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Notice under s66 of the Commerce Act 1986 by

Valley Diagnostic Laboratories Limited

and

Wellington Pathology Limited

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COMMERCE ACT 1986: BUSINESS ACQUISITION

SECTION 66: NOTICE SEEKING CLEARANCE

7 December 2005

The Registrar
Business Acquisitions and Authorisations
Commerce Commission
PO Box 2351
Wellington

Pursuant to s66(1) of the Commerce Act 1986 notice is hereby given seeking **clearance** of a proposed business acquisition.

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Glossary	
Abano	Abano Healthcare Group Limited and its interconnected bodies corporate.
Applicants	Valley Diagnostic and Wellington Pathology
CHL	Canterbury Health Laboratories, the laboratory arm of the Canterbury DHB.
Decision 559	The decision of the Commerce Commission declining clearance for the mergers of the businesses of Sonic and NZDG in six DHB areas.
DHB	District Health Board
Greater Wellington region	The area funded by the Hutt Valley and Capital & Coast District Health Boards
Labco Wellington	A new company to be formed, which will be owned in, or approximately in, equal shares by Wellington Pathology and Valley Diagnostic.
LabPLUS	The laboratory arm of the Auckland DHB
NZDG	New Zealand Diagnostic Group Limited
Regional Contract	A contract to provide community referred pathology services for the Greater Wellington region (i.e. the combined Hutt Valley and Capital & Coast DHBs).
RFP	Request for Proposal
Sonic	Sonic Healthcare Limited and its interconnected bodies corporate.
Valley Diagnostic	Valley Diagnostic Laboratories Limited, a wholly owned subsidiary of Sonic Healthcare (New Zealand) Limited.
Wellington Pathology	Wellington Pathology Limited, a wholly owned subsidiary of Abano Healthcare Group Limited.

EXECUTIVE SUMMARY

Proposal

1 Clearance is sought for:

1.1 the acquisition by Labco Wellington (a new company to be formed) of certain assets of the pathology services businesses of Wellington Pathology Limited and Valley Diagnostic Laboratories Limited; and

1.2 the acquisition of shares in Labco Wellington, in approximately equal proportions, by Abano Healthcare Group Limited and Sonic Healthcare Limited or their wholly owned subsidiaries,

(the *Transaction*).

2 It is proposed that Labco Wellington will submit a bid for a contract for the provision of community referred pathology services for the combined Hutt Valley and Capital & Coast DHB regions (the *Regional Contract*). The submission of a bid will be conditional on Commerce Commission approval of the Transaction having been obtained – and the Transaction is conditional on that bid being successful.

Background

3 The current contracts for the provision of community referred pathology services to the Hutt Valley and Capital & Coast DHBs are due to expire on 30 September 2006. On 2 December 2005, the DHBs issued a Request for Proposal (*RFP*) for the provision of these services, with proposals to be submitted by 17 February 2006.

4 The RFP invites tenderers to submit bids for each of the Hutt Valley and Capital & Coast DHB regions individually – as well as a bid for the two areas combined. The proposed contract term is 5 years. The RFP confirmed the Applicants' assumption that contracts will be sole supply contracts – i.e. that the DHBs are proposing to appoint a single provider of community pathology services in each region, or the combined region, rather than having multiple providers.

5 The DHBs are also considering whether specialist referred testing will be removed from the scope of the contracts and the RFP asks tenderers to submit prices inclusive and exclusive of specialist referred testing. The consequence of the exclusion of specialist referred testing from the scope of the contracts (if that is how the DHBs elect to proceed) is that this testing will ultimately be paid for by the patient (or potentially his/her insurer).[1]

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[1] Regardless of whether or not specialist testing is included in the contract, the effect of a sole supply contract is that unsuccessful bidders will exit the region as the volume of specialist work would not be enough to sustain a firm performing only specialist work.

6 It is expected that the Applicants will submit their own individual bids for the individual DHB regions (although neither Applicant knows whether that is in fact the case in relation to the other). However, the Applicants consider that considerable savings can be derived, and passed on to the DHBs, by the Applicants utilising their complementary collection facilities and resources in the Hutt Valley and Capital & Coast regions and providing community pathology services for both regions through Labco Wellington.

Valley Diagnostic and Wellington Pathology

7 As the Commission is aware, Valley Diagnostic is a wholly owned subsidiary of Sonic Healthcare, which also has other subsidiaries providing pathology services in a number of other regions in New Zealand.

8 Wellington Pathology is a wholly owned subsidiary of Abano Healthcare, which has subsidiaries providing pathology services only in the Wellington and Nelson/Marlborough regions.

9 Valley Diagnostic's revenues are primarily derived from community referred pathology services provided in the Hutt Valley DHB region.

10 By contrast, Wellington Pathology's revenues are primarily derived from community referred pathology services provided in the Capital & Coast DHB region.

11 Accordingly, the activities of Valley Diagnostic and Wellington Pathology in the wider Wellington region are complementary rather than competitive. Each has infrastructure designed to serve the community testing needs of a different DHB. The complementary rather than competitive nature of the two businesses is evidenced by the fact that no GPs have switched between Valley Diagnostic and Wellington Pathology in the last three years.

Markets Affected

12 The Applicants do not agree with the Commission's product market definitions in Decision 559 and in particular the separation of community referred, hospital referred and send-away testing into separate markets. For the purposes of this application, the competition effects of the Transaction have been assessed against the following market definitions:

12.1 the market in the Hutt Valley and Capital & Coast DHB regions (the *Greater Wellington region*) for the provision of hospital and community referred pathology services;[2] and

12.2 the national market for the provision of cervical screening tests.

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[2] Note that Valley Diagnostic and Wellington Pathology operate largely in separate DHB areas and that it is only as a consequence of the Hutt Valley and Capital & Coast DHBs' RFP which seeks a price for their combined regions that the combined region has been considered as a market on its own. Where the Applicants are submitting tenders for the individual Hutt Valley and Capital & Coast contracts, each of these regions comprises a separate market.

Competition Effects – Greater Wellington region

13 The competition effects of the Transaction need to be considered at three stages:

13.1 competition for the contract(s) that will be awarded in the current contract round;

13.2 competition during the contract term; and

13.3 competition for next contract(s) after expiry of the contracts awarded in this contract round (*the next contract round*).

14 The merger will have no effect on competition during the term of the contract. The sole supplier status of the provider of community referred services means that there is no scope for competition during the contract term. No further consideration is given to this aspect in this application.

15 In the current contract round:

15.1 Valley Diagnostic and Wellington Pathology are, at best, potential competitors for the combined region. Neither can be considered 'incumbents' for the entire region. Valley Diagnostic does not have testing infrastructure in the Capital & Coast DHB region or collection rooms in the central Wellington area. (It has two collection rooms on the Kapiti Coast.) Wellington Pathology does not have collection or testing infrastructure in the Hutt Valley DHB region.[3]

15.2 There are other potential bidders. In particular, in Decision 559 the Commission concluded that NZDG was likely to be recognised as a capable and strong service provider with a proven track record.

15.3 In Decision 559, the Commission considered the DHBs' own provider arms as 'backstop options' or 'bidders of last resort'. Without commenting on that conclusion, the Applicants do not consider that to be the case here. The Applicants have received information that indicates that the DHB provider arms are preparing bids in response to the RFP and that they are only to be submitted if they are realistic ones. There is no doubt that the Applicants consider that the DHBs' own labs have the capacity, either on their own or with support from Canterbury Health Laboratories (*CHL*), to provide community pathology services in the region. That knowledge alone will represent an immense constraint on the Applicants' bid and on any individual bids submitted by the Applicants.

[3] Wellington Pathology has a small collection centre in Paraparaumu on the Kapiti Coast, which provides services for one or two doctors and has one staff member.

15.4 The DHBs also have the option of purchasing individually from separate providers for each of the Hutt Valley and Capital & Coast regions.

15.5 In a counterfactual with both Valley Diagnostic and Wellington Pathology bidding independently for the Regional Contract (if that is in fact the correct counterfactual) the combined effect of the various conditions each would face is such that neither would have any overall advantage over other potential bidders. For example:

(a) Wellington Pathology would have greater existing resources within the region so would need to employ fewer additional staff and establish less infrastructure than Valley Diagnostic or NZDG;

(b) on the basis of the Commission's findings in Decision 559, Valley Diagnostic and NZDG would have the advantage over Wellington Pathology of national networks and more significant resources on a national level;

(c) the DHB laboratories would have the advantage of scale and scope economies through combining hospital and community testing volumes; and

(d) Wellington Pathology, Valley Diagnostic, NZDG and the hospital laboratories (including CHL) all have some knowledge of providing services to the region.

15.6 Since neither Valley Diagnostic nor Wellington Pathology presently has sufficient personnel to provide the services under the Regional Contract itself, they would each face uncertainty, as would the other bidders, as to whether they would in fact be able to obtain the staff (particularly pathologists and scientific officers) required to carry out the Regional Contract.

15.7 The Transaction may provide the merged entity with an advantage through the utilisation of existing resources but, relative to the counterfactual, it does not raise the barriers to entry for other bidders for the Regional Contract (or separate contracts for the two DHB regions).

15.8 Against this background, the countervailing power of the DHBs, as sole purchasers of community pathology services, will not be lessened by the Transaction.

15.9 There is no certainty that either Valley Diagnostic or Wellington Pathology would bid for a contract outside their current primary area of operation. In Decision 559, the Commission considered that Abano "would be unlikely to exert much competitive pressure outside [its] own regions of incumbency". Against that counterfactual, the

Transaction will not lessen the number of bidders for the Regional Contract.

15.10 The Transaction provides certainty that there will in fact be a bid for the combined region. Separate confidential papers will be provided by the Applicants in relation to their intentions with regard to tendering for work outside the Hutt Valley and Capital & Coast DHB regions respectively.

15.11 The accompanying paper from CRA International establishes that, even if in the counterfactual, Valley Diagnostic and Wellington Pathology were each to submit an independent bid for the combined region, the merged entity bid would not result in a substantial lessening of competition.

16 Each of the above points applies equally in relation to the next contract round. In addition, the Applicants refer the Commission to their separate confidential papers regarding the anticipated outcome should they be unsuccessful in the current round.

17 Accordingly, the Applicants do not consider that the Transaction will result in a substantial lessening of competition in the market for the provision of community referred pathology services in the Greater Wellington region.

Other regional markets

18 The Transaction will not enhance the likelihood of co-ordinated behaviour occurring in other regional markets such that the Transaction would give rise to a substantial lessening of competition in those markets. Abano's only pathology businesses are in the Capital & Coast DHB region (covered by this application) and in the Nelson/Marlborough region (which is outside the scope of this merger). In each DHB area (including Nelson/Marlborough), there are other current or potential providers of community referred pathology services and the DHBs have a number of structuring options available to them. These options include gearing up their own labs to provide community referred services, subcontracting some services to DHB labs outside the region or combining with another DHB in a neighbouring region.

Differences with Sonic/NZDG clearance application

19 There are several aspects of this Transaction that differ from the Sonic/NZDG merger proposals to which Decision 559 relates, in particular:

19.1 There is very little overlap in the activities of Valley Diagnostic and Wellington Pathology.

19.2 Unlike the Otago/Southland situation, the Hutt Valley and Capital & Coast DHBs are not tendering out the hospital referred work. This merger relates only to community referred work. This will mean that the DHBs will maintain their capacity to bid for community referred

testing in a future round, whatever the outcome in the current contract round.

19.3 In contrast to NZDG, which has provided pathology services in 13 DHB regions, Abano has provided pathology services only in the Capital & Coast DHB region and in the Nelson/Marlborough region. Abano is a small second tier player which, in Decision 559, the Commission appears to have dismissed as a potential competitor for contracts outside the DHB regions where it has facilities.

19.4 While in Decision 559 the Commission concluded that the DHB labs did not represent a constraint on the merged entity (a conclusion which the Applicants do not agree with) that is not the case here. The DHB labs in the Wellington region clearly have the ability and have indicated their willingness to provide community referred services.

Cervical Screening

20 Wellington Pathology and Valley Diagnostic both have contracts with the National Screening Unit (*NSU*), the division of the Ministry of Health responsible for the Cervical Screening Programme.

21 In Decision 559 the Commission considered the implications of the Sonic and NZDG mergers in the national market for the provision of cervical screening tests since both Sonic and NZDG are both providers in this market.

22 The Commission found that there are currently 12 pathology laboratories that hold contracts with the NSU. These providers are:

- Diagnostic Medlab (Sonic)
- Valley Diagnostic (Sonic)
- Medlab Central (Sonic)
- Medlab South (Sonic)
- Medlab Hamilton (NZDG)
- SCL Christchurch (NZDG)
- SCL Dunedin (NZDG)
- Medlab Bay of Plenty (PAL)
- Pathlab Waikato (PAL)
- Wellington Pathology (Abano)
- LabPLUS (DHB)
- CHL (DHB)

27 The Commission concluded that the mergers to which Decision 559 relates would not have the effect of substantially lessening competition in the

national market for the provision of cervical screening tests on the basis that:

27.1 before and after the mergers, there would continue to be considerable competition in the market; and

27.2 the NSU has a substantial degree of countervailing power in that it is a price-setter, decides who to contract with, and can cancel any providers' contract if it is not satisfied with the level of service provided.

28 It is evident, without further explanation, that a similar conclusion must be reached in relation to the proposed Transaction as there would continue to be four groups of current providers unaffected by the Transaction: Sonic, NZDG, PAL and the DHB labs.

29 No further consideration of cervical screening is contained in this application. However, should the Commission consider that it may depart from its conclusion in Decision 559 in this respect or wish to receive any further information on this aspect of the application from the Applicants, the Commission is requested to contact the Applicants' legal advisors.

Confidential information

30 In preparing this application, the Applicants have adopted a strict process to ensure that confidential information of each Applicant, that would otherwise not be available about their individual businesses, is not disclosed to the other. In order to preserve the confidentiality of information as between the Applicants, they have undertaken the following process:

30.1 Lindsey Lawton, an independent consultant, has been engaged to gather and collate costing information about:

(a) the Applicants' businesses and likely costs to supply the Regional Contract on their own (if that is what they choose to do); and

(b) the Applicants' views of the likely costs for the DHB labs to provide the services covered by the Regional Contract.

Lindsey Lawton's report is attached as Annexure 2

30.2 CRA International has been engaged to review the costing data provided by Lindsey Lawton, and to use this as an input into an analysis of the unilateral effects of the Transaction. CRA International's report is attached as Annexure 1.

30.3 Both Lindsey Lawton and CRA International have signed undertakings not to disclose to either Applicant the information provided by the other or to disclose to either Applicant any

information containing data from both Applicants or any report they produce.

30.4 In order to assist with the preparation of this application, the Applicants' legal counsel have worked with Lindsey Lawton and CRA International and have been provided with information about both Applicants and the reports (including drafts) they have produced. The Applicants' legal counsel have undertaken not to disclose to their respective clients confidential information relating to the other's client and the Applicants have waived their right to enforce the usual solicitor obligations in this regard.

PART I: TRANSACTION DETAILS

1 What is the business acquisition for which clearance is sought?

1.1 The Transaction for which clearance is sought is:

(a) the acquisition by Labco Wellington (a new company to be formed) of certain assets of the pathology services businesses of Wellington Pathology Limited and Valley Diagnostic Laboratories Limited; and

(b) the acquisition of shares in Labco Wellington by Wellington Pathology Limited and Valley Diagnostic Laboratories Limited.

1.2 It is proposed that Labco Wellington will submit a bid for a contract for the provision of community referred pathology services for the combined Hutt Valley and Capital & Coast DHB regions (the *Regional Contract*). The submission of a bid will be conditional on Commerce Commission approval of the Transaction having been obtained – and the Transaction is conditional on that bid being successful.

1.3 Labco Wellington has yet to be incorporated and the proportionate shareholdings of Wellington Pathology and Valley Diagnostic have yet to be finally determined. However, it is anticipated that the shares will be held in, or in approximately, equal proportions.

1.4 The parties have yet to negotiate an agreement for sale and purchase relating to the transaction.

2 Who is the person giving this notice?

2.1 This notice is given by:

Valley Diagnostic Laboratories Limited

C/o Sonic Healthcare Limited
2-4 Kirksway Place
Hobart
Tasmania 7000

AUSTRALIA

Telephone: +61 613 6223 7513

Facsimile: +61 613 6223 1275

Attention: Colin Jackson

Wellington Pathology Limited

C/o Abano Healthcare Group Limited
Level 16, West Plaza Building
3-7 Albert Street
PO Box 106-514
Auckland

NEW ZEALAND

Telephone: +64 9 300 1410

Facsimile: +64 9 300 1419

Attention: Alan Clarke/Andrew Tapper

2.2 All correspondence and notices in respect of this application should be directed in the first instance to:

Chapman Tripp Sheffield Young

Level 35
ANZ Tower
23-29 Albert Street

Auckland

Telephone: +64 9 357 9020
Facsimile: +64 9 357 9099

Attention: Lindsey Jones / Jane Baker

Buddle Findlay

State Insurance Tower
BNZ Centre
1 Willis Street

Wellington

Telephone: +64 4 498 7304
Facsimile: +64 4 462 0484

Attention: Tony Dellow / Susie Kilty

3 Confidentiality

3.1 Do you wish to request a confidentiality order for the fact of the proposed acquisition?

No. Confidentiality is not required for the fact of the proposed merger.

3.2 Do you wish to request a confidentiality order for specific information contained in or attached to the notice? If so, for how long? Why?

(a) Yes. Confidentiality is sought in respect of:

- the CRA International report in Annexure 1; and
- Lindsey Lawton's report in Annexure 2,

until the relevant Applicant confirms in writing to the Commission that the particular information is no longer confidential.

(b) Confidentiality is sought under section 100 of the Commerce Act 1986 and under section 9(2)(b) of the Official Information Act 1982 on the grounds that:

(i) the information is commercially sensitive and contains valuable information which is confidential to the Applicants; and

(ii) disclosure of it is likely to give an unfair advantage to the Applicants' competitors and unreasonably prejudice the commercial positions of the Applicants.

(c) The Applicants also request that they are notified of any request made to the Commission under the Official Information Act for the confidential information, and that the Commission seeks the relevant Applicant's views as to whether the information remains confidential and commercially sensitive at the time those requests are being considered.

4 Who are the participants (i.e. the parties involved)?

4.1 **Valley Diagnostic Laboratories Limited**

C/o Sonic Healthcare Limited
2-4 Kirksway Place
Hobart
Tasmania 7000

AUSTRALIA

Telephone: +61 613 6223 7513
Facsimile: +61 613 6223 1275

Attention: Colin Jackson

4.2 **Wellington Pathology Limited**

C/o Abano Healthcare Group Limited
Level 16, West Plaza Building
3-7 Albert Street
PO Box 106-514

Auckland
NEW ZEALAND

Telephone: +64 9 300 1410
Facsimile: +61 9 300 1419

Attention: Alan Clarke / Andrew Tapper

5 Who is interconnected to or associated with each participant?

Valley Diagnostic

5.1 Valley Diagnostic is a wholly owned subsidiary of Sonic Healthcare (New Zealand) Limited, which is in turn a wholly owned subsidiary of Sonic Healthcare Limited.

5.2 Sonic Healthcare Limited is a medical diagnostics company, providing pathology and radiology services to medical practitioners, hospitals, community medical services and their patients. Sonic Healthcare is listed on the Australian Stock Exchange. For further details see http://www.sonichealthcare.com/sonic/internet/. A diagram of the Sonic group in New Zealand is attached at Schedule 1.

Wellington Pathology

5.3 Wellington Pathology is a wholly owned subsidiary of Abano Healthcare Group Limited. The Abano group incorporates a range of healthcare and medical services companies, including rehabilitation, diagnostic and dental divisions. Abano Healthcare works in partnership with the various businesses within the group, providing support in terms of management and financial processes to these businesses. Abano is listed on the New Zealand Stock Exchange. For further details see http://www.abanohealthcare.co.nz/. A diagram of the Abano group in New Zealand is attached at Schedule 2.

6 Does any participant, or any interconnected body corporate thereof, already have a beneficial interest in, or is it beneficially entitled to, any shares or other pecuniary interest in another participant?

6.1 Neither Valley Diagnostic nor Wellington Pathology nor any of their interconnected bodies corporate has any beneficial interest in shares or any other pecuniary interest in the other.

7	**Identify any links, formal or informal, between any participant/s including interconnected bodies corporate and other persons identified at paragraph 5 and its/their existing competitors in each market.**

There are no links, formal or informal, between any participant(s) including interconnected bodies corporate and other persons identified at paragraph 5 and its/their existing competitors in each market other than the following:

7.1 Existing arrangements between Valley Diagnostic or Wellington Pathology and DHBs:

Valley Diagnostic

(a) Agreement between Valley Diagnostic and the Hutt Valley DHB in relation to the provision of community laboratory services. Valley Diagnostic is presently paid under this contract for work it carries out in the Hutt Valley, Capital & Coast and Wairarapa DHB areas.

