals, or more particularly, certain kinds of test referrals.

We are not aware of any evidence that private physicians or others utilising laboratory services in private are doing so outside the best interests of their patients ... Nevertheless, unnecessary testing is undoubtedly occurring ... Targeting these practices, not a group of practitioners, would be better strategy to ensure that the laboratory budget is focussed on investigations that can enhance care. (stakeholder letter)

Audit GPs and provide feedback

More than 40 respondents felt that checks and balances needed to be put in place to make GPs more accountable for their test referrals. Suggestions were that GPs justify their test referrals, that GPs be audited and given feedback, and general monitoring put in place to ensure that the GPs are only referring for tests deemed necessary.

Audit of individuals doing referrals on a regular basis to try and reduce 'habits' of some health workers (panel survey respondent)

Doctor education and get GP's to justify certain tests (public survey respondent)

It was noted that for auditing to be transparent, the 'rules' of appropriate testing would have to be made clear and accessible, and that auditing and feedback should be regular.

Regular monitoring and follow up (panel survey respondent)

Make the feedback easy to obtain and useful to the outcome. (public survey respondent)

Almost 20 respondents felt that to improve the efficiency of test referrals, a constructive feedback system between peers was most appropriate. Some respondents included patients as a suitable source of feedback.

I do believe that feedback from patients and GP's/Nurses are crucial, to ensure all standards are being met. (panel survey respondent)

The feedback part needs to allow the practitioners to have input on what they see as appropriate and someone needs to be actually taking notice of the feedback. (panel survey respondent)

Feedback is always helpful as part of the CME and peer review process (public survey respondent)

It was observed, however, that variation in test-referral rates between GPs was to be expected and was difficult to control for. Some felt that only those practitioners outside the range of 'normal' referral behaviour should be audited.

There will always be variation. It is inevitable. What you can sensibly monitor is the range of tests ordered by practitioners or PHOs and provide feedback on this at regular intervals compared with mean utilisations (public survey respondent)

Audit all GP practices regularly and ensure they are accountable for the validity of all tests in relation to the illness and investigation. Ensure each GP has and abides by guidelines for when testing is/is not appropriate. (panel survey respondent)

Audits on doctors who are at either extreme of normal testing levels. (public survey respondent)

Monetary incentive/disincentives to reduce over-testing

A small number of respondents (20) suggested introducing an incentive/disincentive system to reduce to reduce the number of unnecessary lab test referrals.

Some incentive for the practitioners to alter their practice. eg bonus for correct ordering. (public survey respondent)

Educate doctors and bill them for unnecessary tests (panel survey respondent)

While some suggested that the GP be at the centre of such an approach, others suggested that the patient should pay for unnecessary tests, or testing beyond a 'cap'.

I think if patients had to pay for their tests the unnecessary demand will reduce tremendously and doctors again would be more cautious (public survey respondent)

Perhaps charge for tests if they reach a threshold above normal practice guidelines, or make patients who want more frequent testing where there is no clinical need pay for those tests (public survey respondent)

Not all agreed, however, with this approach. One organisation was concerned that the ARDHBs seemed to be heading towards caps on testing, and expressed opposition to this approach.:

In Australia, general practitioners are limited to three blood tests only, whereas specialists are limited to eight. Why should it be that the Auckland District Health Board should follow the Wellington District Health Board in adopting such an inept and irresponsible approach for health management? What of Men's Clinics, Women's Clinics, the Menopause Clinic and clinics where people order A – Z in terms of laboratory tests, with no limitation imposed on the doctors who are ordering these tests? Some of these doctors expend up to \$500 worth of tests on patients who have a basic medical problem, but no-one is assessing the ability of that doctor with regards to the relevance of the tests that have been ordered. (stakeholder letter)

Best practice guidelines

A large number of respondents (100) suggested that a set of guidelines, standards or regulations be established to detail best practice and clarify which tests were deemed necessary in which instance.

This is an issue that GPs need to address, they're the one ordering the tests. There needs to be guidelines that GPs adhere to and those that consistently over-order need to be accountable. (public survey respondent)

In certain situations there should be a required amount of tests that are compulsory to be taken. A rule book, a code of conduct. (panel survey respondent)

Some comments noted that there was already a BPAC lab report that partially fulfilled this function and that more could be made of this tool to minimise over testing.

BPAC education information. Laboratory feedback through pathologists. PHO best guidelines for testing/treating different diseases. (public survey respondent)

The amount of tests that happen and why they happen should all be the same and should all follow a general practice standard. (public survey respondent)

One stakeholder suggested that alongside, or as part of, a set of guidelines, should be an indication of the cost of laboratory tests.

