

PRIVATE SPECIALIST REFERRED LABORATORY TESTING

Cessation of subsidies

IMPACT EVALUATION REPORT

**Capital and Coast DHB
Hutt Valley DHB
March 2008**

EXECUTIVE SUMMARY

The Capital and Coast and Hutt Valley District Health Boards decided in February 2006 to no longer fund private specialist referred laboratory tests from 1 November 2006. The principle objective in doing this was to redirect the available funding to better uses. Boards asked management to evaluate the policy and report back.

The policy corrected a longstanding anomaly in which private laboratory tests had been funded but other private diagnostic procedures, such as X-rays, ultrasounds or MRIs, were not. DHBs are not required to fund private specialist referred laboratory tests. Funders have been discussing correcting the anomaly for around 10 years but until recently it wasn't possible to easily distinguish specialist testing from GP testing. Prior to putting this policy in place, the DHBs consulted with the public and the affected groups, and examined the impact it would have on various groups.

The Capital and Coast and Hutt Valley District Health Boards have realised total savings in the first year of \$1.6m, compared with an estimated \$2.0m. These savings, which are expected to increase over time, are or will be used to support the following additional services:

- Improved access to health and social services through a 'one-stop-shop' service in a high needs Hutt Valley area
- Additional primary care graduate nurse training in the Hutt Valley (where there are considerably lower than average practice nurse ratios)
- After-hours primary care services for Hutt Valley patients not able to find a permanent GP
- Bariatric (obesity) surgery for Capital & Coast residents
- Initiatives to reduce avoidable admissions to hospitals in the Capital & Coast District
- Increased investments in Capital & Coast home and community care services.

Capital and Coast DHB and Hutt Valley DHB expect these services to make a considerably greater contribution to the public health than any negative effect from the policy change on private specialist referred laboratory tests.

Private patients paid an average of \$16.51 per test and had an average of 3 tests per visit in the first year of the policy. For most individuals seeking private treatment, this is likely to amount to a small proportion of the total cost of their private care.

There have been no unanticipated consequences of the policy and there has been a high degree of acceptance by patients. There was a degree of resistance initially, and there continues to be a level of bad debt experienced by Aotea Pathology Ltd, the community laboratory provider, but there have been only five complaints in the last six months, several principally concerned with the nationwide policy inconsistency.

There were concerns raised about increased demand on public hospital services if people elected to switch from private to public service provision. There has been no discernable impact on demand for public hospital services.

GPs and private specialists were asked for any evidence of adverse health outcomes as a result of the policy. A total of 9 out of 474 GPs responded to the letter from the DHB, and collectively noted two patients who had been temporarily adversely affected. Eight of 124 private specialists responded, and were principally concerned with cost, GP/private specialist boundary of care issues, and noted the risk of harm to patients that had elected to stop or cut down on testing.

Cost aside, two issues have been highlighted, hospital waiting times, and duty of care. Comments made by members of the public and private specialists in communications on the policy suggest they believe there are long waits to access public hospital services. These perceptions don't appear consistent with the significant waiting time reductions for most services, over recent years. Both Hutt Valley DHB and Capital and Coast DHB meet the Government's target of patients' first specialist assessment being within six months.

Patient pressure on GPs to order private specialist tests, to avoid the new charges, was anticipated. There is some evidence this has been an issue for GPs. While some GPs admit to ordering tests for private specialists, others have resisted. The data show there have not consequently been material changes in GP ordering of laboratory tests but since it is occurring in some cases, it raises duty of care issues.

Some GPs have expressed discomfort at ordering tests for private specialists, as they consequently become responsible for responding to the test result. The ordering of tests for private specialists raises the question of which practitioner is responsible for the ongoing care of the patient. GPs and private specialists must consider and clarify their role and accountability associated with duty of care to avoid the risk of patients *'falling through the cracks'*. It is appropriate for GPs to refuse to order tests for specialists, not just to avoid cost shifting, but more importantly to ensure clarity about which practitioner is responsible for patient care.

Pressure on GPs to order tests for private specialists is expected to subside over time. As other DHBs adopt the policy, insurance companies are expected to respond with policy changes that recognise the cost of lab tests in the same way they recognise radiology tests.