(b) Valley Diagnostic has an arrangement with Hutt Valley DHB under which the DHB's lab does some testing work for Valley Diagnostic and Valley Diagnostic does some testing work for the DHB's lab, where either lab does not have the capability to perform the particular test. There is no formal contract but invoices are generated between the two labs. Valley Diagnostic's work for the DHB in this situation is predominantly in the cytology field.

(c) Two of the pathologists employed by Valley Diagnostic are also employed part time by Hutt Valley DHB and two pathologists are employed part time by Capital & Coast DHB.

Wellington Pathology

(d) Agreement between Wellington Pathology and Capital & Coast DHB in relation to the provision of community laboratory services. Wellington Pathology is also paid under this contract for the limited amount of testing work it carries out that is generated from the Hutt Valley DHB area.

(e) Agreement between Wellington Pathology and Capital & Coast DHB for the provision of cytology screening services and for "backup" pathology testing services for tests that are common to both parties.

(f) Five pathologists employed by Wellington Pathology are also employed part time by Capital & Coast DHB.

7.2 Other arrangements:

(a) Weekly meetings are held between pathologists from Valley Diagnostic, Wellington Pathology and Hutt Valley DHB to discuss clinical issues.

(b) The Sonic/NZDG Clearance Application lists other arrangements between interconnected bodies corporate of Valley Diagnostic and competitors. In addition, other companies in the Sonic group have arrangements with DHBs in other regions not covered by that clearance application. Further details can be provided if the Commission so wishes.

(c) Similarly, Abano's subsidiary in Nelson/Marlborough has arrangements with the Nelson/Marlborough DHB. Details are available if the Commission wishes.

(d) As the Commission is aware from the Sonic/NZDG clearance application, Sonic and New Zealand Diagnostic Group Limited (NZDG) were proposing to merge their businesses in the Hawke's Bay, Canterbury, South Canterbury, the West Coast, Otago and Southland DHB areas. Sonic and NZDG are presently considering their options in relation to those transactions.

7.3 Industry association: Valley Diagnostic, Wellington Pathology and other companies in the Sonic and Abano groups are members of the New Zealand Association of Pathology Practices (NZAPP), formerly the Association of Community Laboratories (ACL).

7.4 Wellington Pathology is a member of the Allied Laboratories of New Zealand (ALANZ), an association of independent laboratories, which exists mainly to facilitate the joint purchasing of laboratory supplies. Two executives of Wellington Pathology are directors of ALANZ.

8	**Do any directors of the 'acquirer' also hold directorships in any other companies which are involved in the markets in which the target company operates?**

8.1 None of the directors of the companies in the Sonic Group hold directorships in any other companies (other than companies in the Sonic group) which are involved in the provision of pathology services in New Zealand.

8.2 None of the directors of the companies in the Abano Group hold directorships in any other companies (other than companies in the Abano group) which are involved in the provision of pathology services in New Zealand.

9 What are the business activities of each participant?

9.1 The core services provided by Valley Diagnostic and Wellington Pathology are diagnostic laboratory services (also called pathology services). As noted in Decision 559, these services involve examining clinical specimens to provide information for the diagnosis, prevention and treatment of disease, and reporting the diagnosis to the referring health professional. Ancillary to the analysis itself is the collection and transportation of the samples.[4]

9.2 In the context of the Sonic/NZDG clearance application, the Commission has already received extensive submissions and information on the scope of diagnostic laboratory services and the activities of the wider Sonic Group in New Zealand. We do not repeat that here but if the Commission requires any further analysis or clarification of any matter relating to the wider pathology industry, the Applicants are happy to provide that.

9.3 In the interests of avoiding unnecessary repetition, the following paragraphs focus specifically on:

(a) the pathology services provided by Valley Diagnostic in the Greater Wellington region; and

(b) the pathology services provided by Wellington Pathology in the Greater Wellington region.

Valley Diagnostic

9.4 Valley Diagnostic has one lab located in Lower Hutt and seven collection centres, four of which are located within the Hutt Valley DHB region, two are located in the Kapiti Coast area and one in Wairarapa. Those collection centres are located in Lower Hutt, Upper Hutt, Wainuiomata, Petone, Waikanae, Paraparaumu and Carterton.

9.5 As with other privately owned laboratory businesses, around 96% of Valley Diagnostic's annual revenues are currently derived from DHB funded testing. The remaining 4% comes from privately funded testing.

9.6 Most of Valley Diagnostic's testing work comes from patients in the Hutt Valley DHB region. Valley Diagnostic also derives some revenues from the Capital & Coast DHB region (primarily in the Kapiti Coast), and the Wairarapa DHB region (South Wairarapa only). A breakdown of these revenues is contained in Valley Diagnostic's separate confidential paper. A very small proportion of Valley Diagnostic's work is also derived from other DHBs around New Zealand (which is a result of people from other DHB regions being treated in the Hutt Valley).

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[4] Decision 559, paragraph 26.

9.7 Valley Diagnostic is presently funded as follows:

(a) by the Ministry of Health for work carried out for the Cervical Screening Unit;

(b) for the majority of work, by the Hutt Valley DHB, with the DHBs settling between themselves the funding for the services provided within their districts; and

(c) by privately funded testing.

Wellington Pathology

9.8 Wellington Pathology has one lab located in central Wellington and 10 main collection centres, all located within the Capital & Coast DHB region. Those collection centres are located in central Wellington (two collection centres), Paraparaumu, Porirua (two collection centres), Johnsonville, Newtown, Miramar, Karori and the Wakefield Hospital Specialist Centre. Wellington Pathology also sub-leases rooms, which are open for a short period each day at Mana, Khandallah, Tawa, and Bowen Hospital.

9.9 As with other privately owned laboratory businesses, around 96% of Wellington Pathology's annual revenues are currently derived from DHB funded testing. The remaining 4% comes from privately funded testing.

9.10 Most of Wellington Pathology's testing work comes from patients in the Capital & Coast DHB region. A breakdown of these revenues is contained in Wellington Pathology's separate confidential paper.

9.11 Wellington Pathology is presently funded as follows:

(a) by the Ministry of Health for work carried out for the Cervical Screening Unit;

(b) for the majority of work (including work undertaken for Sexual Health Services), by the Capital & Coast DHB, with the DHBs settling between themselves the funding for the services provided within their districts; and

(c) by privately funded testing.

Summary

9.12 As the above illustrates, the activities of Valley Diagnostics and Wellington Pathology in the wider Wellington region are complementary rather than competitive. Each has infrastructure designed to serve the community testing needs of a different DHB. The complementary rather than competitive nature of the two businesses is evidenced by the fact that no GPs have switched between Valley Diagnostic and Wellington Pathology in the last three years.

Other regions

9.13 The Commission is aware, from the Sonic/NZDG clearance application, of the pathology businesses of Sonic subsidiaries elsewhere in New Zealand. Abano's only other pathology business is in the Nelson/Marlborough region.

9.14 However, the Transaction for which clearance is sought does not affect Abano and Sonic businesses in the other DHB regions.

10 What are the reasons for the proposal and the intentions in respect of the acquired or merged business?

10.1 Having considered the Sonic/NZDG clearance application, the Commission is now aware of recent developments that have occurred in the pathology sector, including the DHB-led trend towards sole supply contracts, the integration of the community and hospital labs and the collective purchasing (or supply) of pathology services by DHBs – all driven by the desire to make cost savings. The Commission will also be aware of specific reports prepared in relation to the Wellington region, in particular the LECG report.[5]

10.2 The current contracts between the Hutt Valley and Capital & Coast DHBs and private providers of pathology services in the region originally expired on 30 September 2005 but have been renewed through until 30 September 2006. As with DHBs in other regions throughout New Zealand, the Hutt Valley and Capital & Coast DHBs, having held down the testing fees and refused to increase the fees for over 10 years (evidence of their countervailing power), are exploring ways to further reduce the cost of pathology services.

10.3 The Hutt Valley and Capital & Coast DHBs have together released an RFP which invites providers of laboratory services to submit a proposal to provide the services for a fixed price, bulk funded payment. A copy of the RFP is attached as Annexure 3.

10.4 The RFP states that its purpose is to obtain information from potential providers to enable selection of a *service provider or providers of community referred medical laboratory testing*. The RFP notes that potential providers will be invited to submit a response in respect of either DHB region separately and, if they wish, prices for each region if their price for the other region is accepted.

10.5 The RFP confirmed the widely held view that the DHBs are looking for a single provider of community referred pathology services.[6] Given the DHBs' invitation to potential providers to submit a response for one DHB region or the combined regions, it is possible that the RFP could result in a sole supplier covering both regions, if that is what the DHBs conclude will deliver them best value for money.

10.6 Since:

(a) Valley Diagnostic does not have a lab (and has only two collection centres) located within the Capital & Coast DHB area;

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[5] Central Region Laboratory Project – Report from the Central Region Laboratory Working Party, LECG February 2005.

[6] See Part Two: General Terms, Section D: Standard Conditions of Agreement, cl D1 "Exclusivity of Rights" of the RFP, which states that "This Agreement gives you exclusive rights to provide Primary Referred Laboratory services for us as defined in this Agreement."

(b) Wellington Pathology does not have a lab or collection centres located within the Hutt Valley DHB area; and

(c) both parties have the lab facilities and staff required to provide the community referred services required in each of the Hutt Valley and Capital & Coast areas,

the Applicants have together, through the engagement of independent consultants (ringfenced from the Applicants themselves), determined that they can best respond to the Hutt Valley and Capital & Coast DHBs' desire to reduce expenditure on pathology services by combining their facilities and resources in these areas. In addition to this, given the Applicants' complementary activities in the two DHB regions, the Applicants are the only providers who would be able to immediately meet the DHBs' requirements without incurring additional costs or exposing the DHBs to significant risk of non-performance.

PART II: IDENTIFICATION OF MARKETS AFFECTED

Horizontal Aggregation

11	**Are there any markets in which there would be an aggregation of business activities as a result of the proposed acquisition?** **(Please identify for each market:** ❑ **the product(s), functional level, geographical area and (where relevant) timeframe;** ❑ **the specific parties involved; and** ❑ **the relationship of those parties to the acquirer or the target company as the case may be.**

Market Definition

11.1 Extensive submissions were made in the Sonic/NZDG clearance application on the issue of market definition. That application explained in particular, the reasons why the Commission should analyse the competitive impact of the transactions in terms of the market for the provision of pathology services which comprised:

(a) both hospital and community referred services (as opposed to a separate community referred market);

(b) the collection, transport, analysis and reporting of samples; and

(c) in the relevant geographical (DHB-defined) region.

11.2 For the reasons given in the Sonic/NZDG clearance application, the Applicants believe that the market definition adopted in that application is the appropriate definition in the present circumstances, with appropriate changes to reflect the geographic areas of the businesses affected by the proposed merger.

11.3 The Applicants do not agree with the Commission's conclusion in Decision 559 that community referred and hospital referred testing should be defined in separate product markets. The Applicants consider that the Commission has over-emphasised the differences and has incorrectly concluded that the scope for demand and supply side substitution is limited.

11.4 With reference to the Commission's reasoning in paragraphs 107 – 116 of Decision 559, and having regard to the circumstances that apply in the Wellington region, the Applicants comment as follows.

Turnaround times

11.5 The Commission noted (at paragraph 108) that the testing needs of public hospitals are often more time-critical than community tests. There are several observations to be made here:

(a) By far the majority of hospital tests are not time critical. The Applicants estimate that less than 5% of hospital testing would require a turnaround time of less than two hours.

(b) For the remaining 95% of non-urgent tests, hospital and community turnaround times are similar. The Applicants are unclear how the Commission concluded that community providers typically offer 24-hour turnaround times (refer Decision 559, paragraph 107).

(c) In the greater Wellington region at least, the vast majority of routine automated tests are turned around (in hospital or community labs) within three to four hours.

(d) Some testing requires a longer turnaround time, simply by the nature of the test itself (for example, microbiology and histology). These times apply irrespective of where the test is done.

(e) With good operating efficiency, turnaround times for non-urgent testing are the same as for urgent testing. In most modern labs, there are no longer clear differences between the two.

(f) Even if there were differences between the turnaround times presently offered by hospital and community providers, there would be few barriers to community providers delivering shorter turnaround times. Turnaround times are simply a matter of utilising existing infrastructure and skills in different ways, or supplementing existing resources. Neither of the Applicants' labs is subject to any resource consent restriction that would prevent them operating 24 hours a day.

(g) The Commission has overstated the degree to which operational systems would need to be re-configured. The Applicants consider that all that is needed onsite in a hospital (or nearby) is a small "stat" facility to do the small number of urgent tests (such as blood gases and cardiac testing.)

(h) Accordingly, the Commission's observation that the 24-hour turnaround times presently offered by community providers would not be a close enough substitute for hospital-based referrers fails to recognise:

- that community testing turnaround times are generally much less than 24-hour, where labs are located within the region; and

- the low barriers to the community providers adjusting their resources to meet the terms of a contract that includes urgent turnaround times

(i) The Commission's finding in Decision 559 is inconsistent with actual practice at both Wellington Pathology and Valley Diagnostic.

- Wellington Pathology operates a three tiered system, based on whether a test should be categorised as "routine", "urgent" or "critical" (the latter includes tests that need to be turned around

within one to two hours). This system ensures that Wellington Pathology is able to perform tests as readily as hospital labs are, and indeed, Wellington Pathology already offers a quick turnaround service on a 24/7 basis to Wakefield Hospital.

- Valley Diagnostic also operates a three tiered system. Tests which are given priority and need to be processed through the lab as soon as possible are classified as "urgent" (equivalent to Wellington Pathology's "critical"). The second category relates to specimens that require a result to be sent as soon as it is available, by phone or by fax. Non-urgent work is passed through the lab in a routine manner.

(j) The Applicants note that systems such as these are used in all labs, whether hospital or community based. The only difference for the most urgent specimen might be the time taken to transport the sample to the community lab.

Range of tests

11.6 At paragraph 109, the Commission states:

> "Hospital providers... typically also offer a range of more advanced testing... In pathology, as with most medical fields, complex work is labour intensive and demands a high level of skill and training to perform. The upshot is that hospital providers require a greater proportion of technical staff, such as pathologists and scientists, than do community providers...

11.7 There are two observations here:

(a) The Applicants consider that the Commission has placed too much emphasis on the extent of advanced testing and the additional level of technical staff that are required. For instance, the test menu at Hutt Hospital is almost identical to that at Valley Diagnostic. This is because the range of tests is largely determined by funding arrangements, rather than the level of technical expertise. In any event, in the RFP issued by the Hutt Valley and Capital & Coast DHBs, Schedule B testing (generally referred to as send-away testing) is quoted as being $600,000 for the Capital & Coast region and $300,000 Hutt Valley region. This amounts to only around 5% of the DHBs' current combined spend on community pathology services.[7]

(b) In the Wellington region, the hospital and community labs share the same staff. For example, an individual pathologist might work at a community lab in the morning and at a hospital lab in the afternoon. Of the six pathologists employed at Valley Diagnostic, four of them divide their time between Valley Diagnostic and either Hutt or Wellington Hospitals. Similarly, Wellington Pathology employs five pathologists who

[7] See RFP, Section A, cl 37.

also work for Wellington and Hutt Hospitals. This system only works because of the high degree of similarity between the hospital and community labs. In addition, many technical staff have been employed at both the hospital and community labs in the course of their careers, and staff at both labs undertake the same educational path to qualification and registration.

Demand for tests

11.8 At paragraph 111 the Commission stated:

> The demands for community and hospital testing also tend to differ greatly. Hospital providers must operate 24 hours a day, everyday, to meet the round-the clock testing needs of the associated hospital. Demand for hospital testing is driven by the incidence rate of acute referrals, and the work routines of clinicians.... Hence demand for hospital testing can be quite lumpy.

11.9 It is not clear to the Applicants why the Commission should think that lumpy demand cannot be accommodated by a private provider but can be accommodated by hospital providers. Community work is also "lumpy", as demand increases markedly in peak times (between 11am-12.30pm, and 4.30pm-7pm). As noted above, community providers are able to reconfigure operational systems with relative ease and within a relatively short timeframe to meet the different demands of hospital testing.

11.10 As noted earlier, only a small proportion of hospital testing falls into the "urgent" category and has to be done onsite (or nearby) immediately. The balance is either routine or send-away work. It is only (less than) 5% of testing that is urgent that creates any element of lumpiness. This is not material.

11.11 The fact that community labs are able to perform urgent work is evidenced by the fact that they currently do urgent work, as in the case of Wellington Pathology performing urgent work for Wakefield Hospital.

Reconfiguration

11.12 At paragraph 110, the Commission states:

> Given that community providers would need to incur the time and cost associated with altering the staffing mix (i.e. hiring specialist staff) in order to perform hospital testing, there appears little scope for immediate supply-side switching to take place.

11.13 The Applicants estimate that the time required for a community provider to reconfigure current operational systems in order to provide hospital testing would be no more than 6 to 12 weeks.

11.14 Also relevant here is that within the greater Wellington region, staff actually work in both the public and private sector, that is, the same people are employed at the hospital and community labs.

11.15 With regard to the comment that "there appears little scope for immediate supply-side switching", there are two responses:

(a) DHBs looking to private providers to provide hospital testing do not look for "immediate supply-side switching" and would generally allow a lead in time of a few months to enable a private provider to commence the provision of hospital testing. Conversely, in the context of the upcoming RFP for community testing, the Hutt Valley and Capital & Coast DHBs have allowed a lead time of 6 months between the date on which the successful bidder or bidders is advised that they have been awarded a contract and the actual commencement date.

(b) "Immediate" supply-side switching is not the test for substitutability.[8]

Lab opening hours

11.16 Referring again to paragraph 111 the Commission stated:

> Hence demand for hospital testing can be quite lumpy. In contrast, community providers tend to only operate during normal working hours, and due to the non-urgent nature of most community referrals, are able to smooth workloads throughout the day. Schedule-based tests, which represent all community testing, are the most routine and commonly-ordered kind. Hence, community providers tend to deal in high-volume throughput, whereas most hospital testing is low-volume work. This means that hospital providers contemplating a switch or expansion into the provision of community testing must build up enough capacity to cope with volume demands.

11.17 The statement that community providers "tend to only operate during normal working hours" is not correct for the Greater Wellington region. Valley Diagnostic's lab operates between 7am and 9pm Monday to Friday, and 8am and 5pm on Saturday. Wellington Pathology's lab operating hours are the same as Valley Diagnostic's, with the addition of Sunday from 8am-4pm.

11.18 The Commission also appears to have overestimated the difficulty that a hospital provider would have in building up capacity to meet the additional demand from community testing. The Commission has already noted that

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[8] In Decision 492 (Wakefield Hospital Limited and Bowen Hospital Limited, Feb 2003), the Commission said that:

*"The Commission takes the view that the appropriate time period for assessing substitution **possibilities is the longer term, but within the foreseeable future**. The Commission considers this to be a period of one year, which is the period customarily used internationally in applying the 'ssnip' test to determine market boundaries. The Commission will take into account recent, and likely future, changes in products, relative prices and production technology in the process of market definition."*

In the decision, the Commission refers to *Tru Tone Ltd v Festival Records Retail Marketing Ltd* [1988] 2 NZLR 351 (Court of Appeal), which quoted an earlier decision of the Commerce Commission in *Edmonds Food Ind Ltd v W F Tucker & Co Ltd* (Decision 21, June 1984) where the Commission said: *"A market has been defined as a field of actual or potential transactions between buyers and sellers amongst whom there can be strong substitution, at least in the long run, if given a sufficient price incentive"*.

The Court in *Tru Tone* also referred to the Australian case, *News Limited v Australian Rugby Football League Limited &Ors* (1996) ATPR at 41,687, which stated: *"Long term prospects that can be more or less clearly foreseen are, to that extent, a present reality, from the point of view of identifying the constraints upon commercial action. This fact emphasises the importance of the principle…"*.

demand is lumpy – so downtime on equipment can be used to undertake non-urgent testing. In addition, the Applicants consider that the Hutt Valley and Capital & Coast DHBs would have to purchase a relatively small amount of additional equipment in order to service community contracts.

11.19 The Applicants also have evidence that the hospital labs currently have excess capacity.

11.20 Further, the Commission's view that most hospital testing is low-volume is not accurate. However, the issue is not the volume of work, but the type of test being performed. As discussed above, the tests performed in hospital and community labs are largely identical.

Community testing by DHB labs

11.21 At paragraphs 113 and 114, the Commission notes that:

> Historically, most DHBs have not permitted their provider arms to conduct community testing, except to meet overflows in demand (e.g. after-hours community testing). ... In recent times, some hospital providers have been allowed, and in some cases encouraged, by their DHBs to compete for community testing, although this practice has not become commonplace. **Nor is it clear it will become the norm.**

11.22 There are numerous examples of DHB labs being involved in community testing or of community providers being engaged in hospital testing. There are 21 DHBs in New Zealand. The table in Schedule 3 illustrates where hospital and community work has been, or is currently being, provided by the same provider. It does actually look relatively commonplace.