We suggest that Guidelines are developed for referrals to laboratory services. Given the costs, hidden to both patients and doctors, it could be useful for all to be reminded of the actual costs involved in each referral. We collectively are all ultimately paying for laboratory costs and we may prefer to save in this area where possible and allow DHBs to use savings in other areas. (received by letter)

Any further training or monitoring unnecessary

Although most respondents supported practitioner training and individual feedback, some did not. Those who opposed it and commented (40) felt that it was already happening, was unnecessary, or the costs did not justify the benefits.

Spend that training money on the tests you're trying to save costs on (public survey respondent)

The current systems provide detailed feed back to relevant practitioners esp GPs, nothing extra needed, referrals are low here by developed world standards (public survey respondent)

DML provided excellent training evening sessions with specialist and GP input discussion / best practice etc for those who took the time to attend. (public survey respondent)

'Better safe than sorry'

Some respondents (70) felt that current testing levels were in fact necessary as testing for all possibilities would ensure that no illnesses went undetected, thereby saving on more costly, more complicated, interventions further down the track.

Health is important - better to err on the side of caution and get tests that are not needed than to miss test that are needed (panel survey respondent)

I am interested in optimal health for my patients and avoiding illness. This is far more cost effective than ending up in the tertiary hospital and losing work due to illness. (public survey respondent)

Better safe than sorry - in that, meaning, is it not better to discover a condition early on and treat it rather than allow it to get to the stage where it costs the system even more money (public survey respondent)

One respondent suggested that the threat of medico-legal action encourages excess:

It looks as if some excessive use by some specialists is due to medical/legal pressure (NDSA meeting)

Trust Medical Professional's discretion

Similarly, another 70 respondents considered that the decision on which tests to order and when, should always be left to the medical professionals' discretion and that, ultimately, GPs and medical professionals should be trusted to make the right decision on behalf of the patient. Hence, these respondents had similar sentiments to those who thought that what may be thought of as 'excessive' testing, was in fact better thought of as precautionary testing.

Some of these respondents felt that some guidance or education could usefully inform decisions about which tests to order, but felt intervention beyond this would be unwarranted.

I tend to think that if the doctor takes his/her time in the consultation process they will be able to access the needs of the patient accordingly. (panel survey respondent)

Clear directives and training on recommended frequencies may help but in the end doctors will do what they believe is best for each individual patient. (panel survey respondent)

Its up to the gp to decide on blood tests (public survey respondent)

Surely this is an education issue with those referring patients for tests. Having said that, if the Dr has the patient's best interest in mind, then so be it. (public survey respondent)

13: Other feedback¹⁰

This section of the report presents points frequently made by public meeting attendees, survey respondents or letter writers (not all of whom are identified here) that, while pertaining to decisions the ARDHBs have to make, do not fit under one of the proposals put to stakeholders and the wider public for consultation.

A lot of respondents used the 'other feedback' section of the survey questionnaire to reinforce their support for DML, convey their satisfaction with the service DML provides, and argue that the ARDHBs should retain or recover their contract. Much of this information sits in the section titled 'Preferred number of providers'.

Consultation process

At the public meetings held to discuss the ARDHBs' proposals, many stakeholders, particularly those working in the health sector, expressed their discontent with the DHBs having progressed as far as they had with the reconfiguration of the provision of the region's laboratory services without what they perceived to be sufficient consultation.

There must be negotiation between Labtests and GPs. It is important that GPs are considered re consultation. We want to be considered (ADHB GP meeting)

Don't do this consultation as a token gesture (NDHB workshop)

The DHBs haven't assessed impact on the community (CMDHB public meeting)

There has not been enough recognition of public disapproval (ADHB public meeting)

Why weren't the community consulted before the contracting process got underway? ((ADHB GP meeting)

Why wasn't a similar consultation done before the contract was let? (WDHB public meeting)

This "consultation" isn't selling – a contract is already in place (WDHB public meeting)

We are here as DML staff. We find it ridiculous that consultation with the community wasn't done before the tendering process. Everyone is happy with the service we deliver and now we are wouldn't be concerned about our jobs (WDHB public meeting).

¹⁰ Many of the responses to the 'other feedback' section of the questionnaire have been incorporated into other sections of the report and hence do not appear here.

Awarding the contract to Healthscope

Shortly after the High Court's decision, a meeting was held with GPs and there was considerable anger expressed about both the process and the decision to change provider.

There is huge unhappiness now from GPs re the new contract. So now we're in the same place as 2 years ago. I can't understand how this happened. [Labtests] are a new, untried, untested laboratory. We have no faith in it. It foregoes all the years of good faith built up re DML. Basically we want no-less than the very efficient, lets say world class service we get now. It seems as if labs are the only thing in health that's really working properly – the shining light. (ADHB GPs meeting)

DML service has to be one of the best services in the country.