Tairāwhiti DHB has now adopted the policy and five South Island DHBs have proposed to adopt it and have completed a period of consultation. Other DHBs are watching with interest and await this evaluation.

Recommendations:

- Note that DHBs will undertake some additional communication including:
 - Writing to GPs and private specialists to provide written material about the hardship funding, and publishing this info on DHB websites
 - Writing to GPs and private specialists about duty of care.
- Note that the implementation of the private specialist laboratory testing policy has:
 - Corrected a long-standing anomaly
 - Produced savings that have been reinvested in services that are a better use of the available funding
 - Not had a significant negative impact on patient outcomes when weighed against the benefits from the services where the funding has been reinvested.

PURPOSE

The principal purpose of this evaluation is to ascertain whether the decision by the Hutt Valley DHB (HVDHB) and Capital and Coast DHB (CCDHB) in February 2006, to no longer pay for private specialist referred laboratory testing (PSRT), has met the objective it set out to achieve. The objective was to use funding for services funded through the public health system that made a greater difference to the health of the Capital and Coast and Hutt Valley residents. The evaluation examines both financial and non-financial impacts of the policy that took effect from 1 November 2006.

BACKGROUND

Policy Development

CCDHB and HVDHB considered introducing the policy when entering into new funding arrangements for community laboratory services. The national service coverage requirements do not require DHBs to provide laboratory tests for private specialists. The idea of excluding private specialists from the community referred laboratory test contract had been considered a number of times by funding bodies over the previous ten years, but until recently, the information systems had not enabled DHBs to distinguish specialist testing from GP testing.

DHBs do not pay for private diagnostic services such as X-rays, ultrasounds, echocardiograms, CT scans, skin biopsies or MRIs. However, CCDHB and HVDHB were paying for diagnostic laboratory tests for private patients. Ceasing payment for private patient's laboratory services is consistent with not paying for other private specialist ordered diagnostic services.

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

The option of funding private patients laboratory tests scored ^{*1}:

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

¹ The criteria have weightings as follows: 15%, 25%, 25%, 15%, 5%, 10%, and 5%.

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

As part of the policy process the DHBs consulted widely on the proposal. Overall there was a fairly even split with 48% of the 191 submissions in favour of the proposal to cease funding private referred tests and 52% against, with 66% of specialists being against it.

The DHBs also considered the possible impacts on various groups including:

- GPs (shifting of test volumes from private specialists to GPs)
- Public hospitals (more people seeking public health care)
- Other DHBs (inconsistency with other DHBs, which fund the tests)
- Private patients (increased cost of care – directly or through premiums)
- Insurance companies (policy & premium changes if the policy becomes more widespread)
- Private providers (depending on whether the patient or private specialist/hospital paid for the test).

The DHBs had difficulty in obtaining data on the level of private specialist testing but using total specialist testing volumes estimated savings of approximately \$2.0m that might more appropriately be spent on the provision of services through the public health system.

The DHBs agreed that private specialist testing should be funded where it was related to publicly funded services, or where there were public benefits in doing so. The DHBs developed a set of (business) rules (see Appendix 1) to guide Aotea Pathology and allow it to distinguish between patients that should and should not be charged. Provision was also made to fund cases of hardship for people with chronic medical conditions requiring ongoing testing.

Minister of Health Agreement

The Minister of Health (Hon Pete Hodgson) agreed in principle, on 14 February 2006, that DHBs should fund only those laboratory tests referred by public providers, including midwives and providers working for PHOs. He also agreed that the DHBs be allowed to apply the savings from the proposal to locally determined health priorities.

Community Laboratory Contract

The policy was put in place through HVDHB's five-year contract with Aotea Pathology for community laboratory services for the CCDHB and HVDHB region. The contract allows Aotea Pathology to charge patients of private specialists for the cost of the test, plus an encounter fee to cover the administration costs of collecting the fees.

FINDINGS ²

Financial Savings

The Board anticipated savings of approximately \$2.0m per year as a result of the PSRT policy change. For the first year (November 2006 to October 2007) the DHBs were reimbursed \$1,619,379 (excl GST) by Aotea Pathology. These came from 43,566 patients who had a total of 129,825 tests.