11.23 In addition, the Applicants note that most hospital labs, including Hutt Hospital, do a small volume of community testing. This occurs where patients present at the hospital with a community lab form requesting to have the relevant test carried out at the hospital lab.

11.24 Reference is also made here to the *Southern Cross* case[9] where the Court stated:

> The Commission's premise that there has been little, if any, expansion or entry into the market in the past, a premise which the updating material somewhat undermines, does not in our view justify the inference that supra-competitive pricing by the merged entity would also be met by little, if any, entry or expansion." [10]
>
> [The] lack of or limited entry or expansion may well be better interpreted as an indicator of a competitive market into which there was little incentive for entry or expansion. ... This interpretation is also consistent with the evidence of low profitability

[9] *Commerce Commission* v *Southern Cross Medical Care Society* (2002) 10 TCLR 269

[10] At paragraph 87.

> in the market, a factor which is indicative, at least prima facie of a competitive environment."[11]

11.25 Clearly, DHBs providing community testing does not have to be "the norm" in order for the DHBs to be recognised as being able to be actual, or potential, competitors for community work.

Facilities

11.26 At paragraph 115 the Commission comments:

> Hospital providers receive all referrals from within the attached hospital so have no need to offer ancillary services, such as facilities and staff for sample collection and transportation of samples. In contrast, referrals for community testing typically derive from a wide geographic area, so provision of such ancillary services to ensure access to referrals is essential. Hence, hospital providers wanting to expand or switch into community testing would likely need to invest in at least some collection facilities and a transport system.

11.27 The Applicants do not consider that the need to invest in collection facilities and a transport system represents an impediment to hospital providers providing community testing. In the Hutt Valley and Capital & Coast region, collection facilities are required in only 14 locations across both districts. A transport system can be contracted in through the use of owner/drivers or courier companies. Another option would be for medical practices to collect samples in the interim (as they currently do on behalf of some providers), until the hospital lab establishes its own collection facilities. The transportation costs associated with the community service are a small percentage of the total cost of providing the service.

11.28 The Applicants note that hospital providers do not receive all referrals from within the attached hospital – some referrals are outpatients.

Summary

11.29 The differences between the provision of hospital testing and community testing are not sufficiently material for them to be categorised as being in separate markets for the purposes of this application. Accordingly, the competition effects of the proposed merger have been assessed against the following market definitions:

(a) the market in the Hutt Valley and Capital & Coast DHB regions (the *Greater Wellington region*) for the provision of hospital and community referred pathology services; and

(b) the national market for the provision of cervical screening tests.

Specific parties involved

11.30 The parties involved in the Transaction for which clearance is sought are:

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[11] At paragraphs 81 – 82.

(a) Valley Diagnostic Limited (a wholly owned subsidiary of Sonic Healthcare);

(b) Wellington Pathology Limited (a wholly owned subsidiary of Abano Healthcare); and

(c) Labco Wellington (a company to be formed) and which will be owned by Valley Diagnostic and Wellington Pathology.

Differentiated Product Markets

12	**Please indicate whether the products in each market identified in question 11 are standardised (buyers make their purchases largely on the basis of price) or differentiated (buyers make their purchases largely on the basis of product characteristics as well as price).**

There is very little product differentiation. The products offered, in terms of the testing available and the quality of assessment and reporting, are relatively homogenous.

13 **For differentiated product markets:**

- **Please indicate the principle characteristics of products that cause them to be differentiated one from another.**
- **To what extent does product differentiation lead firms to tailor and market their products to particular buyer groups or market niches?**
- **Of the various products in the market, which are close substitutes for the products of the proposed combined entity? - which are more distant substitutes?**
- **Given the level of product differentiation, to what extent do you consider that the merged entity would be constrained in its actions by the presence of other suppliers in the market(s) affected***?*

13.1 There is some (but very little) differentiation between hospital referred and community referred testing in that:

(a) a slightly larger proportion of hospital testing could be categorised as urgent (although urgent testing is still a very small proportion of overall volumes, and community labs also perform urgent testing); and

(b) community testing requires the provision of collection facilities (or arrangements being made for collection), the transportation of tests and the reporting of tests to a wider client base.

13.2 The buyers (i.e. the DHBs) determine the extent to which suppliers tailor their products/service provision. If a DHB awards a community provider a contract for the provision of hospital referred testing it will be because that provider has demonstrated the ability to tailor its service provision to meet the requirements of the hospital service. The same applies in relation to community provision by hospital providers.

13.3 As noted earlier, the Applicants do not consider these differences to be such that hospital and community referred testing should be delineated into separate markets.

14 Will the proposal result in vertical integration between firms involved at different functional levels?

14.1 The proposal will not result in any vertical integration.

15 **In respect of each market identified in questions 11 identify briefly:**

- **all proposed acquisitions of assets of a business or shares involving either participant (or any interconnected body corporate thereof) notified to the Commission in the last three years and, in each case,**
  - **the outcome of the notification (e.g. cleared, authorised, declined, withdrawn)**
  - **whether the proposed acquisition has occurred.**
- **any other acquisition of assets of a business or shares which either participant (or any interconnected body corporate) has undertaken in the last three years.**

15.1 The only proposed acquisitions of assets of a business or shares involving either participant (or any interconnected body corporate thereof) notified to the Commission in the last three years are the proposed acquisitions outlined in the Sonic/NZDG clearance application (which was declined).

15.2 Sonic has not undertaken any other acquisition in the last three years.

15.3 Abano has acquired the following businesses in the last three years:

- August 2003, Burtons Healthcare & Health Partners
- November 2004, Auckland Dental Group
- December 2004, Victoria Dental
- February 2005, 40% share of Ascot Radiology
- March 2005, Dargaville Dental
- June 2005, Dinsdale and Te Awamutu Dental
- August 2005, Karen Harris Dental Wellington
- October 2005, 70% share of Bay Audiology
- October 2005, 70% share of Orthotics NZ Limited

PARTS III, IV AND V: CONSTRAINTS ON MARKET POWER BY EXISTING AND POTENTIAL COMPETITION AND OTHER POTENTIAL CONSTRAINTS

16 Existing Competitors

Counterfactual

16.1 Given that the DHBs are seeking sole providers for either the individual DHB regions or the combined regions, the Applicants consider that in the factual and the counterfactual there will either be:

(a) a sole supplier of community referred pathology services for the greater Wellington region (covering the Hutt Valley and Capital & Coast DHB regions); or

(b) separate but sole suppliers of community referred pathology services for each of the Hutt Valley and Capital & Coast DHB regions.

That supplier (or suppliers) may also be the supplier of hospital referred services in the regions.

16.2 The Applicants expect that, in the factual and the counterfactual, it is likely that each party would bid for the contract in its current area of 'incumbency' – i.e. Valley Diagnostic would bid for the Hutt Valley contract and Wellington Pathology would bid for the Capital & Coast contract.

16.3 With regard to the Regional Contract, the Applicants have approached this analysis as if each would, in the counterfactual, bid for the Regional Contract. However, given that neither Applicant has sufficient resources within the region to service the Regional Contract with current resources, in that counterfactual the combined effect of the various conditions each would face is such that neither would have any advantage over other potential bidders. In the next contract round, any unsuccessful bidder(s) in this contract round would be in exactly the same position as any other potential entrant. (Refer Applicants' separate papers for their views on the anticipated outcome should they be unsuccessful in the current contract round.)

16.4 While each has some existing resources, significantly, those resources do not enable either Valley Diagnostic or Wellington Pathology to guarantee the availability of the technical and clinical staff necessary to carry out the Regional Contract, any more than any other likely bidder.

Other competitors

16.5 The Applicants note the Commission's classification of potential bidders in Decision 559 and have, for the purposes of this application, assessed potential bidders for the Greater Wellington region against those classifications i.e.:

(a) previous providers;

(b) new domestic bidders;

(c) international bidders;

(d) DHB owned labs outside the region; and

(e) the local DHB owned hospital lab in the region.

Previous providers

16.6 For the Greater Wellington region, there are no bidders that could properly be classified as "previous providers". While Valley Diagnostic, Wellington Pathology and NZDG all provide pathology services in parts of the greater Wellington region, none of them has facilities that cover the entire region.

16.7 The situation in the greater Wellington region must be contrasted with the position of Sonic and NZDG in the regions covered by Decision 559:

(a) In Otago/Southland, both Sonic and NZDG have labs, collection facilities and staff located within the Otago DHB region and the Southland DHB region.

(b) In Canterbury, Sonic and NZDG have labs, collection facilities and staff located within the Canterbury DHB region.

(c) In Hawkes Bay, Sonic and NZDG have labs, collection facilities and staff located within the Hawkes Bay DHB region.

(d) In South Canterbury, before the change to the sole supplier contract, both Sonic and NZDG had labs and collection facilities in the region.

16.8 In contrast:

(a) Wellington Pathology does not have a lab, collection facilities or staff located in the Hutt Valley region. It has no history of contracting with the Hutt Valley DHB or of providing services to the region.

(b) Valley Diagnostic does not have a lab located in the Capital & Coast DHB region (but does have collection centres and a small number of technical staff in the Kapiti Coast). It has no history of contracting with the Capital & Coast DHB.

New domestic bidders

16.9 Potential new domestic bidders for the greater Wellington region include (in addition to Valley Diagnostic and Wellington Pathology): NZDG; Healthscope; Pathology Associates Limited; and Medical Laboratory Taranaki Limited.

16.10 In Decision 559, the Commission considered that Pathology Associates Limited and Medical Laboratory Taranaki Limited would be unlikely to bid for contracts outside their current areas of operation. While the Applicants do not agree with this, no further consideration is given to these providers in this application.

16.11 The Applicants also note that the Commission dismissed Abano as a likely bidder for contracts outside its current area of operation. Against that counterfactual, the Transaction will not lessen the number of bidders for the Regional Contract.

16.12 However, whether it is categorised as a "previous provider" or a "new domestic bidder", it is quite clear that NZDG should be viewed as a strong contender for the Regional Contract (and the individual Hutt Valley and Capital & Coast contracts). Further consideration of the constraint represented by NZDG is set out in section 17.

International bidders

16.13 In Decision 559, the Commission discounted international providers such as Mayne Pathology, St John of God and Healthscope as likely to offer sufficient competitive constraint to the merged entities in either the factual or

counterfactual. The Applicants do not agree with this conclusion and note the following:

(a) These firms are all large providers with significant financial resources. Access to capital is not an issue.

(b) They all have established reputations in Australia. New Zealand DHBs could readily reference check their quality standards by contacting Australian purchasers and medical bodies.

(c) Pathology testing standards between Australia and New Zealand do not differ (both work to the same standard, ISO 15189).

(d) DHBs can readily correct information advantages of local providers by providing detailed data about testing numbers in their areas – as the Hutt Valley and Capital & Coast DHBs have done. Other information about the New Zealand health sector can be readily obtained through the Ministry of Health, the DHBs, health sector consultants and generally available information on websites. 'Information asymmetries' as a barrier to entry by Australian providers should not be overstated.

(e) Healthscope already has a subsidiary, Northland Pathology Limited (*NPL*), operating in the pathology sector so is familiar with the sector. The following points are noted:

- Relative to Wellington Pathology, NPL is not at a disadvantage in terms of size and scale. At paragraph 306 of Decision 559, Brian Watson, the Managing Director of NPL is reported as saying that he believed NPL would also be disadvantaged when bidding for contracts against the large providers, due to its small size and referred to the economies of scale realised by large companies such as Sonic and NZDG (given that both Sonic and NZDG have the ability to centralise a substantial portion of test volumes).

- If the observation that NPL's size relative to Sonic and NZDG would be a disadvantage is correct, it applies equally to Wellington Pathology.

- However, given that NPL is a wholly owned subsidiary of a large Australian company, Healthscope, it too has a size and scale advantage. It also has the advantage of already having a subsidiary in New Zealand with knowledge of the New Zealand market and a prior relationship with a DHB.

- Mr. Watson also considered that the risk of bidding for a contract in another region, without first having secured the necessary pathologists, would be significant. In relation to the Regional Contract, Valley Diagnostic and Wellington Pathology also face the risk of being able to secure additional staff to provide the services under the Regional Contract (although Valley Diagnostic does have some ability to refer testing work to staff in other regions).

DHB owned laboratories outside the region

16.14 The Applicants are surprised by the Commission's finding in Decision 559 that CHL would be unlikely to bid for community testing outside the Canterbury region. CHL was represented at a meeting on 6 September 2005 held by the Hutt Valley and Capital & Coast DHBs to discuss the RFP – and the Applicants

have since heard that CHL is preparing a bid for the Wellington region contracts. Further consideration of the constraint represented by CHL is set out in section 19.

Local DHB owned hospital laboratory in the region.

16.15 The Applicants are also very surprised by the Commission's finding that the DHB labs within the regions covered by Decision 559 are considered to be only 'back stop options' or 'bidders of last resort'.

16.16 The Applicants consider that the Commission would be wrong to reach that conclusion in relation to the Wellington region. The position of the Wellington region DHB labs is outlined further in section 18.

Summary of potential bidders

16.17 The following table summarises the potential bidders for contracts in the Wellington region in the current contract round.

	Factual	Counterfactual
Hutt Valley	Valley Diagnostic NZDG Hutt Valley DHB lab (possibly in conjunction with CHL) Possibly Healthscope Possibly Wellington Pathology	Valley Diagnostic NZDG Hutt Valley DHB lab (possibly in conjunction with CHL) Possibly Healthscope Possibly Wellington Pathology
Capital & Coast	Wellington Pathology NZDG Capital & Coast DHB lab (possibly in conjunction with CHL) Possibly Healthscope Possibly Valley Diagnostic	Wellington Pathology NZDG Capital & Coast DHB lab (possibly in conjunction with CHL) Possibly Healthscope Possibly Valley Diagnostic
Combined Region	Labco Wellington NZDG Hutt Valley & Capital & Coast DHB labs (possibly in conjunction with CHL) Possibly Healthscope	Valley Diagnostic Wellington Pathology NZDG Hutt Valley & Capital & Coast DHB labs (possibly in conjunction with CHL) Possibly Healthscope

16.18 For the next contract round, in the counterfactual, if one or both of Valley Diagnostic and Wellington Pathology is not successful in this contract round, it is possible that the unsuccessful party or parties will not be bidders for the next contract round.

16.19 Although the proposed merger may see a reduction in number of potential bidders for the Regional Contract, the Applicants do not consider that this will result in a substantial lessening of competition. As outlined in the attached paper by CRA International, nor will there be an increase in the price for the contract in the factual compared with the counterfactual – even in the worst case (i.e. that only Labco and the DHBs submit bids). The Applicants will

comment separately to the Commission on their own considerations with regard to bidding for the Regional Contract.

16.20 The Applicants are not "mavericks", as neither of them could be described as "atypical". For example, neither of the Applicants has business models that differ from the industry norm, nor do they have a history of aggressive pricing behaviour.

17 New Zealand Diagnostic Group Limited

Introduction

17.1 In Decision 559, the Commission observed that NZDG had all the characteristics necessary to represent strong competition to Sonic. In particular, the Commission concluded that NZDG is a larger provider by financial size and market penetration relative to the other small providers (including Abano)[12] and is likely to remain a large national operator.[13]

17.2 The Commission has identified a number of entry conditions that providers would face when attempting to enter a new region by bidding against an incumbent sole provider at the next bidding round.[14] These entry conditions include:

(a) access to scarce technical labour: e.g. pathologists, scientists, and highly specialised technicians;

(b) capital: land, purpose-specific buildings, and equipment;

(c) scale of operations;

(d) incumbent knowledge; and

(e) reputation and prior relationships with the purchasing DHB(s).

17.3 Although NZDG already operates in the Wellington region, these entry conditions have been examined to test whether they would prevent NZDG from competing for the Regional Contract (or the individual DHB contracts). The Applicants consider that the Commission must conclude that they will not and that its conclusions about NZDG in relation to the regions covered by Decision 559 apply equally to NZDG in the Wellington region.

Technical labour

17.4 The Commission considered that access to technical labour might be less of an issue for NZDG or Sonic than it would be for smaller players. For the regions covered by Decision 559, the Commission considered that:

(a) given its scale and access to funds, NZDG would have the financial resources to offer sufficiently attractive employment terms to secure most of the required technical staff when re-entering a region; and

(b) contracting DHBs are also likely to view NZDG's ability to secure key staff more credibly (relative to smaller, less well-known operators).[15]

17.5 There is no reason for the Commission to conclude that these characteristics would not apply to NZDG in relation to the Greater Wellington region.

17.6 Furthermore, the Commission noted that NZDG has a significant pool of technical staff in regions outside the regions covered by Decision 559, which it could move between regions to meet short-term staffing needs.[16] While NZDG

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[12] Decision 559, paragraph 229.

[13] Decision 559, paragraph 249.

[14] Decision 559, paragraph 182.

[15] Decision 559, paragraphs 233 – 235.

[16] Decision 559, paragraph 236.

may not presently have technical staff within the Greater Wellington region, it would appear that NZDG could move staff from other regions, at least as an interim measure, to the extent necessary to meet the demands of the Regional Contract.

Capital

17.7 The Commission concluded that access to capital is unlikely to limit NZDG's re-entry into the regions covered by Decision 559, noting that NZDG operated from a considerable asset base and has, through its seven subsidiary companies in New Zealand, the ability to shift under-utilised equipment between regions.[17]

17.8 Furthermore, the Commission noted that:

(a) industry participants had advised that even if spare equipment could not be sourced from other regions, potential bidders could either purchase or, as is more commonly done, lease equipment from reagent suppliers such as Roche and Bayer;[18] and

(b) in general, lab sites may be purchased or leased (although some refurbishment would typically be required to convert generic sites into purpose-specific ones).[19]

17.9 In addition, the Commission noted:

(a) the scale of NZDG's operations may offer it significant purchasing power with respect to equipment (as well as inputs, such as reagents and lab supplies), in contrast to smaller players such as Abano, Medlab Taranaki, PAL, and NPL. This would give them an advantage over other smaller providers; and

(b) industry participants raised the possibility of NZDG shifting samples for processing to other regions where it already has established laboratories.[20]

17.10 At paragraphs 246 and 247, the Commission said:

> "The Commission recognises that some community testing is of an urgent nature and therefore cannot be performed outside the region of origin due to the delays that that would entail. However, the Commission considers it is possible that for non-urgent testing, which represents the bulk of community work, inter-regional testing is possible. This would reduce the size (and therefore, the cost) of any new testing facility that may need to be established when re-entering Otago/Southland.
>
> This may be particularly feasible for NZDG ..., given that [it] operate[s] in several regions throughout New Zealand already. For example, ... NZDG may send work to its Waikato laboratory. There is evidence of this already occurring; for example, samples from the West Coast (a remote and small DHB region) are presently transported to Christchurch for testing by ... NZDG.

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[17] Decision 559, para 241.

[18] Leasing allows providers to annualise the capital expenditure, and mitigate the risk of technical obsolescence, associated with outright purchase of equipment, making it a common practice in this industry (Decision 559, para 242)

[19] Decision 559, paragraphs 242 and 243.

[20] Decision 559, paragraphs 245 and 246.

17.11 Clearly, there is no reason for the Commission to conclude that NZDG could not also do this in the Greater Wellington region. Indeed, NZDG is already collecting samples from the Wellington region and sending them to its lab in Canterbury for testing, and is understood to have operated a "stat" lab facility in the past in Paraparaumu.

Scale of Operations

17.12 With regard to scale of operations:

(a) Industry participants apparently advised the Commission that operational scale offers many advantages in the provision of pathology services and considered it would be difficult to compete for contracts on price because of the economies of scale realised by large companies such as NZDG (given that NZDG has the ability to centralise a substantial portion of test volumes). The Commission considered it likely that NZDG would have operations in a number of other regions, and may be able to shift samples between regions for non-urgent tests, in order that the tests can be done at the lowest possible cost.

(b) The Commission considered that NZDG would have access to a larger pool of technical expertise via a network of pathologists and scientists throughout the country than small fringe players and this allows them to offer specialist opinions over a wide range of services and testing procedures (economies of scope).

(c) The Commission noted that greater size provides greater buying power with respect to equipment, reagents, and other raw materials.

17.13 On the basis of these arguments the Commission concluded that scale is unlikely to represent a significant barrier to NZDG.[21]

Incumbent Knowledge

17.14 At paragraph 559, the Commission said:

> The incumbent is likely to have an advantage when forecasting the cost of provision over the term of the future contract, which in turn informs the appropriate level at which to bid for work. Contracting DHBs recognise this fact. Given their apparent (and legitimate) concerns over bidders miscalculating the cost of provision under a capped funding scheme, DHBs are likely to favour bids that they consider to be the most credible when awarding contracts.