It's a world standard service

Putting at risk is stupid/illogical

Pathologists will go

Cost to our society will be huge

Improvement cannot be achieved

The only correct action is to tear up lab tests agreement and wear the consequences.

Not credible, it's a sham (ADHB GP meeting)

DHBs can not afford to "test" if Healthscope set-up will work (ADHB GP meeting).

What can Healthscope deliver that DML isn't, can not, will not? What will the benefit be? You should build these into the contract (ADHB GP meeting).

What happens if as a result of the consultation you have to top up the contract by another 20 million? It is most unfair to top up the contract. Frankly DML has not been treated equally and that is unfair. (ADHB GP meeting).

The DHBs should have asked both providers to re-tender (WDHB public meeting)

Getting the process and structure right in Auckland will have a positive impact for the rest of New Zealand. We all need to learn from the lessons of the last few years. To achieve this, we would suggest that this Auckland specific process would benefit from a meaningful, two-way partnership with the RCPA both during the consultation period and beyond. (stakeholder letter)

On-going measurement of quality of lab services

*What will happen if the new provider doesn't deliver a quality service?
(WDHB public meeting)*

There are going to be great debates about validity and fudging the factors you come up with as KPIs. We need to use the next 6mths to work these up together (ADHB GP meeting)

One very important KPI will be customer satisfaction. We need to repeat these surveys using an independent company. (ADHB GP meeting)

Re performance indicators...measure this now so we can compare Labtest against DML. If not how will you know if the service has deteriorated and over time? (ADHB GP meeting)

The KPIs will change according to your practice. Can you get these to us. We want to input. GPs are a disparate group. Your clinical advisers can't represent all of us, not the one or two GPs reps you have (ADHB GP meeting)

The PHO performance management has no impact on clinical behaviour. They report months after the behaviour so the opportunity is lost for feedback (ADHB GP meeting)

Appendix 1: Consultation meetings and focus groups

Public meetings

Stakeholder	Location	Date	DHB
Public	Pukekohe	30th Sept	Counties Manukau
Public	Papakura	2nd Oct	Counties Manukau
Public	Pakaranga	3rd Oct	Counties Manukau
Public	Manukau	3rd Oct	Counties Manukau
Public	Warkworth	6th Oct	Waitemata
Public	Alexandra Park	7th Oct	Auckland
Public	Orewa	9th Oct	Waitemata
Public	Takapuna	16th Oct	Waitemata
Public	Alexandra Park	16th Oct	Auckland
Public	Massey	20th Oct	Waitemata
Public	Waitakere	22nd Oct	Waitemata
Public	Browns bay	23rd Oct	Waitemata
PHO& Clinical Leaders	ADHB	23rd Sept	Auckland
PHO	Manukau	16th Oct	Counties Manukau
PHO		28 Oct	Waitemata
Pacific	Counties Manukau	6th Oct	Counties Manukau
Pacific	Lincoln Green	7th Oct	Waitemata
Pacific	Takapuna	15th Oct	Waitemata
Maori - Urban	Manurewa	29th Sept	Counties Manukau
Maori - Rural	Pukekohoe	7th Oct	Counties Manukau
Maori	Ruapotaka Marae	16th Sept	Auckland
Maori	Fickling Centre	23rd Sept	Auckland
Maori	Kelston	20th Oct	Waitemata
Maori	Northcote	4th Nov	Waitemata
Korean	Takapuna	30th Oct	All
Indian	Fickling Centre	21st Oct	All
GP	Robb Lecture Theatre	1st Oct	All
GP	Robb Lecture Theatre	15th Oct	All
Community Boards	Manukau	22nd Oct	Counties Manukau
Community Board	Takapuna	2nd Oct	Waitemata
Community Board	Glenfield	13th Oct	Waitemata
Chinese	Fickling Centre	14th Oct	All

Focus Groups

Stakeholder	Location	Date	DHB
Patients COPD support group	Sunnynook	9th October	All
Patients Diabetes support group	Mt Eden	28th October	All
ADHB Public Focus	Avondale	22 September	Auckland

Group			
ADHB Public Focus			
Group	Grey Lynn	23 September	Auckland
ADHB Public Focus			
Group	Glen Innes	25 September	Auckland
ADHB Public Focus			
Group	Mt Roskill	29 September	Auckland
ADHB Public Focus			
Group	Remuera	30 September	Auckland

Appendix 2: Report authors' responsibilities

Tony O'Connor had overall responsibility for the data analysis and authoring of this report. Alex Woodley analysed the quantitative data from the online survey and provided some associated report content. Marc Thornley coded the qualitative data from the online survey and provided some report content associated with that. Pinaman Owusu coded the email submissions.