New Services

The savings has or will enable the DHBs to support the following services:

- HVDHB
 - Improved access to health and social services through a 'one-stop-shop' service in a high needs Hutt Valley area
 - Additional primary care graduate nurse training in the Hutt Valley (where there are considerably lower than average practice nurse ratios)
 - After-hours primary care services for Hutt Valley patients not able to find a permanent GP
 - CCDHB
 - Bariatric (obesity) surgery
 - Initiatives to reduce avoidable admissions to hospitals
 - Increased investments in home and community care services.
-

Impact on the Value and Volume of Laboratory Tests

The table below shows an overall reduction in the number and value of Schedule A laboratory tests after the policy was introduced, as part of the new fixed price contract with Aotea Pathology. The volume includes private specialist testing in both years and has declined by 7.4%. The value in 2006/07 is not what the DHBs paid but for comparative purposes is the estimated value assuming the 2005/06 prices.

Schedule A tests - HVDHB & CCDHB ³	Total Value	Total Volume
1 Nov 2005 to 31 Oct 2006	\$21,046,956	2,232,575
1 Nov 2006 to 31 Oct 2007	\$19,805,917	2,066,729

There are local and national factors that affect laboratory test volumes. All Primary Health Organisations have had incentives to reduce high volumes of laboratory testing through the Performance Management Programme. Whether due to these or other factors, test volumes at a national level appear to have declined by 4.5%.

Schedule A tests - NZ	Total Volume
1 Nov 2005 to 31 Oct 2006	23,558,129
1 Nov 2006 to 31 Oct 2007	22,498,946

² Quantitative data from the NZHIS laboratory claims warehouse covers the 12 months prior to policy implementation (1/11/05 to 31/10/06). Data from Aotea Pathology Limited covers the following 12 months (1/11/06 to 31/10/07).

³ Schedule A tests comprise 94% of community laboratory tests by value.

The previous fee-for-service regime gave laboratory providers a financial incentive to encourage more testing, where that was possible. The fixed-fee community laboratory contract, introduced in November 2006, gives Aotea Pathology Limited a strong incentive to reduce costs by reducing unnecessary testing. The DHBs have observed a strong orientation by Aotea Pathology to improved practice in the ordering of laboratory tests by referrers. Aotea Pathology points out that educational initiatives (their own as well as national initiatives by Best Practice Advocacy Centre), testing protocols and altered claiming practice have all impacted on volumes.

In summary, it is very difficult to attribute the volume changes to the policy. The new contract with Aotea Pathology incorporated a major change in the funding of laboratory tests and also came into force at the same time. Of the 13.2% decrease in subsidised test volumes, only 5.8% is directly attributable to PSRT. The balance of volumes represents a 7.4% decrease in overall testing.

It was considered very likely that there would be some shifting of tests from private specialists to GPs. The risk was greater for HVDHB and CCDHB because they were the first to introduce the policy, and insurance policies had not yet changed. (For “Specialist and Test Cover” insurance provisions currently vary from no cover (unless part of hospitalisation) up to \$3000 per annum.) While some GPs admit they are ordering for private specialists, others have resisted the pressure.

In the twelve months prior to the PSRT change, GPs accounted for approximately 75% of testing ordered by doctors (midwives and dentists etc are excluded) compared with 79% in the twelve months following the change. While there is anecdotal evidence of some pressure on GPs, and there is likely to have been some impact, other factors also impact on the laboratory testing (see discussion above) and the materiality of the impact on GP ordering is difficult to determine, especially considering the 7.4% decline in total test volumes.