17.15 The Commission considered that:

(a) since NZDG had operated to some degree and at some point in time in each of the regions covered by Decision 559, this prior experience is likely to aid NZDG in estimating the cost of provision and the testing needs of the population in the region – even after ten years; and

(b) since NZDG operates in several regions throughout New Zealand, it enjoys the ability to pool information and benchmark volumes/costs when tendering for new contracts. This would reduce its research and bid preparation costs and likely reduce the disadvantage they face when bidding against one another.[22]

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[21] Decision 559, paragraphs 249 - 254.

[22] Decision 559, paragraphs 256 - 257

17.16 The Commission concluded this to be the case for NZDG in regions such as Southland (where NZDG has a small presence), South Canterbury (where NZDG has no current presence and historically only a small presence) and West Coast where NZDG's only involvement is the collection of a small number of samples that are transported out of the region for testing.

17.17 If this 'incumbent knowledge' advantage does in fact exist for NZDG in these areas,[23] then:

(a) the Commission must conclude that NZDG will have an information advantage in relation to the Capital & Coast DHB region; and

(b) if, in the counterfactual Valley Diagnostic and Wellington Pathology were to submit independent bids for the Regional Contract, Wellington Pathology will be at an information disadvantage for the Hutt Valley DHB portion of that contract.

17.18 However, the Hutt Valley and Capital & Coast DHBs have made extensive testing data available (including pathology and specialist test volumes) to all potential bidders so no bidder should in fact suffer an information disadvantage.

Reputation and Prior Relationships with Purchasing DHB

17.19 As the Commission established in Decision 559, NZDG has provided community testing, at one time or another, to 13 of the 21 DHB regions. The Commission noted that Capital & Coast was one of those regions. The Commission concluded that if NZDG were to bid for a contract in any of these regions in the future, it would be likely to be recognised by most DHBs as a capable and strong service provider, with a proven track record in that region. The Commission also noted that the NZDG's nationwide coverage would also give other DHBs comfort that NZDG would have the resources and the expertise to adequately service a contract.[24]

Conclusion in relation to NZDG

17.20 Having regard to the above, the Commission should conclude that NZDG is a strong competitor for the Regional Contract (and also for each of the Hutt Valley and Capital & Coast contracts separately) and, as such, will represent a considerable constraint on the Applicants in their pricing of the Regional Contract.

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[23] The Applicants doubt the extent to which 'incumbent knowledge' advantage actually exists and, if it does, the DHBs are able to minimise its effect by simply making the requisite data available to potential bidders.

[24] Decision 559, paragraphs 259 and 260.

18 Hutt Valley and Capital & Coast DHB laboratories

18.1 The Applicants do not consider that the Commission can dismiss the threat to the merged entity from the Hutt Valley and Capital & Coast DHB labs. In these regions, the threat of self-provision is a very real constraint.

18.2 The Applicants are aware of the bases on which the Commission discounted the threat of self-provision by the DHBs in the regions covered by Decision 559. Should the Commission wish to explore, in relation to the Hutt Valley and Capital & Coast DHBs, any of the specific matters referenced in Decision 559 (such as the ability to benchmark, access to capital, access to labour, corporate knowledge, or transfer of risk) the Applicants are happy to make further submissions.

18.3 However, the Applicants have been provided with ample evidence that the DHBs labs are likely to submit serious responses to the RFP and that responses are to be submitted only if they are considered to be realistic and achievable. The Applicants view this as meaning that the DHB labs will not be considered 'bidders of last resort'. They are undoubtedly treating the DHB labs as real competitors for these contracts. The reason for doing so is evidenced in the following:

(a) A record of resolutions of the Hutt Valley DHB on 1 March 2005 (refer Annexure 4) notes:

> "Agreed that we develop jointly with Capital and Coast DHB funder arm a long term capped contract for community referred laboratory services that includes the following features…:
>
> - Opportunity for a provider arm proposal to be compared against proposals from external providers…"

(b) A summary of the resolutions reached by the Board of the Capital & Coast DHB in April 2005 includes the following statement (refer copy at Annexure 4):

> "Agreed that the preferred medium term outcome for C&CDHB is a consolidated, integrated laboratory services for the sub region… The service will include hospital services as well as those currently provided in the community. The service may be publicly owned, privately owned, or delivered through both public and private providers with aligned contract incentives."

(c) In a letter to Valley Diagnostic on 25 May 2005[25] (refer copy at Annexure 4) Hutt Valley DHB stated:

> "To decide the best party/ies to perform community service the DHBs will ask existing and potential providers to put proposals in for the Capital and Coast service, the Hutt Valley service or both combined. It is expected that hospital and community providers will bid for this service".

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[25] The same letter was sent to Wellington Pathology.

(d) The paper issued by the DHBs entitled "Community Referred Laboratory Services Consultation Questions and Answers" (refer copy at Annexure 4) states:

> **Can a hospital provider bid for community services?**
> Yes. As the laboratories will be providing hospital testing, they could also provide community testing and might be able to achieve economies of scale in doing so. Our aim is to get the best value from our spending on laboratory services...

(e) The DHBs have also clearly indicated that bids by their own labs are likely and have indicated that they will structure the review and assessment of bids in such a way that competing bids by private providers will not be seen by their own labs. (Refer Draft Minutes of Community Referred Medical Laboratory Services (CRMLS) meeting RFP 6 September 2005 at Annexure 4). The Applicants have recently been advised that the Hutt Valley DHB has split into two divisions – one which is responsible for overseeing the preparation of the DHB's own in-house bid, and another which will review all tenders received.

18.4 The ability of the Hutt Valley DHB to carry out "100% of hospital and community referred testing in the Hutt Valley" is reinforced in the Report of the Central Region Laboratory Working Party (refer copy at Annexure 6, at paragraph 6.4.2). While that report suggests that Capital & Coast is unable to integrate the community lab on its site until 2008, the Applicants understand that Capital & Coast DHB (in conjunction with CHL) has since considered alternatives that will enable it to do so and are preparing a bid to respond to the RFP.

18.5 Furthermore, the Hutt Valley and Capital & Coast DHBs have signed a Memorandum of Understanding (*MOU*) with the following statement of intent:

> **Statement of Intent**
> The parties agree that they will work together and support each other in achieving their objectives as set out in their respective district strategic plans, annual plans and statements of intent and particularly to improve health and disability outcomes for people and to enhance efficiencies in the health sector through collaboration.

More specifically, Schedule 1 of the MOU addresses laboratory services pursuant to which they agree that they will "work together and support each other in achieving their objectives "to collaborate on the hospital laboratory services".[26]

18.6 The MOU provides, amongst other things, for:

(a) the purchase of reagents and other consumables to be jointly negotiated with suppliers to achieve bulk purchase savings;

(b) the labs to attempt to purchase or lease the same or similar equipment, reagents and consumables – to improve the comparability of testing

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[26] Refer Question and Answer paper in Annexure 4.

across the sub region, the ability to provide back-up and possibility of making bulk purchase savings;

(c) prior discussion of purchasing or leasing of laboratory testing equipment over $10,000;

(d) the development over time of a shared asset register and a common asset management and capital replacement plan;

(e) where a lab is considering purchasing equipment that has a greater capacity than that required for the particular lab, the other lab is to consider transferring testing to help fund the equipment purchase;

(f) the development of common quality systems;

(g) the labs to work together to retain a medical laboratory workforce for the sub region;

(h) the potential for shared appointments where a specific position is filled by one person employed by both labs (including sharing registrars, clinical specialists and IT staff);

(i) the development of a common laboratory information system and in the meantime an integrated laboratory clinical data repository; and

(j) exploring opportunities to improve the efficiency, quality and timeliness of testing by allocating low volume or high complexity test to one or other laboratory.

18.7 There is nothing in the MOU that indicates that it is limited to the provision of hospital laboratory services. (Even if it was, collaboration on hospital referred services will enable the DHB labs to free up capacity for providing community referred services.)

18.8 The MOU and the ability of the DHB labs to collaborate on service provision with the objective of driving efficiencies means that, whether or not the DHB labs intend to bid together for the Regional Contract or separately for the individual contracts for their regions, they will represent a constraint on Labco Wellington's proposed pricing.

18.9 Clearly, as funders of the service, the DHBs have access to detailed data about testing numbers and testing profiles for the Wellington region. They do not suffer an information disadvantage.

18.10 The Applicants consider that the DHB labs should be considered likely potential bidders. Even if it eventuates that they do not bid for the current contract round, the DHBs have been at pains to let the community providers know that their labs are intending to bid. That of itself represents a constraint on pricing.

18.11 The independent consultants engaged by the Applicants have prepared an assessment of the competitiveness of a DHB bid for the Regional Contract. This is set out in the attached papers by Lindsey Lawton and CRA International.

19 Entry Conditions

19.1 The Commission has given consideration to entry conditions in Decision 559 and Sonic made submissions in this regard in the context of that clearance application.

19.2 The Applicants do not concur with a number of aspects of the Commission's conclusions with regard to entry conditions. However:

(a) Section 17 above addresses the Commission's view of entry conditions insofar as they apply to NZDG; and

(b) Section 18 outlines the reasons why the Applicants have reason to treat the Hutt Valley and Capital & Coast DHBs as likely competitors for the Wellington region contracts.

19.3 In addition, the table in Schedule 4 lists the entry conditions that the Commission outlined in Decision 559 and compares the extent to which those conditions are faced by Valley Diagnostic, Wellington Pathology, NZDG, the DHBs' own labs, and the merged entity.

19.4 The conclusions from that comparison are that, when all entry conditions are considered together:

(a) neither Valley Diagnostic nor Wellington Pathology has any meaningful advantage over the other bidders in terms of entry conditions for Greater Wellington region;

(b) competition from Valley Diagnostic nor Wellington Pathology is no greater than competition between other bidders; and

(c) combining Valley Diagnostic and Wellington Pathology will not result in a substantial lessening of competition.

19.5 Even if the Applicants were to agree with the Commission's view of entry conditions, each of the potential bidders (as the summary table indicates), faces the same entry conditions in the factual and the counterfactual.

Ability for DHB labs to compete in next contract round

19.6 In addition to increasing the capacity of their existing labs, there are a number of options available for the Hutt Valley and Capital & Coast DHBs for the next contract round in terms of self-provision which suggest that the entry conditions identified by the Commission in Decision 559 will not represent a barrier to entry.

(a) Working within the terms of the MOU between them, they can configure the provision of hospital and community referred testing in a way that best utilises the respective equipment and staffing resources of the two DHBs. They should be able to drive considerable efficiencies given the volume of hospital testing they already have;

(b) They could subcontract parts of the work to other DHB labs such as CHL and LabPLUS (see further below); and

(c) They could join with other neighbouring DHBs (as has occurred in Otago/Southland) to:

- streamline the provision of services across their own labs; or
- increase the size of the contract in order to attract new entry from offshore.

19.7 As the attached CRA International paper indicates (and the DHBs themselves have said), access to capital is not a barrier to entry for hospital labs. Capital expenditure makes up a very small proportion of total costs, and would not prevent a DHB from competing in the next contract round.

Canterbury Health

19.8 CHL provides support to a number of DHBs around the country and clearly has the ability and an appetite for work outside the Canterbury region. In particular:

(a) CHL supported the joint bid of the Otago/Southland hospital labs in the recent tender round for the hospital and community referred work for the combined region;

(b) CHL has indicated that it will provide similar assistance to the hospital labs in Nelson and Blenheim; and

(c) CHL has competed (unsuccessfully) for histology and cytology testing for Hastings and Greymouth hospitals.

19.9 CHL already provides community testing in Christchurch, which is one of the largest DHBs in New Zealand. CHL is also active in Greater Wellington, providing transport, testing and reporting services for send-away tests.

19.10 The Applicants do not agree with the Commission's observation in Decision 559 that because CHL does not currently provide a large volume of community work it would be prevented from doing so in the future. As discussed in the following paragraph, there are strong reasons to suspect that CHL is gearing up to bid for community work in regions outside the Canterbury area.

19.11 The powerpoint presentation, "Planning for Automation of a DHB and Reference Laboratory", set out in Annexure 8[27] illustrates the depth of the CHL business, and its national coverage. CHL quite clearly considers it has the resources and skills to provide community work in other DHB regions.

19.12 The Applicants understand that the work that CHL has been chasing is not confined to non-schedule testing but includes other non-urgent testing. If non-urgent testing is referred to CHL (or potentially LabPLUS in Auckland) the hospital labs are better able to use their existing facilities to focus on urgent work.

19.13 It is noted that CHL attended the 6 September 2005 meeting called by the Hutt Valley and Capital & Coast DHBs to discuss the RFP process (refer minutes in Annexure 5).

[27] This paper was presented at a Scientific Education Seminar held at Auckland Hospital on Process Improvement and Automation in November 2005.

Off-shore bidders

19.14 In addition, it should be recognised that the health sector is a sector that undergoes considerable change over relatively short periods of time. It cannot be assumed that the sector will remain in its current structure in five or ten years' time. In particular, the pathology markets are in the midst of a restructuring that is changing the nature and scope of a number of significant contracts. The Australian pathology firms will undoubtedly be monitoring the New Zealand pathology sector and seeing:

(a) moves towards fixed price, exclusive contracts;

(b) greater integration of the primary and secondary care sectors; and

(c) the possibility for further moves towards regionalisation, with groups of DHBs co-operating in relation to service provision to the larger region. A combined Hutt Valley and Capital & Coast pool of work is clearly more enticing for an off-shore player than either DHB alone.

19.15 These developments are likely to make the market more attractive in future contract rounds and, as a result, the Australian pathology firms should be viewed as potential competitors for contracts in the next round – and, therefore, as exerting a degree of constraint on the merged entity in the future.

Conclusion

19.16 The Applicants have no doubt that the DHBs have options for facilitating new entry in future contract rounds in the event existing suppliers look to price above competitive levels.

20 Countervailing Power

20.1 The DHBs are effectively the sole funders of pathology services (providing over 96% of the Applicants' funding), and the Hutt Valley and Capital & Coast DHBs will exert a significant degree of countervailing power over the Applicants, in both the factual and the counterfactual.

20.2 The Commission has consistently noted that DHBs, in their capacity as purchasers of health services, are able exert downward pressure on prices.[28] The Applicants do not agree with the Commission's finding in Decision 559 that the move to a sole provider contract would lessen the DHBs' level of countervailing power. However, the situation in Decision 559 can in any event be distinguished from the situation in Greater Wellington for the reasons contained in this application.

20.3 In Decision 535, iSOFT NZ Limited and Hewlett-Packard Limited, the Commission considered that the countervailing power of the relevant DHBs, having recently moved towards regional collaboration and alignment, would be strong and likely to significantly constrain the combined entity. As the Commission noted in that Decision:

> *These [DHB] alliances will ultimately increase the countervailing power held by the DHBs when negotiating together, particularly in light of the value and length of the contracts to be won.*

20.4 The same analysis should be applied to the Transaction, especially given the joint RFP (and the process flowing from that), and the MOU between the DHBs. Further, because the contracts that were to be acquired by the applicant in that case were high value, long term contracts and because they were put out to tender, the Commission found that the DHBs were able to exert even more countervailing power over the combined entity.

20.5 In the context of the Transaction, the incumbent providers (in particular Wellington Pathology) have no alternative use for their assets. The very fact that the DHBs are moving to sole supply contracts (exerting their unilateral power to do so) means that incumbent providers are under pressure to ensure that their assets are not stranded.

20.6 As an example of the unequal relationship between DHBs and private providers, the current agreement between Capital & Coast DHB and Wellington Pathology is for a fixed annual fee with agreed risk sharing corridors. The fixed fee is determined annually in advance along with the corridor limits. This variation was first agreed in the (DHB) financial year beginning 1 July 2003 as a means to brake funding costs.

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[28] For example, Decision 535, iSOFT NZ Limited and Hewlett-Packard New Zealand.

21 Co-ordination Effects

21.1 As the Commission noted in Decision 559 (at paragraph 580) the issue here is whether the application would, if approved, materially increase the prospects of co-ordination between the Applicants in other regional markets.

21.2 The Applicants submit that the answer is "no".

21.3 The Applicants do not consider that a merger in the Wellington region would change their individual propensities for bidding for contracts in other DHB regions.[29]

21.4 The merger of the Valley Diagnostic and Wellington Pathology businesses provides no incentive for Sonic to co-operate with Abano for other DHB contracts. Sonic has independent businesses in other regions where it has no commercial incentive to engage with Abano in bidding for any contracts.

21.5 Commission staff may wish to test separately with Sonic and Abano whether:

(a) they consider themselves likely tenderers for contracts in other regions; and

(b) they consider the other to be a likely tenderer in another region (recognising that a belief that another party is a likely bidder for a contract is a powerful constraint, even if, in fact that party does not see itself that way).

21.6 However, the Applicants observe that in Decision 559 (at para 596) the Commission noted that Abano "would be unlikely to exert much competitive constraint outside [its] own regions of incumbency".

[29] Abano's business in the Nelson/Marlborough region currently sends some of its testing to Wellington Pathology. There is no reason this could not continue if Wellington Pathology were to merge its operations with Valley Diagnostic.

22 Conclusion

22.1 While the merger, and the combined bid by the merged entity, for the combined Hutt Valley and Capital & Coast contract will, in theory at least, reduce the number of bidders for the Regional Contract by one, the Applicants do not consider that the result would be a substantial lessening of competition, or an increase in price for the current contract, or any future contract. This is detailed further below and in the paper by CRA International set out in Annexure 1.

22.2 The Applicants believe that the threat of self-provision by the DHB labs (either jointly or singly but with the efficiencies that can be gained from the MOU between the two DHBs) is sufficient to ensure that competition would not be substantially lessened in the market for the provision of hospital and community referred testing in the Greater Wellington region – both in the current and in future contract rounds.

22.3 NZDG represents a further constraint and based on the Commission's reasoning in Decision 559, NZDG can be expected to remain a strong competitor for the next contract round as well.

22.4 In the counterfactual, Valley Diagnostic or Wellington Pathology (or potentially both) face the prospect of being exited from market within the Hutt Valley or Capital & Coast regions in the current contract. It is not clear that either of them would re-enter for the next contract round. Abano particularly, will be more vulnerable in that respect given that its only other pathology business is a relatively small operation in the Nelson/Marlborough area. This suggests that the Transaction will not result in a decrease in the number of bidders for the next contract round compared to the counterfactual.

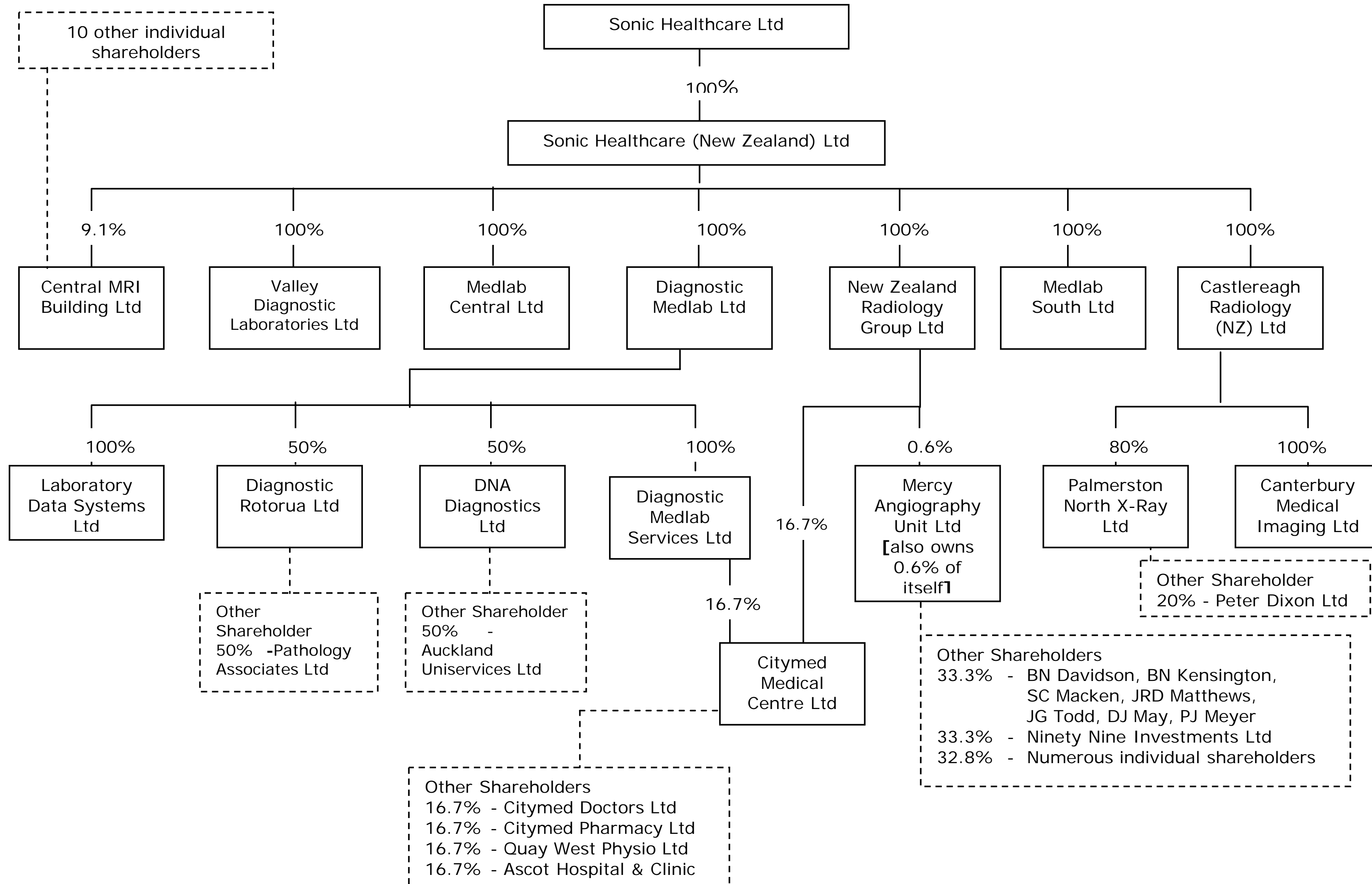
22.5 In the meantime, if it is successful in winning the Regional Contract, Labco will continue to be constrained by the threat of the loss of its business in the next contract round. Any failure to adhere to quality standards during the contract term, or any attempt to push prices above competitive levels at the end of the contract term, has the potential to result in a total loss of the business in the Wellington region. It is self evident that Labco Wellington would not want that to occur so will behave during the contract term in a manner that best positions it to remain in the running in the next contract round (or which avoids the chance of the contract being terminated during the term).