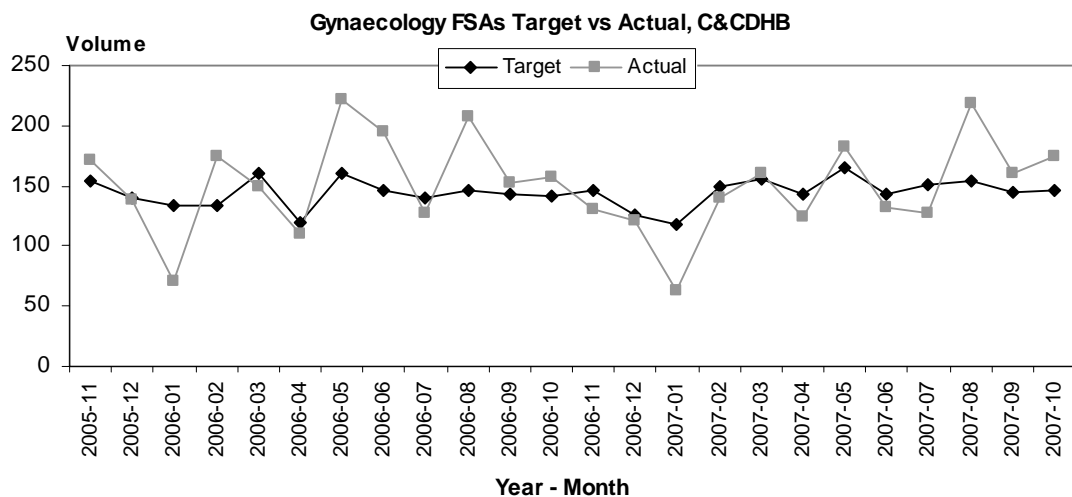
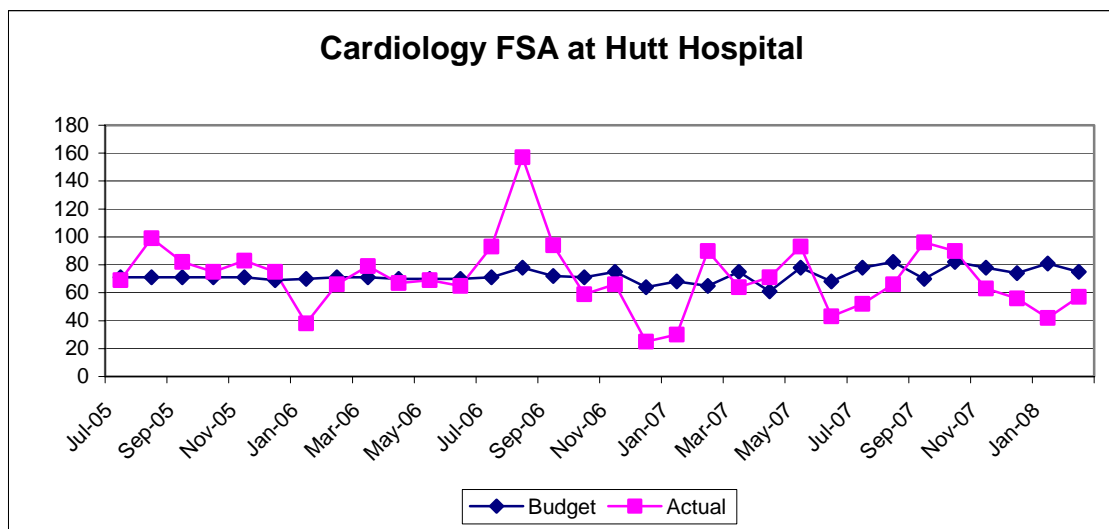
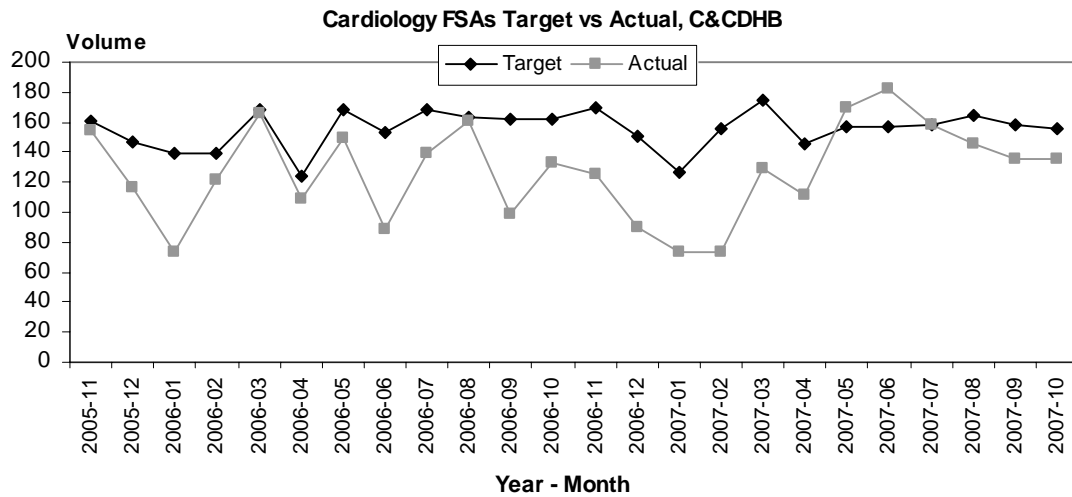
Selection of ‘marker’ tests for analysis of GP ordering presents some difficulty. For most private specialties, the laboratory tests ordered would be no different from those routinely ordered by GPs. Biopsies have been considered as a potential marker test here, as GPs are able to perform small excisions instead of the specialist. GP ordering of biopsies has not changed significantly. GPs accounted for 35.4% of biopsies for the twelve months prior to the PSRT change, and 35.9% for the twelve months after the change.