22.6 The Applicants are firmly of the view DHBs possess countervailing market power as the funders of pathology services and as vertically integrated competitors in this market.

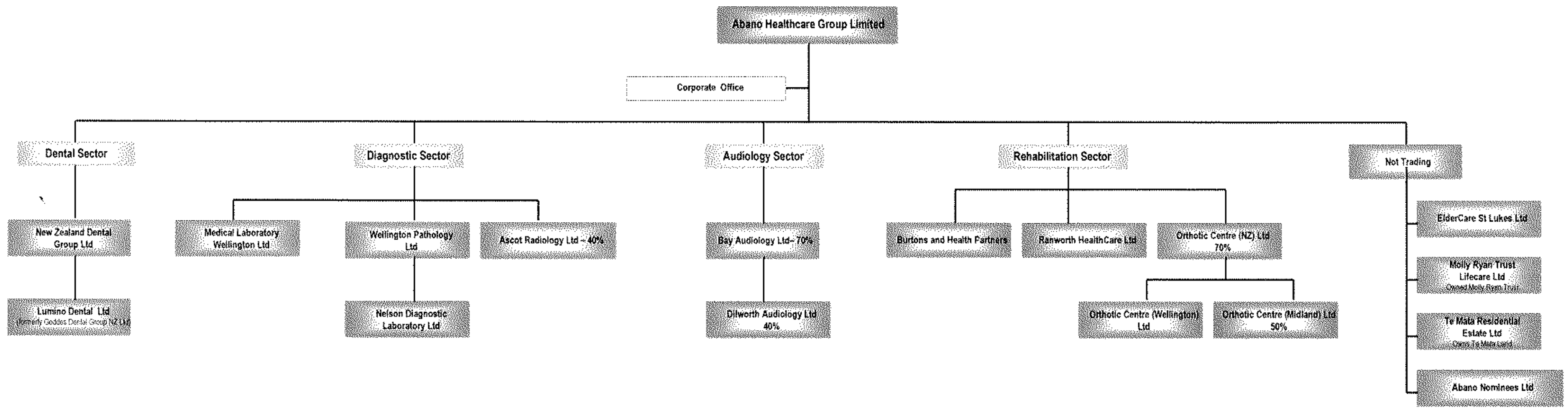
22.7 The Applicants have chosen not to answer any further questions at this stage but are happy to address any further questions the Commission may have.

Schedule 1

Sonic Healthcare (New Zealand) Limited and its interconnected bodies corporate and associated persons



Schedule 2
Abano Healthcare Group Limited and its interconnected bodies corporate and associated persons



Schedule 3
Areas where common provider does hospital and community testing

	DHB region	
1	Northland	
2	Waitemata	
3	Auckland	A+ LabPLUS provides small amount of community work
4	Counties Manukau	
5	Waikato	DHB's own lab provides small amount of community work
6	Bay of Plenty	Pathology Associates Limited does hospital and community referred testing
7	Tairawhiti	Gisborne Hospital currently outsources histopathology and cytology to Medlab Central
8	Lakes	
9	Taranaki	Medlab Taranaki Limited manages the hospital laboratory in New Plymouth and also provides community work
10	Hawke's Bay	Hastings Hospital currently outsources histopathology to Medlab Central
11	Whanganui	Q Lab (the Whanganui provider arm lab) is set to take over all community referred testing
12	Mid Central	Medlab Central provides all hospital and community referred testing
13	Wairarapa	DHB's own lab provides small amount of community work
14	Hutt Valley	DHB's own lab is understood to be bidding for the community contract
15	Capital & Coast	DHB's own lab is understood to be bidding for the community contract
16	Nelson Marlborough	DHB's own lab carries out 10-20% of community work (supported by CHL)
17	West Coast	DHB's own lab carries out over 40% of community work
18	Canterbury	CHL provides small amount of community work, and carries out tests on behalf of hospital laboratories in other DHB regions
19	South Canterbury	Medlab South provides all hospital and community referred testing
20	Otago	DHBs' own labs contender for all hospital and community work
21	Southland	DHBs' own labs contender for all hospital and community work

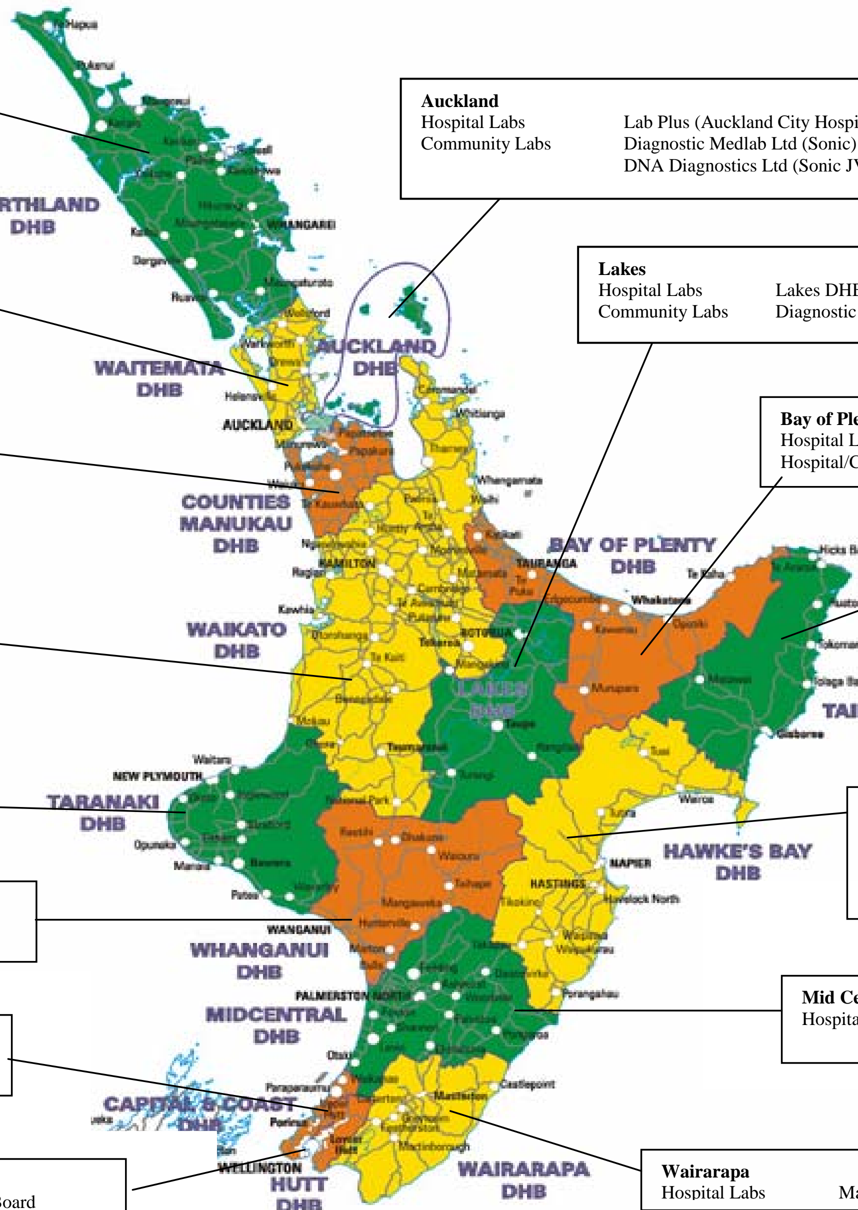
Schedule 4: Entry Conditions for each provider

Entry condition	Sonic	Abano	Hutt Valley and Capital & Coast provider arms	NZDG	Labco Wellington
Technical labour issues	Has some staff in the region but not sufficient to provide services for entire Regional Contract.	Has some staff in the region but not sufficient to provide services for entire Regional Contract.	Has some staff in the region but not sufficient to provide services for entire Regional Contract	Does not have any staff in the region.	Would have staff immediately available to provide services for entire Regional Contract.
	Would need to recruit additional staff.	Would need to recruit additional staff.	Would need to recruit additional staff.	Would need to recruit staff.	No need to recruit additional staff.
	Additional staff required would include: o part-time microbiologist o part-time biochemist o part-time haematologist o full-time histo/cyto pathologist	Additional staff required would include: o part-time microbiologist o part-time biochemist o part-time haematologist o full-time histo/cyto pathologist	Additional staff required would include: o part-time microbiologist o part-time biochemist o part-time haematologist o full-time histo/cyto pathologist		
	In Decision 559, Commission said Sonic could move staff around regions to meet short term staffing need.	No ability to source staff from related businesses elsewhere.	No ability to source staff from related businesses elsewhere. However, changes are being made to the DHBs' IT systems so that they will be able to report directly to GPs (which would reduce staffing requirements).	In Decision 559, Commission said NZDG could move staff around regions to meet short term staffing need.	No need to move staff around.
	In Decision 559, Commission considered Sonic had sufficient scale & access to funds to offer sufficiently attractive employment terms to secure most of required technical staff when re-entering in future contract rounds.		Scale and funds are unlikely to be an issue for the DHBs. DHB pathologists' salaries are already on a par with salaries paid by community providers.	In Decision 559, Commission considered NZDG had sufficient scale & access to funds to offer sufficiently attractive employment terms to secure most of required technical staff when re-entering in future contract rounds. Same principle would apply to Wellington regional contracts	
	In Decision 559, Commission considered DHBs likely to view Sonic's ability to secure key staff more credibly (relative to smaller, less well-known operators).	Considerable uncertainty about bidding for contract without first securing all staff.		In Decision 559, Commission considered DHBs likely to view NZDG's ability to secure key staff more credibly (relative to smaller, less well-known operators).	

Entry condition	Sonic	Abano	Hutt Valley and Capital & Coast provider arms	NZDG	Labco Wellington
Access to capital	Some outlay required: o expansion of existing lab (some refurbishment required) o 8 additional collection centres (can be leased) o some additional equipment	Some outlay required: o expansion of existing lab (some refurbishment required) o 7 additional collection centres (can be leased) o some additional equipment	Some outlay required: o expansion of existing lab (with some refurbishment required), space has been allocated for a community lab in the existing building at Hutt Valley Hospital o 14 collection centres (can be leased) o some additional equipment	Will require: o lab premises (can be leased but some refurbishment required) o 14 collection centres (can be leased) o equipment	1 additional collection centre required (Naenae – can be leased)
	Able to lease additional equipment from reagent suppliers.	Able to lease additional equipment from reagent suppliers.	Able to lease additional equipment from reagent suppliers.	Able to lease additional equipment from reagent suppliers.	
	In Decision 559, Commission said that Sonic may be able to source excess equipment through other NZ businesses. May have ability to shift: o under-utilised equipment between regions o work to other regions.	No ability to shift equipment between regions or work to other regions – but could subcontract to other providers out of the region.	No ability to shift equipment between regions or work to other regions – but could subcontract to other providers out of the region (especially CHL.)	In Decision 559, Commission said that NZDG may be able to source excess equipment through other NZ businesses. May have ability to shift: o under-utilised equipment between regions o work to other regions.	Additional equipment not required.
	In Decision 559, Commission said that Sonic's scale advantage may offer significant purchasing power in relation to equipment (as well as inputs).	No scale advantage.	DHBs have scale advantage, which may offer significant purchaser power in relation to equipment and inputs (refer also to Memorandum of Understanding with regard to equipment purchases). In any event, the DHBs have indicated that access to capital is not an issue.	In Decision 559, Commission said that NZDG's scale advantage may offer significant purchasing power in relation to equipment (as well as inputs).	Will be able to utilise Sonic's scale advantage

Entry condition	Sonic	Abano	Hutt Valley and Capital & Coast provider arms	NZDG	Labco Wellington
Scale	In Decision 559, the Commission concluded: o Sonic is likely to remain a large national provider; o has ability to shift samples between regions for non-urgent tests; o has access to a pool of expertise via network of pathologist and scientists around the country; o greater size provides greater buying power with respect to equipment, reagents and other raw materials.	o not likely to remain a large national provider; o does not have ability to shift samples between regions for non-urgent tests; o does not have access to a pool of expertise around the country (other than through sub-contracting); o does not have buying power with respect to equipment, reagents and other raw materials.	o will remain providers in the region; o has ability to shift samples to other DHB labs for non-urgent tests; o has access to a pool of expertise via DHB network of pathologist and scientists around the country; o part of network of DHBs, with buying power in respect of equipment, reagents and other raw materials (refer also Memorandum of Understanding).	In Decision 559, the Commission concluded that. o NZDG is likely to remain a large national provider o has ability to shift samples between regions for non-urgent tests. o has access to a pool of expertise via network of pathologist and scientists around the country. o greater size provides greater buying power with respect to equipment, reagents and other raw materials.	
	In Decision 559, Commission reported that some competitors considered Sonic could realise economies of scale given that it has ability to centralise a substantial portion of test volumes.	Little ability to centralise test volumes (Other than through Nelson/Marlborough).	DHBs able to realise economies of scale given that they also have hospital test volumes.	In Decision 559, Commission reported that some competitors considered NZDG could realise economies of scale given that it has ability to centralise a substantial portion of test volumes.	
Incumbent knowledge	In Decision 559, Commission considered that Sonic has the ability to pool information and benchmark volumes/costs when tendering for new contracts. Would reduce research and bid preparation costs.	In Decision 559, Commission considered that Abano is not well-placed to forecast conditions in a completely new region. Currently operates only in the Capital & Coast part of Greater Wellington region.	Would have good knowledge of combined Hutt Valley and Capital & Coast regions and existing relationships with GPs.	In Decision 559, Commission considered that NZDG has the ability to pool information and benchmark volumes/costs when tendering for new contracts. Would reduce research and bid preparation costs.	Would have good knowledge of combined Hutt Valley and Capital & Coast regions.
Reputation and prior relationships with DHBs	In Decision 559, Commission considered Sonic likely to be recognised by most DHBs as capable and strong service provider with proven track	Has reputation in Capital & Coast area but not in Hutt Valley.	(Self – evidently) the DHB labs have reputations and prior relationships with their funder arms.	In Decision 559, Commission considered NZDG likely to be recognised by most DHBs as capable and strong service provider with proven track	Likely to be recognised by Hutt Valley and Capital & Coast DHBs as capable and strong service provider with proven track record.

Entry condition	Sonic	Abano	Hutt Valley and Capital & Coast provider arms	NZDG	Labco Wellington
	record.			record.	



Northland

Hospital Labs	Bay of Islands Clinical Lab
	Kaitaia Clinical Lab
	Whangarei Hospital
Community Labs	Northland Pathology Lab (Healthscope)

Auckland

Hospital Labs	Lab Plus (Auckland City Hospital)
Community Labs	Diagnostic Medlab Ltd (Sonic)
	DNA Diagnostics Ltd (Sonic JV with Auckland University)

Waitemata

Hospital Labs	North Shore Hospital
	Waitakere Hospital

Lakes

Hospital Labs	Lakes DHB
Community Labs	Diagnostic Rotorua (Diagnostic Medlab JV between Sonic and PAL)

Counties Manukau

Hospital Labs	Middlemore Hospital

Bay of Plenty

Hospital Labs	Whakatane Hospital
Hospital/Community Labs	Medlab Bay of Plenty

Waikato

Hospital Labs	Taumarunui Public Hospital
	Te Kuiti Hospital Lab
	Thames Hospital Lab
	Tokoroa Hospital
	Waikato Hospital Lab (Hamilton)
Community Labs	Medlab Hamilton (NZDG)

Tairawhiti

Hospital Labs	Gisborne Hospital
Community Labs	Medlab Gisborne (NZDG)

Taranaki

Hospital Labs	Labcare Ltd
Community Labs	Medlab Taranaki

Hawke's Bay

Hospital Labs	Healthcare Hawke's Bay Lab
	Wairoa Hospital Lab
Community Labs	SCL Hawke's Bay Ltd (NZDG)
	Medlab Hawke's Bay (Sonic)

Whanganui

Hospital Labs	Good Health Wanganui Ltd
Community Labs	Wanganui Diagnostic Laboratory (Sonic)

Mid Central

Hospital/Community Labs	Medlab Central (Sonic)

Hutt

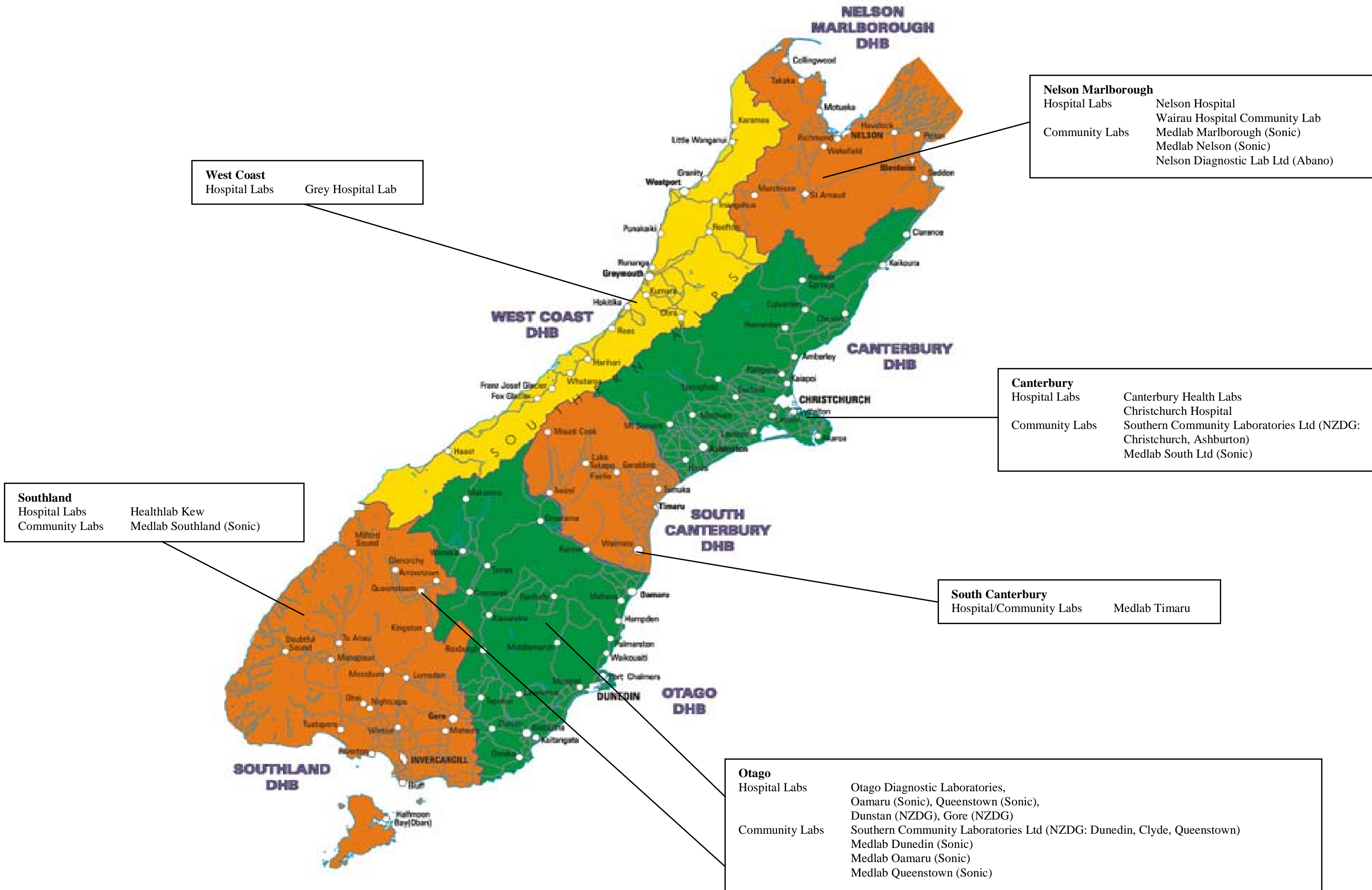
Hospital Labs	Hutt Hospital
Community Labs	Valley Diagnostic Laboratories Ltd (Sonic)

Wairarapa

Hospital Labs	Masterton Hospital Laboratory

Capital & Coast

Hospital Labs	Capital & Coast District Health Board
	Wellington Hospital
Community Labs	Medical Laboratory Wellington (Abano)


NELSON MARLBOROUGH DHB
WEST COAST DHB
CANTERBURY DHB
SOUTH CANTERBURY DHB
OTAGO DHB
SOUTHLAND DHB
NELSON
CHRISTCHURCH
DUNEDIN
INVERCARGILL
Nelson Marlborough
Hospital Labs Nelson Hospital
Wairau Hospital Community Lab
Community Labs Medlab Marlborough (Sonic)
Medlab Nelson (Sonic)
Nelson Diagnostic Lab Ltd (Abano)
West Coast
Hospital Labs Grey Hospital Lab
Canterbury
Hospital Labs Canterbury Health Labs
Christchurch Hospital
Community Labs Southern Community Laboratories Ltd (NZDG: Christchurch, Ashburton)
Medlab South Ltd (Sonic)
Southland
Hospital Labs Healthlab Kew
Community Labs Medlab Southland (Sonic)
South Canterbury
Hospital/Community Labs Medlab Timaru
Otago
Hospital Labs Otago Diagnostic Laboratories, Oamaru (Sonic), Queenstown (Sonic), Dunstan (NZDG), Gore (NZDG)
Community Labs Southern Community Laboratories Ltd (NZDG: Dunedin, Clyde, Queenstown)
Medlab Dunedin (Sonic)
Medlab Oamaru (Sonic)
Medlab Queenstown (Sonic)

ANNEXURE 1 – CONFIDENTIAL

Report by CRA International on Implications of Auction Theory

ANNEXURE 2 – CONFIDENTIAL

Report by Lindsay Lawton on Modelling the cost of Provision Scenarios

ANNEXURE 3

“Capital & Coast and Hutt Valley District Health Boards Request for proposal for Primary Referred Medical Laboratory testing

Capital & Coast District Health Board
Hutt Valley District Health Board

Request for proposal for
Primary Referred
Medical Laboratory testing

CAPITAL & COAST DISTRICT HEALTH BOARD
Private Bag 7902
Riddiford Street
Wellington
Tel (04) 385 5999

HUTT VALLEY DISTRICT HEALTH BOARD
Private Bag 31 907
Lower Hutt
Tel (04) 570 9488

[1] Please note that this RFP may change significantly following Reference Group feedback

Section A - Overview, RFP process and conditions

Overview

Purpose of request for proposal

1. This request for proposal ('RFP') is issued by Capital and Coast District Health Board ('C&CDHB') and Hutt Valley District Health Board ('HVDHB') and invites proposals for the provision of primary referred medical laboratory testing in accordance with this RFP.

2. The purpose of this RFP is to obtain sufficiently detailed information from potential providers about their respective organisations and the way they propose to provide services to enable selection of a service provider or providers of primary referred medical laboratory testing.

Background

3. The Capital & Coast and Hutt Valley District Health Boards have agreed to work together to build a more integrated laboratory service for the sub-region (Wellington and Hutt Valley). The Boards have agreed to jointly issue this proposal for primary referred medical laboratory testing for the sub-region. Hospital referred testing is not part of this proposal – and will continue to be provided by the existing hospital providers. The two hospital providers will work more closely together under a Memorandum of Understanding. It is expected that the provider(s) of community services will also work with hospital providers to improve services for the sub-region through such things as shared clinical standards and compatible IT systems.

4. The vision for laboratory services is an integrated laboratory service for the sub-region, with integrated information systems, common standards, aligned service goals, improved management of the community schedule, better demand management and rationalisation of production. Maintaining or improving service quality, safety and access for referrers and consumers; and ensuring efficient provision of laboratory services are some of the key guiding principles. The service must be acceptable to community referrers, and provide the DHBs with the best value from their public health spending.

5. The contract period offered is for five years from 1 October 2006.

6. C&CDHB and HVDHB are seeking fixed price proposals that cover all primary referred testing (both schedule and non-schedule). Inpatient testing is not included in this proposal. The price should include the costs associated with delivering all other services within this RFP and associated contract/service specifications.

   Please note: An exceptional circumstances clause is within the contract but does not include any routine inflation adjustment or population adjustment.

How to use this document

7. This RFP consists of:

- Section A - Overview and RFP Process;
- Section B – RFP Requirements;
- Section C – RFP Conditions;
- Section D – Evaluation;
- Section E - Notification;
- Appendix 1 - Proposal Cover Form;
- Appendix 2 - Proposal Format and Information Required;
- Appendix 3 – Contract Price Form;
- Appendix 4 -Contract Terms & Service and Quality Specifications;
- Appendix 5 – Pathology Test Volumes

8. Section A of this document provides background information.

9. Sections B, C, D and E set out instructions and conditions for responding to this RFP. You need to read and understand these sections. Please complete and return with your proposal the proposal cover form in Appendix 1.

10. The appendices contain information about C&CDHB and HVDHB and the service to be provided, that may be of assistance to you in the preparation of your proposal.

Request for proposal process – instructions

RFP timetable

11. The anticipated timetable for this RFP is:

Date	Activity
Friday 2nd December 2005	Issue of RFP
Friday 17th February 2006	Proposal submissions closing date
Feb/March 2006	Evaluation & Selection of preferred proposer(s) (if any)
March 2006	Negotiation with preferred proposer(s)
7th April 2006	Contract award(s) (if any)
1st October 2006	Services Commence

12. Please note, this timetable is indicative only and may be subject to change at the sole discretion of C&CDHB and HVDHB. C&CDHB and HVDHB will notify participants of any changes.

Section B – RFP Requirements

Proposal form

13. Your proposal should be submitted with the proposal cover form attached to this RFP (Appendix 1).

14. The information and other items required by this RFP must be enclosed with the proposal and (where relevant) clearly labelled as part of the proposal.

15. You may attach any other documents you wish to lodge in support of your proposal to the completed proposal form. Please summarise any attachments in a covering letter.

16. Please provide 14 hard copies of your proposal (excluding price information). You only need to supply 1 copy of any additional material (eg brochures/attachments) not specifically requested by this RFP. In addition, please also provide a copy of your proposal on CD or hard disc format utilising Word. Please do not email us an electronic copy of your proposal.

17. The 14 copies of your proposal should be placed in 14 separate sealed envelopes marked 'proposal for primary referred medical laboratory testing – non price information'. The reason for this is that the dimensions of the slot in the locked cupboard are 2.8cm high and 36cm wide, so larger documents will not fit. You should include the contract price form as outlined in Appendix 3 in a separate sealed envelope marked 'proposal for primary referred medical laboratory testing – price information'. This will ensure that the evaluation of quality is not influenced by the tender price. **You need only provide one copy of the price information.**

Joint proposals

18. Joint proposals may be submitted, provided one of the joint proposers is identified as the contact point for all communications relating to this RFP.

19. You may submit multiple proposals.

20. We will not accept proposals from laboratories where the proposal is conditional on Commerce Commission clearance.

Lodging of proposals

21. Your proposal must be received by C&CDHB and HVDHB before the closing date of 5pm on 17th February 2006.

22. Your proposal must be placed in the locked tender cupboard located at:

    Capital and Coast District Health Board
    Service Planning and Funding Directorate
    Level 1
    Lotteries Commission Building
    54-56 Cambridge Terrace
    Wellington

It is important for probity reasons that the bids are not handed over in an unsecured manner but are placed in the locked cupboard.

Proposals should be delivered between 8:30am and 5:00pm on business days. Doors to the building may be locked outside these times.

Please note: Offices will be closed from 5pm on December 22nd 2005 until 8am on January 9th 2006.

23. Proposals sent by facsimile or email will not be accepted.

24. You should ensure your proposal is placed in the proposal box before the closing date and time. C&CDHB and HVDHB's policy is not to evaluate late proposals. However, C&CDHB and HVDHB retain the right to evaluate late proposals.

Proposal qualifications

25. Any qualifications to the proposal documentation must be outlined in a covering letter or memorandum and included in your submitted proposal. Any qualifications not included in a covering letter will not be considered to be a part of the proposal.

26. You may be requested to remove unacceptable qualifications. Refusal to remove qualifications may result in the proposal being rejected. If the consequence of the qualification or the qualification itself is unacceptable to C&CDHB and HVDHB, the proposal will be considered to be non-conforming and shall be rejected.

Further communications

27. All communications as to this RFP, or requests for clarification or further information should be directed to C&CDHB and HVDHB's Representative. C&CDHB and HVDHB's representative is:

    Shona Henderson
    Capital & Coast District Health Board
    Private Bag 7902
    Mein St Administration Building
    Wellington Hospital
    Riddiford Street
    Wellington

    Contact phone number: (04) 803 1100 extn 4106

    Email: LabProject@ccdhb.org.nz

Additional information and clarification

28. Requests for clarification or additional information should be in writing. Any requests must be made prior to 3.00pm on Monday 16th January 2006. However, this may be extended at C&CDHB and HVDHBs' discretion.

29. C&CDHB and HVDHB will issue any clarification and change to the RFP by way of written amendment notice. A copy of each amendment notice will be given to each person receiving this RFP. All amendment notices issued will become part of this RFP.

30. Requests for information or clarification that relate solely to a proposer's proposal will be provided to a proposer requesting the information or clarification only.

31. C&CDHB and HVDHB will not be bound by any statement, written or verbal, made by any person other than C&CDHB and HVDHB's Representative. C&CDHB and HVDHB's Representative (or any other person authorised by C&CDHB and HVDHB's Representative) is the only person authorised to make representations or explanations to proposers as to this RFP.

No canvassing

32. Any proposer who indirectly or directly canvasses any officer, employee, Board member or advisor of C&CDHB and HVDHB or C&CDHB and HVDHB other than the authorised representative(s) concerning any aspect of this RFP process may in C&CDHB and HVDHB's discretion be disqualified.

Proposal validity period

33. Every proposal will be a continuing offer and irrevocable until the expiry of six calendar months from the proposal close date or such later date as we may jointly agree on.

Price

34. Prices should differentiate the following elements:

    - Services for each DHB should be priced individually – even if a proposal covering both DHBs is submitted

    - Services for Schedule A tests should be priced separately from schedule B tests.

    - Prices should contain your estimate of the price to supply services to specialists working in private hospitals and private clinics

35. Proposal prices should be quoted exclusive of goods and services tax ('gst') and in New Zealand dollars.

36. Proposal pricing should be submitted in the format set out in Appendix 3.

37. You may submit an offer for only one DHB area or for both, at your discretion. Your proposal must include both Schedule A and Schedule B tests. The GST exclusive pricing guide for schedule B tests is as follows:

    - C&CDHB $600,00 per year

- HVDHB $300,000 per year

As outlined in the service specification and contract, DHBs will work with the contract holder(s) to contain the cost of Schedule B tests within these amounts.

38. Your price exclusive of specialist referred testing should assume that you are able to charge specialist referrers, or consumers, directly for lab tests requested by them. **(Note that this point is subject to consultation and policy decisions and may be the subject of an RFP update and/or final negotiations with the preferred provider(s)).**

Bid clarification

39. You may be asked to clarify your bid or provide additional information during the proposal evaluation process. These requests will require prompt action and must be responded to in writing within 2 working days or the time specified in the request. Otherwise, C&CDHB and HVDHB reserve the right not to consider your proposal.

Proposal format

40. Your proposal should be structured and cover the issues as set out in Appendix 2.

Section C – RFP Conditions

General conditions

41. C&CDHB and HVDHB reserves the right to:

- reject all or any proposals and to not award and to not accept the lowest proposal;
- negotiate with any proposer (to the exclusion of any other proposer), at any time before, or after selection of a preferred proposer or proposers, and upon any terms and conditions;
- deal separately with any of the divisible elements of any proposal, unless the relevant proposal specifically states that those elements must be taken collectively;
- award contracts for all or part or any combination of parts of the services and to one or more proposers;
- re-advertise for proposals;
- waive any irregularities or informalities in the RFP process;
- amend the closing date, the acceptance date or any other date in the RFP process by the issue of a written amendment notice;

- amend this RFP, or any associated documents, by the issue of a written amendment notice;
- seek clarification of any proposal;
- suspend or cancel, (in whole or in part), this proposal process;
- meet with any proposer before and/or after proposal close and prior to award of the contract(s);
- consider or reject any alternative proposal, in C&CDHB and HVDHB's sole discretion.

Service Agreement

42. The contract terms and service specifications included in this RFP are those that C&CDHB and HVDHB will require the successful proposer(s) to meet. However, C&CDHB and HVDHB may amend minor aspects of these terms during the contract finalisation phase.

Errors and omissions

43. C&CDHB and HVDHB are under no obligation to check any proposal for errors. Acceptance of a proposal that contains errors will not invalidate any contract formed based on that proposal.

44. If C&CDHB and HVDHB discovers errors and/or omissions in your pricing submitted in your proposal prior to award of a contract, C&CDHB and HVDHB may notify you as soon as practicable and where, in C&CDHB and HVDHB's opinion, the error and/or omission is an obvious error, or other material change to the proposal then C&CDHB and HVDHB may amend the error and invite the proposer to confirm that its proposal remains open for acceptance as amended. Unless the proposer confirms its proposal as amended, the proposal may be deemed to be withdrawn.

Tenderers investigations

45. You must examine this RFP yourself, and make all other investigations you consider necessary, (including as to information provided by C&CDHB and HVDHB in relation to this RFP), before submitting your proposal.

46. You are advised to seek your own advice about the potential Commerce Act implications of responding to this RFP and/or providing services under the resulting contract(s).

47. C&CDHB and HVDHB accept no responsibility for any error or misdescription in this RFP, or any associated documents.

No warranties or representations

48. C&CDHB and HVDHB make no representations and give no warranties other than as set out in the contract.

Confidentiality

49. The information supplied by C&CDHB and HVDHB (either itself or through its consultants or advisors) in connection with this proposal or any contract that may arise out of it may be confidential. You must not release or disclose any information deemed confidential by C&CDHB or HVDHB to any other person, (other than your employees or advisors), without the prior written consent of C&CDHB and HVDHB. Any publicity also requires C&CDHB and HVDHB's prior written consent.

50. C&CDHB and HVDHB may, if it considers it appropriate to do so, require you to sign a confidentiality deed, before releasing any confidential or commercially sensitive information to you. You agree to sign a confidentiality deed, if required to do so.

51. C&CDHB and HVDHB will keep proposals received confidential. However C&CDHB and HVDHB are subject to the Official Information Act 1982. Information provided by proposers may be required to be disclosed under that Act.

Ownership of RFP and proposal documents

52. The RFP documents are the property of C&CDHB and HVDHB and may not be copied or reproduced in any way (other than for the purposes of preparing and submitting your proposal) without the prior written approval of C&CDHB and HVDHB.

53. The proposals submitted to C&CDHB and HVDHB in response to this RFP shall be retained by C&CDHB and HVDHB.

Information complete and accurate

54. By submitting your proposal you warrant that all information provided by you to C&CDHB and HVDHB or C&CDHB and HVDHB's Representative, in or in relation to your proposal is complete and accurate in all material respects. You also warrant to C&CDHB and HVDHB that the provision of that information to C&CDHB and HVDHB, and the use of it by C&CDHB and HVDHB for the evaluation of your proposal and for any resulting negotiation, will not breach any third party intellectual property rights.

Costs

55. You must pay your own costs of preparing and submitting your proposal, including but not limited to:

    - any communications or negotiations with C&CDHB and HVDHB;
    - any meetings, presentations or interviews with C&CDHB and HVDHB;
    - any site inspections.

Governing law

56. This RFP is governed by New Zealand law. The New Zealand courts have non exclusive jurisdiction as to all matters relating to this RFP.

Liability limitation

57. C&CDHB and HVDHB and its agents or advisors will not be liable in contract or tort or in other way for any direct or indirect damage, loss or cost incurred by any proposer or other person in respect of this RFP process.

Section D – Evaluation

Selection process

58. After receipt of the proposal, C&CDHB and HVDHB may require a meeting with you. If required, all meetings will be carried out at C&CDHB's offices in Wellington or HVDHB's offices in Lower Hutt or such locations as we may advise on.

59. Proposals will be evaluated by C&CDHB and HVDHB against the requirements as set out in this RFP.

60. There will be no public opening of proposals.

61. Bill Inglis of Audit NZ has been appointed as probity auditor to ensure the fairness of the selection process. A probity procurement plan has been developed.

Evaluation process

62. Proposals will be evaluated by three separate but overlapping groups. The clinical evaluation group will look at the clinical elements of the proposals and help determine whether the first stage technical competency requirements are met. This group will make recommendations to the other two groups. The second will evaluate proposals on behalf of C&CDHB, the third will evaluate proposals on behalf of HVDHB. These two DHB groups will meet separately and reach independent conclusions on the best proposal for Capital & Coast, and Hutt Valley DHBs respectively and prepare a report with those findings. The two DHB groups will then meet together to discuss the best solution for the sub-region as a whole.

The following members, chosen for their understanding of tender subject matter will be invited to form the clinical/technical review panel:

Name and role
Win Bennett - GM Planning and Funding (C&C) (chair) General Practitioner(s) Independent Pathologist Martin Hefford – Director of Quality and Integrated Care (C&C) Robert Logan – Chief Medical Advisor (Hutt) Geoff Robinson – Chief Medical Advisor (C&C) Shona Henderson - Project Manager (in attendance)

The following members, chosen for their understanding of tender subject matter will invited to form the Capital and Coast evaluation panel:

Name and role
Win Bennett - GM Planning and Funding (C&C) (chair)
Sandra Williams – Manager Planning and Funding Operations (C&C)
Michael Hundleby - Legal adviser (Hutt)
Martin Hefford - Director quality & integrated care (C&C)
External Financial Analyst – Name of panel member TBC
Geoff Robinson - Chief Medical Officer (C&C)
Shona Henderson - Project Manager (in attendance)

The following members, chosen for their understanding of tender subject matter will be invited to form the Hutt Valley evaluation panel:

Name and role
Bridget Allan - GM Planning and Funding (Hutt) (chair)
Marion Thomas - Portfolio manager (Hutt)
Michael Hundleby - Legal adviser (Hutt)
Martin Hefford - Director quality & integrated care (C&C)
External Financial Analyst – Name of panel member TBC
Robert Logan - Chief Medical Advisor (Hutt)
Shona Henderson - Project Manager (in attendance)

Please note: Canvassing of members may result in disqualification.

63. Panel membership may be subject to change depending on availability.

64. The proposal evaluation process shall be conducted in accordance with the following method: The evaluation panels will evaluate proposals in two stages. In the first stage the panels will evaluate the ability of the potential provider to demonstrate competency in the following areas:

    64.1 Ability to provide a clinically effective service;

    64.2 Ability to meet reporting requirements;

    64.3 Ability to meet IANZ accreditation requirements;

    64.4 Ability to provide responsiveness to the needs of GPs and other referrers – both in the provision of testing and advice;

    64.5 Accessibility of sample taking facilities for all users within the subregion, but in particular for high needs groups;

    64.6 Workforce competency and suitability (including such things as appropriate ratios of pathologists, scientists, technicians and phlebotomists);

    64.7 The ability to provide the majority of tests required by community referrers and establish linkages with those referrers;

64.8 Ability to meet Information system requirements such as, but not limited to, the provision of results in electronic form to GP's;

64.9 Ability to provide an effective demand management and referrer education service to promote evidence based testing;

64.10 Ability to deliver the service in accordance with the contract and service specifications – issues not previously specifically covered in the above criteria.

Each provider proposal will be assessed against the criteria and a majority view formed as to whether they meet the criteria – scoring a yes (meets), a no (does not meet) or conditional yes (may meet if conditions are met). Should the potential provider adequately meet these requirements in the view of the panel, they will be referred to the second stage.

The panels will then assess the providers based on value for money and fit with the strategic interests of the DHBs. Note that the clinical evaluation panel will not evaluate the proposals at this second stage, but members with clinical expertise may be invited to take part in the second stage at the discretion of the DHBs. The two criteria to be considered at the second stage are:

64.11 Price – the provider will be expected to submit a fixed price bid per year for each of the five years.

64.12 Strategic fit – the provider will be assessed based on their fit with the strategic interests of C&CDHB and HVDHB in relation to laboratories and the long term market implications of the proposal.