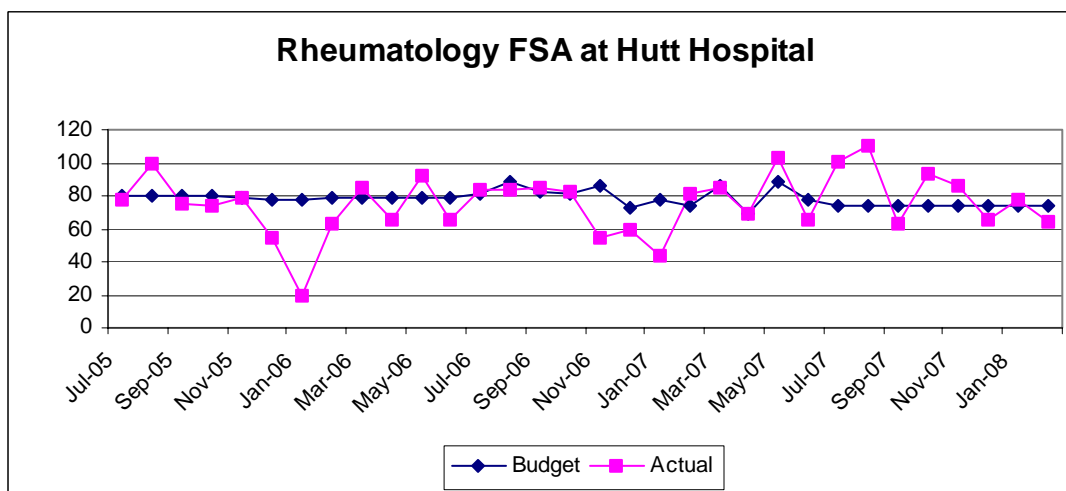
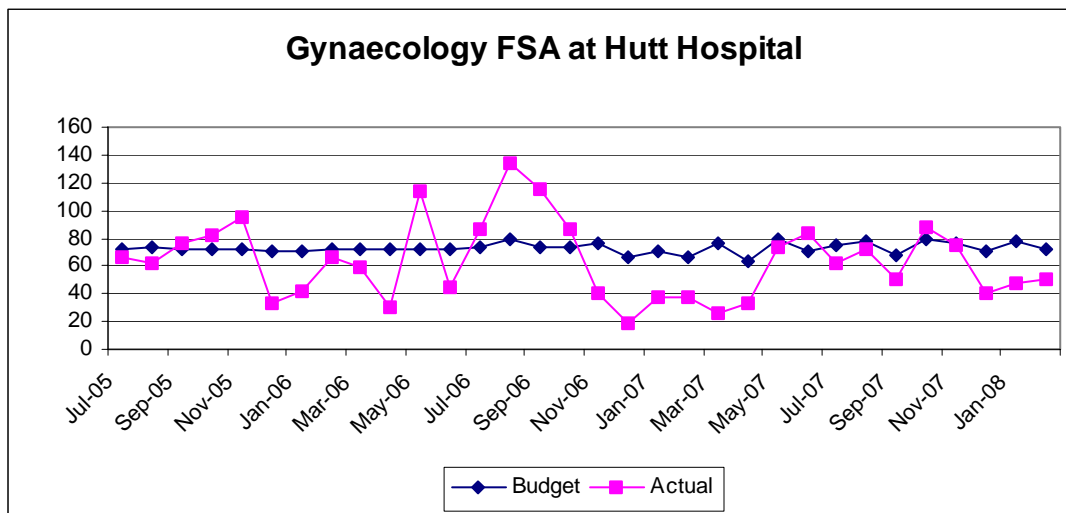
Impact on Public Hospitals

The risk raised in both the policy development, and by specialists in their communications, is that some private patients who are price sensitive may decide to go through the public system to avoid the laboratory costs.

The following graphs show the outpatient first specialist assessments (FSAs) in three specialties for which there is a private market. They have been tracked for the 12 months before and after the policy change. Rheumatology is included as there was particular concern expressed by rheumatologists about people with rheumatoid arthritis.

Catch-ups, annual leave, conference leave, and additional elective services funding may affect volumes from month to month but there does not appear to be any evidence of the policy having an impact on public hospital outpatient volumes at CCDHB and HVDHB. Volumes have not changed significantly, nor have they exceeded projected targets.





Evidence of Adverse Health Outcomes

The evaluation sought to answer this question principally by inviting GPs and private specialists in the two districts to provide any evidence that they may have regarding adverse health outcomes for their patients. A number of the responses focussed principally on the cost issue while a few raised pertinent issues in relation to the risk of harm and whether the duty of care rested with the private specialist or the GP.

General practitioners

All General Practitioners in the two districts were sent a letter inviting them to provide evidence of adverse health outcomes from the policy. A total of 9 responses were received from the 474 GPs.

Three responses cited cases of private specialists' patients who had not complied with requests to present for testing, with cost being the suggested reason for non-compliance. Two of the patients have resumed testing. There are no cases cited by GPs where harm is attributed to the policy. There is one case of a patient that had stopped having tests and then stopped taking medication with the eventual result being a urinary tract infection. There is a tenuous link to the change of policy being the direct cause of harm (the UTI).

Some GPs noted that any lack of evidence of adverse health outcomes should not be regarded as a reliable indicator that adverse outcomes are not occurring. It is the case, as with any service that incurs a fee that some people will decide not to pay for the service on affordability grounds. The average amount paid for private laboratory tests (around \$62) is significantly less than the cost of a private specialist consult.

Medical specialists

All of the 124 known practicing private specialists in the two districts were sent a letter inviting them to provide evidence of adverse health outcomes from the policy. DHBs received a total of 8 responses.

While there was no evidence of harm that could be directly attributable to the policy, three of the private specialists noted patients who had decided not to have the testing because of the cost. The patients' decision to not have the testing put them at risk of harm. Some of these patients are on medication with potentially dangerous side effects that requires regular monitoring.

The DHBs provided for hardship funding for patients with chronic medical conditions requiring ongoing testing. Applicants would be means tested and funding made available where laboratory costs exceeded \$500 in a six-month period. There have been no applications to access hardship funding to date, although there has been no ongoing promotion of the existence of the hardship funding. It would be appropriate to remind private specialists and GPs of the hardship funding so they can advise their patients.

Duty of Care

Both GPs and private specialists raised issues about the boundary for the duty of care. Some GPs are uncomfortable with ordering specialist tests, as they consequently become responsible for responding to the test result. It may become unclear as to which practitioner is responsible for the ongoing care of the patient. As one GP noted in his letter, "This has the potential to lead to difficulties and patients 'falling through the cracks' if there are abnormal results".

While some practitioners saw this as a negative issue, it is a positive outcome if GPs and private specialists are giving greater consideration to their roles and accountabilities in relation to patient care. After duty of care issues first arose in relation to the policy, the Chief Medical Advisors from HVDHB and CCDHB wrote to all GPs and private specialists about the issue, noting that

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

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

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

Since there will continue to be a risk of patients not being followed up by either practitioner, it is appropriate for GPs to refuse to order tests for specialists, not just to avoid cost shifting, but more importantly to ensure clarity about which practitioner is responsible for patient care.

It may be timely to write again to GPs and specialists to draw attention to this issue.