General

65. C&CDHB and HVDHB anticipate a phase following closure of this RFP during which C&CDHB and HVDHB may hold discussions and/or negotiate with one or more proposers. During that phase C&CDHB and HVDHB will seek to resolve qualifications to proposals and develop proposals to ensure an appropriate outcome is achieved for C&CDHB and HVDHB and to enable C&CDHB and HVDHB to compare credible alternatives. C&CDHB and HVDHB may invite one or more respondents to reprice or amend their proposals during this process.

Checks and Privacy Act

66. You as proposer confirm to C&CDHB and HVDHB, on your own behalf and on behalf of any key personnel referred to in your proposal, that C&CDHB and HVDHB is authorised to verify with any third person any information included in the proposal or disclosed to C&CDHB and HVDHB in connection with the proposal (whether that information relates to such personnel or otherwise).

67. C&CDHB and HVDHB is not obliged to contact referees provided by proposers and may seek further information on any issue from sources other

than the referees provided. C&CDHB and HVDHB may also take into account knowledge of the proposer it already has.

Section E – Notification

Notification of successful proposal(s)

68. C&CDHB and HVDHB may notify the successful proposer or proposers (if any) in writing that it has been selected as a preferred proposer to proceed to the negotiation phase. Alternatively, the DHBs may accept proposals as submitted.

69. C&CDHB and HVDHB will notify all unsuccessful proposers in writing that their proposals have not been successful.

70. All notices will be forwarded to the address provided by proposers in their proposal.

Short-listing on Negotiation

71. Where there is a decision to short-list and proceed to negotiation, the preferred proposer(s) will be notified of their preferred status and the expected timeframe for negotiations.

72. Other proposers will be notified that:

    - their proposals have been unsuccessful, or
    - their proposals are short-listed but not preferred. In this case the proposer will be asked to confirm that their proposal remains open for the period of negotiation with the preferred proposer(s).

Preferred proposer(s)

73. Should C&CDHB and HVDHB advise the proposer(s) that they are one of the 'Preferred Proposers', such advice does not:

    - constitute an acceptance by C&CDHB and HVDHB of the proposers proposal, or create a contract.
    - constitute an award of the contract to the proposer(s).
    - imply or create any obligation on C&CDHB and HVDHB to enter into negotiations with the proposer or award the contract to that proposer.

C&CDHB and HVDHB may discontinue any negotiations at any time.

Appendix 1 – Proposal Cover Form

Proposal cover form

Proposal for primary referred medical laboratory testing

We/I have examined the request for proposal documents ('the RFP') for primary referred medical laboratory testing ('the services').

We/I offer to provide the services in accordance with the RFP including the Agreement terms & conditions and service quality specifications and our proposal for the price set out in the contract price form included in our proposal.

We/I acknowledge receipt of amendment notices numbered [ ] to [ ] (inclusive). The requirements of the notices are included in this proposal.

We/I acknowledge that our proposal is irrevocable and remains open for acceptance until 18th August 2006.

We/I understand you are not obliged to accept the lowest or any proposal you may receive.

We/I attach the other information required by the RFP.

Our contact details for this proposal are:

Proposer's contact person:

Phone:

Mobile phone:

Direct dial:

E-mail:

Fax:

Courier address:

Postal address:

Proposer: ______________________________

Dated: ______________________________

Signature(s): ____________________ in position of ____________________

Witness(es): ____________________ ____________________

Appendix 2 – Proposal Format and Information Required

Proposals should be structured and include the information as set out in this appendix. Additional information may be supplied where appropriate.

Part One – General

Introduction

1. *The introduction to the proposal should state that you have read and understood all the terms and conditions contained in this RFP and that they have been complied with and will continue to be complied with.*

Executive summary

2. *This section should include:*

   - *an overview of your proposal for the provision of services required by this RFP*
   - *a summary of the major benefits which, in your opinion, C&CDHB and HVDHB would gain from accepting your proposal*
   - *an overview of your capability to carry out the services and of any subcontractors (if any) which you propose to engage in connection with the services*
   - *confirmation that your proposal covers all of the requirements of the general conditions of the service specifications or otherwise expressly identifies those requirements which are not covered by your proposal.*

Corporate structure

3. *Full details, as relevant, of:*

   - *the location of your main office*
   - *your corporate structure (eg a partnership? a company?)*
   - *if a company, full names of all major shareholders of the company, including any beneficial shareholders who are not the registered shareholders*
   - *numbers of staff you employ and their roles*

Assumptions

4. *Your proposal should set out clearly any assumptions you have made in respect of the requirements set out in this RFP.*

Part Two – Your vision for laboratory services

Part Three - Relevant experience

Part Four – Personnel and subcontractors

Part Five – Testing equipment and other resources

Part Six – Technical skills (including evidence of IANZ accreditation)

Part Seven – Management skills

Part Eight – Quality and services provided to referrers

Part Nine – Access for consumers (including the locations of your specimen collection centres and opening hours)

Part Ten – Demand management and referrer education

Part Eleven – Information technology

Part Twelve – Willingness to cooperate with the Oversight Group

Please include any other sections you deem appropriate.

Information on Price should be included separately.

Appendix 3 – Contract Price Form

Contract Price Form

Schedule A Tests

Price Table	Yr1	Yr2	Yr3	Yr4	Yr5
Price for services to C&C DHB inclusive of private specialist referred tests					
Price for services to C&C DHB exclusive of private specialist referred tests					
Price for services to HV DHB inclusive of private specialist referred tests					
Price for services to HV DHB exclusive of private specialist referred tests					
Price for services to HVDHB subject to acceptance of your proposals for both HVDHB and C&C DHB inclusive of private specialist referred tests					
Price for services to HVDHB subject to acceptance of your proposals for both HVDHB and C&C DHB exclusive of private specialist referred tests					
Price for services to C&C DHB subject to acceptance of your proposals for both HV DHB and C&CDHB inclusive of private specialist referred tests					
Price for services to C&C DHB subject to acceptance of your proposals for both HV DHB and C&CDHB exclusive of private specialist referred tests					

Schedule B Tests

Price Table	Yr1	Yr2	Yr3	Yr4	Yr5
Price for services to C&C DHB inclusive of private specialist referred tests					
Price for services to C&C DHB exclusive of private specialist referred tests					
Price for services to HV DHB inclusive of private specialist referred tests					
Price for services to HV DHB exclusive of private specialist referred tests					
Price for services to HVDHB subject to acceptance of your proposals for both HVDHB and C&C DHB inclusive of private specialist referred tests					
Price for services to HVDHB subject to acceptance of your proposals for both HVDHB and C&C DHB exclusive of private specialist referred tests					
Price for services to C&C DHB subject to acceptance of your proposals for both HV DHB and C&CDHB inclusive of private specialist referred tests					
Price for services to C&C DHB subject to acceptance of your proposals for both HV DHB and C&CDHB exclusive of private specialist referred tests					

We/I offer to provide the services in accordance with the RFP and our proposal for the sums specified above. *[You may provide more detailed information here if you wish. Please place this appendix into a separate envelope.]*

Proposer: ______________________________

Date: ______________________________

Signature(s): ______________________________

____

Appendix 4 – Contract Terms & Service and Quality Specifications

Attached

Appendix 5 – Pathology Test Volumes

Pathology Test Volumes for 1998-2004

These are included in the separate excel spreadsheet provided.

ANNEXURE 4

Record by Martin Hefford of resolutions of the Hutt Valley DHB on 1 March 2005

Capital & Coast DHB Summary of resolutions reached by Board in April 2005

Letter to Valley Diagnostic from Hutt Valley DHB dated 25 May 2005

"Community Referred Laboratory Services Consultation Questions and Answers"

Draft Minutes of Community Referred Medical Laboratory Services (CRMLS) meeting RFP 6 September 2005

From: Martin Hefford

Re: Regional Laboratory Project – Hutt Valley Laboratory Services

The Hutt Valley District Health Board on 1 March 2005:

1. **Agreed** that management should negotiate a Memorandum of Agreement on collaboration on hospital laboratory services with Capital and Coast DHB that includes (subject to their agreement, and negotiation on the specifics) agreements to:
    - use a common laboratory information system (or at least a common results repository);
    - share pathologists;
    - set common standards for testing and interpreting results;
    - purchase equipment and consumables jointly wherever possible;
    - meet regularly to discuss management issues and future direction.

2. **Agreed** that we develop jointly with Capital and Coast DHB funder arm a long term capped contract for community referred laboratory services that includes the following features (subject to further development work);
    - an explicit service schedule including required response times for different types of test, and requirements for phlebotomy locations and other quality standards;
    - capped price per year for 3 years – based on current volume;
    - supplier takes demand risk (with possibility of some risk corridors if appropriate);
    - price paid 90% as flat fee, 10% as a quality premium;
    - requirement to load all test results into Concerto or other regional data repository – as well as directly back electronically to the referrer;
    - opportunity for providers to bid for the Hutt Valley DHB service, the Capital and Coast DHB service and/or both services combined;
    - contract to include specific referrer education and demand management activities;
    - opportunity for a provider arm proposal to be compared against proposals from external providers;
    - contract includes exclusive right to provide laboratory services to community referrers for the contract term.

3. **Agreed** that the contract in recommendation two be put out to tender;

4. **Agreed** that GPs be involved in developing the terms and conditions of the capped contract and in the selection process.

Capital & Coast DHB Board Decisions on Laboratory Services

The following is a summary of the resolutions reached by the Board in April 2005.

1. **Agreed** that the preferred medium term outcome for C&CDHB is a consolidated, integrated laboratory service for the sub region with common clinical standards, integrated information systems, aligned goals, better management of demand and rationalised service provision. The service will be delivered from several sites (including the HHS campus sites at Hutt, Wellington, Kenepuru and Wairarapa if applicable). The service will include hospital services as well as those currently provided in the community. The service may be publicly owned, privately owned, or delivered through both public and private providers with aligned contract incentives.

2. **Agreed** that the next steps in the development of C&CDHB's laboratory services are:
   a) Develop a memorandum of agreement (MOA) with Hutt Valley DHB to rationalise laboratory services within the sub region (Capital & Coast district and Hutt Valley district). The MOA will outline:
   b) A joint approach hospital laboratory services in the sub region and increased cooperation and integration of hospital laboratories.
   c) A joint approach to purchasing community laboratory services using an RFP process.
   d) The guiding principles of the MOA are: (1) efficiency of laboratory service provision; (2) building quality and safety within the laboratories; and (3) maintaining appropriate levels of service for acute services (hospitals) and community service referrers.
   e) Finalise business plan development and set out short term options as follows:
      - Develop a process to gather costing information from C&C HHS laboratory to contribute to evaluation of options in the future
      - Gather further information about community service options from a joint RFP with Hutt Valley DHB.
      - Use the information from the MOA, HHS information process and RFP to build a joint business plan with Hutt Valley DHB.
   f) Establish clinical and service oversight of the process going forward. The process will include lab managers, pathologists, P&F and clinicians.

3. **Agreed** that management will bring the results from the RFP, the HHS costing and the planning process back to the Board to enable the Board to make a decision on the proposed service configuration and provider(s).

25 May 2005

Karen Wood
Valley Diagnostic Laboratories Limited
PO Box 30-044
Lower Hutt

Dear Karen

This letter is to inform you about some changes the Capital and Coast and Hutt Valley District Health Boards have decided to make to the way their medical laboratory services are run and ask you to be involved. The two Boards have agreed to work together to build a more integrated laboratory service for the subregion.

Subject to negotiation with you and other providers, community laboratory services will continue as they are now until 1 July 2006. On that date we expect a new contract will be put in place. To decide the best party/ies to perform community service the DHBs will ask existing and potential providers to put proposals in for the Capital and Coast service, the Hutt Valley service or both combined. It is expected that hospital and community providers will bid for this service. We expect that a Request for Proposal will be issued in August 2005, with responses due in October 2005. Hospital Laboratory services will also be issued an RFP. To maintain a fair process, hospital providers are not involved in the development of the Request for Proposal.

We would like you to be part of this process by joining a reference group. The reference group will be consulted on draft documents and other laboratory service issues. We are asking GPs, PHO representatives, specialists, laboratory managers, clinical leaders, NZAPP, ASMS, College of GPs and union representative to be members of the reference group. If you agree, we would like you to nominate a representative to be part of this group. We will be interested in your opinions on such things as service specifications, business rules, quality standards, the approach to integrated information systems and other opportunities to improve service efficiency or quality. The group may not actually meet in person, but rather be sent key project documents for feedback.

As discussed, we would also like a representative from VDL on the IS steering group, and you agreed that Niven would attend these meetings.

In addition, a Memorandum of Understanding is being prepared, committing the two hospital laboratory services to shared clinical standards, purchasing strategies, workforce development and an IT solution that allows consistent access to results across the subregion.

If you have any queries please contact Marion Thomas on 570 9466.

Yours sincerely

Bridget Allan
Director Planning Funding and Public Health

P:\Providers (Pr)\Valley Diagnostic Laboratories (VDL)\RFP process.doc

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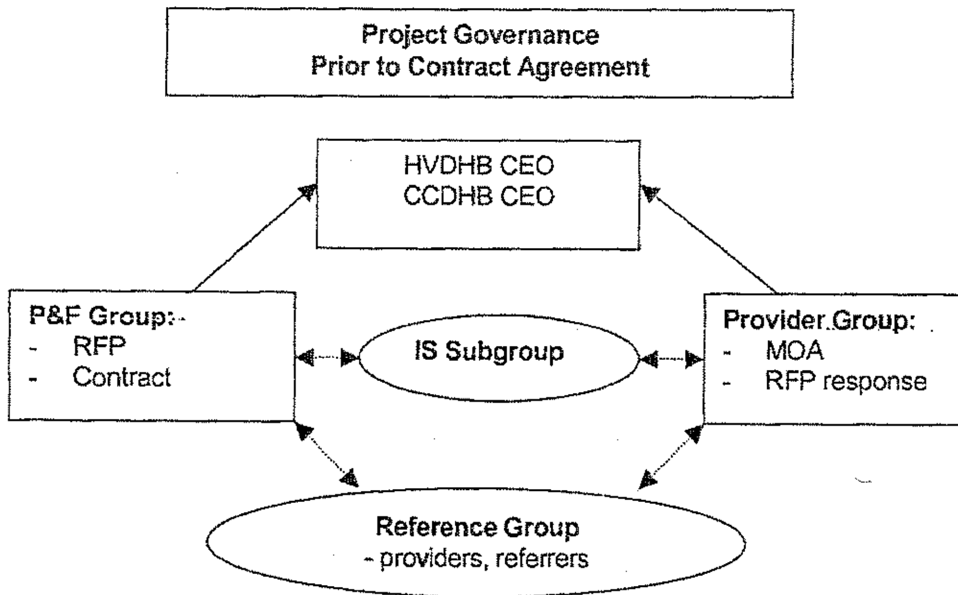
Project Governance
Prior to Contract Agreement
HVDHB CEO
CCDHB CEO
P&F Group:-
- RFP
- Contract
IS Subgroup
Provider Group:
- MOA
- RFP response
Reference Group
- providers, referrers

Capital & Coast
District Health Board
ŪPOKO KI TE URU HAUORA

HUTT VALLEY DHB

Community Referred Laboratory Services Consultation

QUESTIONS AND ANSWERS

Why are the DHBs changing the contract arrangements?
As the current contracts are coming up for renewal, we believe it is an appropriate time to test the market to ensure that we are getting best value from public spending.

What changes to laboratory services are the DHBs planning?
The vision for laboratory services in Wellington and Hutt Valley is an integrated laboratory service, delivered from multiple sites. An integrated laboratory service for Wellington and the Hutt Valley would include integrated information systems, common standards, aligned service goals, improved management of the community schedule, better demand management and efficient production.

How is this occurring?
We plan to issue a Request for Proposal (RFP) for the provision of community referred testing in Wellington and Hutt Valley DHBs. Hospital testing will not be included in the RFP. We expect that the RFP will be issued in November 2005, with responses due 11 January2006 and the new service in place by July 2006. These timeframes may change as the project progresses.

In addition, the two DHBs plan to sign a Memorandum of Understanding to collaborate on hospital laboratory services. This will cover areas such as staff training, shared clinical standards, joint purchasing, and back up. The two laboratories will both continue to provide services at Wellington, Kenepuru and Hutt hospitals.

What are you looking for?
As part of the Request for Proposal we will issue a formal set of evaluation criteria that will describe exactly what we are looking for. However, we are looking for a provider/providers of community referred services to support clinical decision making that meet high quality and safety standards in a timely way. We are also looking to get the best value from public health spending.

Are the DHBs looking to rationalise laboratory services in the greater Wellington region?
Not necessarily. We are simply looking for providers of laboratory services to provide us with fair, cost efficient laboratory tests. How they do that is up to them and, indeed, through this RFP, we intend that there will a competitive process.

Are we looking for just one provider of community services?
A single provider of community services for the sub-region is one of the options, however we are open to other possibilities (such as one provider for Hutt and one for Wellington or a joint bid from multiple providers) if they better meet our needs. We are looking for the best value for the public dollar.

I made a submission last year, what has happened with that?
Thank you again for taking the time to make a submission. Submissions were brought together and analysed, they were then used to formulate the direction for this process. A copy of the final report concluding the regional process will be available on http://www.ccdhb.org.nz/ and http://www.huttvalleydhb.org.nz shortly.

Both Capital & Coast and Hutt DHBs are involved, how does that work?
The Central Region Laboratory Project found that integration of laboratory services at the sub-regional (Hutt and Welington) level could provide significant gains. This process allows potential providers to bid for community services for both Hutt and Wellington combined, or just one of them.

Can community providers bid for hospital services?
Not at this time. This option was not chosen on the grounds that the hospital laboratories are a core central asset, essential for the provision of hospital services, therefore the strategic decision to retain control was taken.

Can hospital providers bid for community services?
Yes. As the laboratories will be providing hospital testing, they could also provide community testing and might be able to achieve economies of scale in doing so. Our aim is to get the best value from our spending on laboratory services. However, the chosen provider(s) will be those able to put forward the best proposal, based on quality, cost and other criteria in the RFP.

Why should patients of private specialists need to pay?
Historically, there has been a clear differentiation between the public and private systems in New Zealand. Private specialists' referrals for radiology tests, for instance, have been paid for by the private system. However, for some reason, private specialists' referrals for laboratory tests have been paid for by the public system. Now that we are going through this process, we believe it is an appropriate time to correct this historical anomaly.

What about public specialists?
Specialists working in the public sector will refer for laboratory tests as in the past. Where the nature of the particular request means that the test will be done by a community laboratory, that test will be paid for by the DHBs. Where a specialist (such as an obstetrician) does both privately and publicly funded work, their publicly funded patients will continue to receive free access to laboratory tests.

Will insurance premiums go up?
That's something for insurance companies to consider. However, we do note that laboratory tests average $10, which is a very small proportion of the total cost of private health care.

What is the difference between a patient getting tests ordered by a private GP and a private specialist?
While GPs operate private businesses, they have always been the cornerstone of primary health and are the first call for all people. The government has always subsidised GP care to make it accessible to all people as part of the public health system. Should they receive care beyond the GP they receive it through the public health system – or, they can then choose to enter the private health system, in which case they pay for that service.

Will it be harder to get tests? Will the locations where a patient can get a test be less?
No. We will specify in the contract/s that the spread of community laboratories and the times they are open will be at the same level as they are now.

I work for a medical laboratory in Wellington/Hutt, what will this mean for me?
Maintaining the number of qualified medical laboratory staff within the region is a priority for us and we want you to stay working in the region. The Wellington and Hutt hospital laboratories are going to begin to work together more closely so, if you work for one of these laboratories you may see some changes to your work practices.

How can I get more information?
Laboratory staff - You can talk to your laboratory manager or contact labproject@ccdhb.org.nz

Others – Contact labproject@ccdhb.org.nz or Shona Henderson on 04 803-1106.

HUTT VALLEY DHB Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA

Community Referred Medical Laboratory Services [CRMLS] meeting – RFP

Draft Minutes

6th September 2005 11.30am

Steering Group Panel
Martin Hefford – Director Integrated Care, Planning & Funding Directorate, Capital & Coast DHB
Michael Hundleby – Legal Advisor, Hutt Valley DHB
Marion Thomas - Portfolio Manager, Planning & Funding, Hutt Valley DHB
Sandra Williams – Operations Manager, Planning & Funding Directorate, Capital & Coast DHB
Shona Henderson – Project Manager – Integrated Care, Planning & Funding Directorate, Capital & Coast DHB

Minutes
Martin opened the meeting with a brief background and panel introduction. Noted the meeting discussion would follow the questions submitted and circulated prior to the meeting.

What are the DHB's intentions with regard to the scope of the RFP? Will it cover both the DHBs? Will it cover hospital referred as well as community referred work?