Costs

Patients

The tangible cost for private patients arises from the combined cost of each test ordered by their private specialist and the administration charge levied by Aotea Pathology. The test costs paid by private patients are comparable to the prices paid to laboratory providers by DHBs with fee-for-service contracts. The Aotea Pathology price for the top 10 tests (for NZ by volume) add up to \$87.50 compared to an average of \$87.51 paid by DHBs to other laboratory providers.

For the 12 month period ending 31 October 2007:

- the average paid per test was \$16.51
- the total number of patient visits for private tests was 43,566
- the total number of tests was 129,825
- the average number of tests per patient visit was 3
- the highest individual invoice was \$1,660.94, which related to pre-operative, intra-operative and post-operative tests for private cardiac surgery (note that a private cardiac operation can cost up to \$50,000).

The average paid per private patient appears to be \$62.20 but can't presently be calculated with accuracy as patients only pay one encounter fee per day but there can be several patient visits in a day (eg there may be 30 tests on the day that a patient has heart surgery).

There is a small intangible cost for patients arising from additional time taken to understand their obligation to pay and to attend to their payments obligation.

Private Specialists and GPs

The transaction cost that arises for private specialists and GPs in relation to laboratory tests for private patients is associated with the additional time taken to consider whether costs will apply to the patients, and to explain it to patients. Additional transactions costs have arisen for private specialists where they have not clearly identified the payer at the point of ordering, resulting in them having to provide clarification to Aotea Pathology. The payer may be the private patient, ACC, or in the case of exceptions to the business rules, the DHBs.

Aotea Pathology, in consultation with the DHBs, developed a brochure for patients to explain the funding of specialist ordered laboratory tests.

Aotea Pathology - The Laboratory Service Provider

The transaction costs for the laboratory service provider are significant but are offset by the administration charge that private patients pay. Aotea Pathology has had IT costs, additional administrative and phlebotomy staff costs, brochures and other communication materials, EFTPOS merchant costs, line rental, stationery, postage, and bad debt costs. Aotea Pathology report higher bad debt costs than expected (\$170,000 – 9%). These are expected to fall over time, as other DHBs adopt the policy and insurance companies respond with changes to allow greater claiming for laboratory test costs.

As noted above, Aotea Pathology is reimbursed test prices comparable to that paid by DHBs with fee-for-service contracts. The DHBs' contract with Aotea Pathology allows test prices to increase by the rate of consumer price inflation.

The DHBs do not have access to Aotea Pathology's detailed accounts to determine whether the annual patient encounter fees are merely adequate or are excessive. (The revenue from encounter fees is less than the number of patients visits multiplied by the encounter fee, as there is only encounter fee per day, for example, where a patient has multiple visits associated with surgery.) They would presently appear to be sufficient to cover Aotea Pathology's additional administrative costs. The DHBs' contract provides a mechanism to agree to adjust the charges to private patients, if there is good reason to believe that the charges are not appropriate.

DHBs

The transaction costs for the DHBs are relatively small, and associated with responding to queries and complaints and monitoring the PSRT related aspects of the contract with the laboratory services provider.

Resistance to the Policy

Evidence of patient resistance was found in complaints to the DHBs and to Aotea Pathology, altered patient behaviour and expectations, altered behaviour by GPs and private specialists.

Complaints

Prior to the policy change and partly in response to the consultation process, the DHBs received a number of formal objections from medical private specialists, particularly those dealing with chronically ill patients (eg those with rheumatoid arthritis), and patients whose treatment requires expensive testing at significant cost (eg patients having cardiac surgery).

In the twelve months following the policy change CCDHB received a total of 11 complaints from patients, and Hutt DHB received 12 complaints. The majority of these complaints were received in the period immediately after the policy change and only five complaints have been received in the last six months. In responding to the complaints, the DHBs have endeavoured to convey the principle behind the policy change and also draw attention to the hardship funding available.

The Health Funds Association has continued to express opposition to the policy, in particular citing the additional transaction cost to the system overall.

The laboratory service provider has reported that patient complaints have been minimal in relation to the number of patients that have been invoiced.

Altered patient behaviours and expectations

As noted above, some private specialists and GPs provided evidence that due to reluctance to pay the charge, some patients had not complied with their request that they provide specimens for testing by the laboratory services provider. The evidence of avoidance is anecdotal and while we know it has occurred in some cases, there is no reason to suspect that it is widespread.

Aotea Pathology has reported a large degree of acceptance from patients of private specialists that they will have to pay. Aotea Pathology has noted, however, that private patients are more likely to ask for a copy of their results, are more resistant to pay if they don't like the test result, and are resistant to paying for reflex testing (subsequent testing that may be determined by best practice). Comments on bad debts have been reported above.

Lessons From Implementing the Policy

Monitoring the impact of the change

It is worth considering more formal systems to capture the main impact of the new policy. It wasn't cost effective to have complete data available to monitor the impact of the policy but information might have been captured on:

- harm to patients associated with non-compliance with test ordering by private specialists
- the degree of volume shifting from private specialists to GPs
- the benefits of the new policy.

Allowing adequate time for implementation

Aotea Pathology agreed to implement the policy change at the same time as gearing up for the commencement of a new bulk funded contract for subsidised testing. There was a relatively short period between reaching agreement in principle on the terms of the contract and the commencement of the service. The short lead-time and relatively rapid speed of implementation meant referrers and patients had incomplete information at commencement. These issues have resolved or lessened as the new regime has become established.

Communication with GPs

The two DHBs communicated with GPs prior to and following the policy decisions. In hindsight GPs could have had more timely support in responding to requests to order tests for private specialists. This matter has caused friction between some GPs and some private specialists, although PHOs were helpful in clarifying the issue for GPs.

Securing and communicating the legal liability to pay for testing

In order to secure a legal obligation to pay, the laboratory must inform the patient of a private specialist of the test charges and obtain agreement to pay, prior to testing.

Unless a formal contract was established with a referrer, there is no liability for the referrer to meet the cost, if the patient refused to meet the costs.

It is important therefore for the laboratory provider to ensure that a contractual liability is established in advance with the patients of private specialists. This can be established reasonably easily where a patient presents in person at the laboratory provider's premises. It is more difficult to achieve where the test specimen is collected by the referrer, for example by a surgeon in the course of surgical treatment.

APPENDIX 1



Business Rules for Private Specialist Referred Laboratory Testing

1. Referrals for laboratory testing from private specialists are excluded except in the following cases:
 - People who are eligible for ACC are eligible for laboratory testing under this Agreement, as laboratory tests are included in Public Health Acute Service Funding.
 - Women requiring antenatal tests specifically for the purpose of ensuring the clinical safety of the foetus and the mother during pregnancy are included under this Agreement.
 - People who are referred for tests by private specialists as part of their treatment at publicly funded non-governmental services. This includes people accessing:
 - Family planning services
 - Fertility services (but only for those whose treatment is being publicly funded)
 - The regional sexual health service funded by C&CDHB & Hutt Valley DHB
 - Welltrust
 - Hospice
 - Other NGO services as advised from time to time by the DHBs.
2. People requiring tests that are for diagnosis and treatment purposes and have a significant element of public good associated with them as defined by the Oversight Advisory Group and approved by the DHBs. Initially this will include:
 - Testing for Tuberculosis
 - Testing related to Gamete donation
 - Certain tests for infectious diseases such as Hepatitis, HIV, Chlamydia and Syphilis
3. The following occupational groups are considered to be specialists:
 - General practitioners working in private hospitals or specialist clinics are considered to be specialists under this Agreement. This includes GPs doing, for example, cardiology, appearance medicine, menopause clinics, men's health, sports medicine.
 - Oral health surgeons.
4. Where a GP is carrying out minor surgery (e.g. skin lesion excision or vasectomy) on primary care premises this is considered to be primary referred rather than specialist testing.
5. Primary Care practitioners include midwives and dentists.
6. People who do not live in the Hutt Valley or Capital and Coast DHB regions are subject to the same rules as those living within the region. This means, for example, that residents of Wairarapa and MidCentral DHB regions will pay for tests referred by private specialists.
7. Where a patient has paid \$500 or more over a 6-month period for a chronic, non-surgical condition and is likely to require ongoing tests a hardship exemption may be available from us, but for the avoidance of doubt, you remain entitled to charge for Private Specialist Referred Tests in accordance with clause H5. Individuals may apply to be assessed on a case-by-case basis through the DHB's contract manager and community laboratories Oversight Advisory Group.