The RFP will be for community referred testing only and not include hospitals. The DHBs will be requesting separate bids for the individual DHBs and also a combined bid with separate prices for each DHB.

The DHBs considered the hospital laboratory service a strategic infrastructure. DHBs had made the decision not to include hospital laboratory testing in this RFP.

Discussion took place regarding at what level this decision was made and questioned where this would be documented and who was consulted. Noted that laboratory provision options were consulted on in the regional laboratory process.

Martin noted that the meeting was to discuss the RFP, not how a decision came about regarding the decision only to request for community laboratory testing. Michael reiterated Martins explanations – that the decision had already been made by the DHBs and that we need to focus on the RFP.

Q: Asked if the panel could outline the appeal methodology if anyone was unhappy with the decision to not include hospital lab services in the RFP process.

A: Martin told the attendee's that there is no the appeal process for that decision.

Will the DHBs be looking for a single supplier of community laboratory services?

The DHBs are interested in gaining services that provide best value for money – not necessarily seeking a single provider of services.

If this is to be a sole supplier contract, what is your view as to whether the current Wellington based laboratories (Wellington Diagnostics and Valley Diagnostics) should enter into a joint venture to bid for this contract?

Martin mentioned that the DHBs do not have an opinion on this; they are concerned with obtaining a service that offers the best value for money.

What are your intentions with regard to the term of the contract?

Proposals to be requested for a contract term of 5 years.

We understand that Commerce Commission investigators have indicated some concern with a 10 year contract term for the Otago/Southland contract. If the contract is to be a 10 year or 5 + 5 contract (which is effectively a 10 year contract), how do you propose addressing any concerns the Commerce Commission might have?

We intend to request a 5 year term.

Q: What would the process be at the end of the term?

A: The DHBs are not intending to pre-specify a process to apply at the end of the contract term.

<u>Commerce Commission</u>

Martin discussed that C&C DHB and HV DHB have taken legal advice around the current situation with other DHBs and the Commerce Commission issues.

Michael mentioned that we don't believe the Commerce Commission's decision will affect our timeframes and we should still be able to meet them if the Commerce Commission's decision is released next week. As yet, we don't know what implications it will have for us, so it is C&C DHB and HV DHB's intention to seek further legal advice after the release if required.

Q: Is there a possibility of C&C DHB and HV DHB electing a single provider and would the commerce commission allow this?

A: There is always that possibility but the DHBs are not prejudging this. The DHBs want a service that provides best value.

Martin went on to discuss the intended process table that will also be included in the draft RFP. He mentioned the intended release time for the draft RFP and specifications for comment is mid-September allowing for 4 weeks to

submit feedback. The final document is planned for release in the first week of November with the intended closing date currently set at 11th January 2006.

Request that the closing date be put back 1 – 2 weeks to be considered by the DHB and advised.

The private providers are in competition with the DHBs own laboratories. What processes will be put in place to ensure that the confidential pricing and other information provided by independent tenderers is kept confidential from the DHB's own laboratory?

All submissions will be kept in a locked cupboard from receipt until the selected opening date. All documents received will be opened in the presence of a witness. The DHBs will be requesting that there are no electronic submissions except CD's attached to a proposal. The Steering group has developed a Probity Plan around this process, including recognition of C&C DHB and HVDHB potentially being the funder and provider of community laboratory services. The Steering group has contracted an external probity auditor to assist and advise throughout this process. Management team members involved in the RFP design and evaluation will not be involved in the RFP provider response.

Will the DHBs be prepared to sign a confidentiality agreement (before we submit our tender) confirming they will not disclose details of our tender to the DHBs own laboratories?

We don't believe this is required as other protections are in place.

How will the DHBs handle Official Information Act requests?

In accordance with current legislation which allows commercially sensitive information to be withheld.

Q: Is this a closed tender?

A: Our proposed process will be in the draft RFP and everyone will have the opportunity to comment and provide us feedback.

Q: Can you clarify confidentiality of proposer's submitted pricing?

A: Yes, those involved in the RFP evaluation will not be involved in the provider response.

Q: Was the process after submission from proposers going to become one whereby there becomes a bidding war?

A: The tender document will be explicit as to our tender process. We intend to run a tender process that meets public sector accountability standards.

Which individuals will be involved in preparing the RFP and considering the tender responses?

There is a division of DHB management between those involved in the evaluation and those from the provider arms involved in any bid. These remain separate. Those representing the Steering group from both DHBs are not and will not be involved in preparing any provider arm tender.

Q: Is there laboratory and consumer representation on the evaluation panel?

A: Yes. Appropriate consumer representation and appropriate levels of professional representation are included in the evaluation panel.

Martin discussed the panels: a C&C DHB panel and a HV DHB panel with a mechanism to deal with tenders across both DHBs. No evaluation panel members will have had any involvement in any RFP response.

What will be the key criteria against which you will be assessing the tender responses? Obviously price will be one factor but what else? And what will the relative weightings be?

This process will be within the draft RFP. It will be a 2 envelope process. The first stage whereby the proposals must meet the key criteria (which will be specified) and the second stage, pricing.

If the RFP is for services for both Hutt Valley and Capital Coast jointly, if different tender responses deliver better outcomes for one or either DHB, how will the DHBs reconcile this between themselves?

The DHBs have a process that includes separate evaluations and also a joint evaluation to resolve this potential issue. It is contemplated by both DHBs that a joint provider may be selected, otherwise we wouldn't be using a joint process. However, it is possible that Boards, as discrete entities, may decide to contract with separate providers.

How will the wishes of GP's be accounted for? What if their preferred option does not accord with the Central Region Laboratory Project Report's preferred option?

GP's are involved with drafting the quality specifications. These individuals were selected to represent PHOs. The aim is to capture initial detail that isn't currently captured in the national contract. GP's will also have a representative within the evaluation process.

How will the tender assessment panel satisfy itself that any bid by the DHB's own laboratory does not involve subsidisation of the service from other aspects of the DHB's operations? How will it ensure that the actual costs to the DHB of the laboratory service are properly assessed and compared with private tenderers?

This will be done in two ways:

1. The provider management teams involved are responsible for ensuring bids are responsibly and fairly priced.

2. The RFP evaluation panel will perform due diligence on critical aspects of proposals.

Q: How can we guarantee a level playing field regarding pricing with internal submitted bids?

A: It is in the DHBs interest to ensure internal bids are fairly priced, otherwise we do not obtain best value for money.

Comment from attendee: Discussion around marginal pricing from DHBs. They felt that the DHBs are in a better position and can provide better efficiency gains due to the current loading of community and hospital services.

Comment from attendee: By going out for only half the market services and still being competitive for private sectors is not going to provide level playing fields for all potential proposers.

Panel response: This is an economies of scale issue – which may also apply to private laboratories in that some may also deliver services to other areas and hence have lower marginal costs.

What measures will ensure that the DHBs own provider arm is not favoured in this process?

As per processes previously described. Noted that DHB would not run a contestable process if we intended simply to allocate the contract to ourselves – we are seeking best value for money. It was pointed out that if a DHB bid was accepted and was not robustly priced the DHB would wear the risk- therefore there is no financial incentive to favour a DHB provider option.

If the contract is awarded to a DHB laboratory, will you be seeking Commerce Commission approval?

Depends on the circumstance, but we think it unlikely that Commerce Commission approval would be required.

We have seen a copy of a letter sent by the Ministry of Health to the DHBs dated 11 July 2005 advising that a halt be put on all tender processes. Have you now received further advice from the Ministry of Health that you can proceed with your tender round?

The letter from the Ministry of Health was a advisory notice. DHBs are autonomous entities. We will continue to take our own legal advice to ensure we do not breach competition law.

What are the DHBs' positions on the recommendations made in the February 2005 Final Report of the Working Party for the Central Region Laboratory Project?

The Central Regional Laboratory Project report was useful. It involved consultation on the issues and is now regarded as background information. We are going forward with our own strategies as per Board decisions.

How do the DHBs view the provision of pathology services in the longer term? Do you see a continuing role for private providers?

We are looking for the best value for the DHBs. We have an open mind as to whether that is best provided by public or private entities.

Will the DHBs consider a bid that is conditional on Commerce Commission approval and allow sufficient time for that approval to be obtained?

Conditions around a bid will weaken it. Bids will be judged on their merit however, so this cannot be ruled out. Ministerial approval is not required for the RFP.

Have you considered other options to a competitive RFP process? A collaborative process between existing providers may offer similar gains to a competitive process without the "winner takes all" outcome and the devastating effect this may have on the losing organisations and their staff. Having been through this in Otago / Southland I would suggest that there must be a better way to achieve savings for the DHBs.

C&C DHB and HV DHB have made the decision to go with a contestable process in line with Office of the Auditor-General procurement guidelines.

Do you see the payment for services being structured as a fixed fee, a fee for service, or a hybrid of these? Why have you chosen this form of payment?

We have a fixed annual fee preference as this will provide certainty for the DHBs and incentives around demand management for provider(s).

Comment from attendee: This then moves all of the risk onto the potential provider.

Q: Will there be any flexibility around exceptional circumstances?

A: There will be discussions on the need for this.

Do you see the Kapiti region as a possible separate sub-region for the RFP process (ie. have three regions Hutt, Wellington and Kapiti)? If not, why not?

No, preference from the DHBs is a single market for each DHB to make use of the economies of scale in laboratory provision.

Have you discussed this proposal with the Commerce Commission? Redesigning the CRMLS market to create one or more monopoly regions while protecting the markets for the hospital laboratory providers may not be legal under the Commerce Act. You should anticipate interest from the Commerce Commission after their thorough investigation of the Otago/Southland DHB laboratory process.

We have taken legal advice on this.

Will you consider joint ventures between private/private or private/public providers?

Yes.

Will you also be providing:

- ***the current population demographics?*** Yes.
- ***high level financial details of community referred laboratory services?*** Provision of test volumes for 5 years and total lab spend.
- ***key specific health needs of the population in the region?*** This will not be included in the RFP. Information is available on websites.
- ***high level details of the current service providers?*** No .
- ***details of the current hospital sector laboratory framework?*** This will not be in the RFP. The DHBs are unsure of the meaning this question and its appropriateness within this process.

Q: What are the hospital overhead components for tests and procedures i.e. corporate overheads carried?

A: Not for this group to comment on. The panel does not have access to this information.

Q: What is the total revenue from hospital laboratories?

A: High level information is already available in the regional report.

Q: Collection facilities. Are the sites defined in the RFP?

A: Yes, the proposed sites are in the RFP based on current sites.

Q: Regarding innovation in technology that hasn't been bought. Why provide it?

A: We're encouraging demand management. There will be opportunities to reduce costs if technology allows. We want to ensure a commitment to responsiveness.

Comment from attendee: This is trying to incentivise the provider to make it more difficult for patients to access the service.

A: access requirements will be specified.

Q: Will there be any contract review clauses?

A: Yes. We anticipate that the contract will be reviewed annually. There will also be an oversight group that will be looking at developing and reviewing information systems and standardisation.

Comment from attendee: 5 years is not long enough for a contract.

Q: Will cervical screening be part of the main community contract?
A: No, it is outside of this contract.

Q: Will Sexual Health be part of the main community contract?

A: Unsure at this stage, will have to check on this and feed back information to the group present.

Comment from attendee: Clarification on breast screening testing also needs to be ascertained.

Q: Do the DHBs have a preference on the testing occurring inside the region or outside the region?
A: No. Preference is around response times and other service and quality standards that will be in the RFP.

Q: Have the DHBs considered any manpower planning?
A: The regional project considered workforce issues, and we are very keen to ensure the retention of pathologists in the area. Other workforce issues are outside the scope of this process.

Q: It has been noted that the RFP release date has been deferred. Is there a possibility that the closing date for submissions could also be referred?
A: The panel will discuss this and inform the group of their decision.

Q: There is no specialist representative currently on the quality standards subgroup. Are there plans to have specialist's involvement?
A: Yes. They will have the opportunity to feedback comments on the draft RFP. All referrers will be given the opportunity to comment.

Q: Will there be payment for collections?
A: This is stated in the drafted RFP and will therefore give everyone the opportunity to comment.

Martin closed the meeting by thanking all those who attended for taking time to meet with C&C DHB and HV DHB.

ANNEXURE 5

Memorandum of Understanding between Capital & Coast District health Board and Hutt Valley District Health Board

Memorandum of Understanding

Capital & Coast District Health Board
Hutt Valley District Health Board

Parties

Capital and Coast District Health Board (C&C DHB)

Hutt Valley District Health Board (HV DHB)

Background

A C&C DHB and HV DHB are DHBs established under the New Zealand Public Health and Disability Act 2000.

B C&C DHB and HV DHB wish to work together in order to improve, promote and protect the health of their respective communities in the Wellington and Hutt Valley regions.

C C&C DHB and HV DHB wish to record in writing the understandings that they have reached to help achieve this objective.

Operative provisions

1 Statement of intent

1.1 The parties agree that they will work together and support each other in achieving their objectives as set out in their respective district strategic plans, annual plans and statements of intent and particularly to improve health and disability outcomes for people and to enhance efficiencies in the health sector through collaboration.

2 Mutual benefits

2.1 The parties have recognised that they can obtain mutual benefits from acting jointly to improve economies of scale, buying power or clinical sustainability in some circumstances.

2.2 Where the parties identify potential mutual benefits they may work collaboratively on the following as appropriate:

2.2.1 Standardisation of processes, procedures, policies and protocols;

2.2.2 Determining the optimal mix of roles and responsibility of each DHB in relation to particular services;

2.2.3 Resourcing of personnel and equipment, including acting jointly in tenders of equipment;

2.2.4 Best use of publicly owned or leased facilities;

2.2.5 Improved access to services by patients;

2.2.6 Reporting, monitoring and audit procedures;

2.2.7 Service planning, funding and contracting activities;

2.2.8 Implementing collaborative service ventures; and

2.2.9 Any other matters the parties consider appropriate.

2.3 The CEOs of each DHB must approve any proposed arrangements arising from this document.

2.4 Each arrangement or project will be separately documented with a copy of the terms and conditions of the arrangement or project to be attached as a schedule to this MOU.

3 Facilities

3.1 The parties will agree on appropriate arrangements to ensure adequate facilities and resources are made available where services provided by one party are delivered in the other party's area. The party which provides the facilities and resources will be reimbursed by the other party on an agreed basis.

4 Database

4.1 The parties acknowledge the patient flows between the two DHBs and agree to cooperate generally to improve access to clinical information required by clinicians to treat patients appropriately at each site.

5 Media and communications

5.1 Public statements made by a party about the other party will be discussed in advance and key messages agreed jointly wherever possible.

5.2 The parties will consult on all media issues arising from any arrangements made in accordance with this document.

6 Relationship

6.1 The CEOs undertake to meet every 3 to 6 months to discuss and review the relationship and the procedures in place, to identify collaborative opportunities and to maintain positive communication flows.

6.2 The CEOs will ensure that project teams are established to coordinate and manage any collaborative projects which the parties undertake. The governance of the project teams, and any objectives the parties wish to achieve from the project, will be determined by the CEOs prior to the project being undertaken.

7 Disputes

7.1 If differences or disputes arise between the parties about or in connection with this document, the parties agree that they shall use their best endeavours to resolve any differences or disputed between them by negotiation in good faith

7.2 If the parties are unable to resolve the dispute or differences within 15 business days of the date of any initial negotiations under clause 7.1, then the parties will refer the dispute or difference to the Chief Executive Officers of the parties who will jointly endeavour to resolve the matter.

7.3 If within 15 days from the date of the referral of the matter to the Chief Executive Officers the matter has not been resolved, then either party may require that the matter be referred to mediation by either party giving the other notice in writing requiring mediation.

8 General

Treaty of Waitangi

8.1 The Treaty of Waitangi establishes the unique and special relationship between iwi, Maori and the Crown. Both parties consider the Treaty of Waitangi principles of partnership, proactive protection of Maori health interests, co-operation and utmost good faith, to be implicit conditions of the nature in which the parties respond to Maori issues.

Assignment

8.2 This MOU, and the rights and obligations under this MOU are personal to the parties, and such rights and obligations are not assignable except with the agreement of both parties in writing.

Severability

8.3 If a clause or part of a clause of this MOU can be read in a way that makes it illegal, unenforceable or invalid, but can also be read in a way that makes it legal,

enforceable and valid, it must be read in the latter way. If any clause or part of a clause is illegal, unenforceable or invalid, that clause or part is to be treated as removed from this MOU, but the rest of this MOU is not affected.

Confidentiality

8.4 Each party agrees to keep confidential any confidential information that it receives or discovers from the other party by virtue of entering into and giving effect to this MOU, and shall not disclose it other than to their respective professional advisors under terms of confidentiality or as required by law.

No partnership

8.5 Nothing in this MOU shall create or constitute or be deemed to create or constitute a partnership between the parties, nor constitute or create, or be deemed to constitute or create a party as an agent of any other party for any purposes whatsoever. No party shall have any authority or power to bind or commit, act or represent or hold that party out as having authority to act as an agent of, or in any to bind or commit the other party to any obligation.

Variations

8.6 This MOU shall not be varied unless recorded in writing and signed by the parties.

Execution

Executed as a deed

Date: 8th November 2005

Signed by Margot Mains for)
Capital and Coast District Health Board)
in the presence of:

Chief Executive Officer

Witness signature:

Witness name:

Occupation:

Address:

Signed by Chai Chuah for)
Hutt Valley District Health Board)
in the presence of:

Chief Executive Officer

Witness signature:

Witness name:

Occupation:

Address:

SCHEDULE 1: LABORATORY SERVICES

Background

A review of the provision of clinical laboratory services in the Hutt Valley District Health Board (HVDHB), Hawke's Bay District Health Board and Capital & Coast District Health Board (CCDHB) areas was held in 2004. The outcome was DHB Board decisions from HVDHB and CCDHB that they would work closely together in the provision of hospital laboratory services and in the contracting for community laboratory services. It was agreed that a formal document be written outlining the cooperation between the two hospital laboratory services. This Memorandum of Understanding (MOU) records those agreements.

Objectives

The objectives are to:

1. improve timely access to clinically relevant information;
2. achieve more efficient laboratory service provision;
3. adopt common clinical standards;
4. improve clinical testing and reporting quality; and
5. support and retain a skilled workforce.

Agreements

Therefore, Capital & Coast District Health Board and Hutt Valley District Health Board agree to the following:

1. Testing within the region

In order to enhance the laboratory services within the subregion, tests originating within the subregion will be performed within the subregion where the capacity and quality exists and it is cost effective to do so.

2. Joint purchasing

In order to improve the comparability of testing across the subregion, the ability to provide back-up and possibility of making bulk purchase savings, the laboratories shall attempt to purchase or lease the same or similar equipment, reagents and consumables.

Any capital purchases or leases of laboratory testing equipment with a combined value of $10,000 or more shall be discussed with the other laboratory prior to purchasing. Recognising that the laboratories have different asset management plans, capital purchase processes and timing requirements, the laboratories may agree to purchase similar equipment at different times.

Over time the two laboratories will develop a shared asset register and a common asset management and capital replacement plan.

Where one laboratory is considering purchasing a piece of equipment which has capacity far greater than that required for that laboratory but would prove an asset to the subregion, the other laboratory shall consider transferring some testing to the other laboratory to help fund the machine. The need for back-up equipment and other testing to be transferred in the other direction shall be considered as part of the agreement.

The purchase of reagents and other consumables will be jointly negotiated with suppliers to achieve bulk purchase savings.

3. Quality

The laboratories shall use common quality systems where appropriate. Representatives will work together to develop the content of manuals, policies, plans, protocols and health and safety guidelines.

Each laboratory shall be involved in the internal audit of the other laboratory. This will enable the laboratories to continue to meet IANZ requirements in a more efficient way, allow staff to learn and share knowledge and expertise, and allow a more rigorous audit to occur. The laboratories will also work together to develop a standardised audit tool.

4. Staff

The laboratories will work together to retain a high quality and capable medical laboratory workforce for the subregion. Staff professional development opportunities will be provided across the laboratories, including such things as joint training sessions, joint journal clubs, and the opportunity for short-term placements in the other laboratory.

From time to time laboratories may agree to explicit shared appointments where a specific position is filled by one person employed by both laboratories. This may include such things as sharing registrars, clinical specialists and IT staff.

5. Back-up

The laboratories will provide back-up for each other in the case of a civil emergency. Should one laboratory require assistance to maintain continuity of service, due to such things as inability to replace key staff, the other laboratory shall provide assistance where it is reasonable and able to do so.

6. Tests

Prior to introducing a new test, removing an existing test or changing restrictions on access to a particular test, the laboratory managers and clinical leaders or their nominated

representatives shall discuss this with each other and try to agree to a common approach to be followed in both laboratories. Efforts will be made to standardise reference ranges across the two DHBs where possible.

7. Transferring testing

The laboratory managers and clinical leaders or their nominated representatives shall explore opportunities to improve the efficiency, quality and timeliness of testing by allocating low volume or high complexity tests to one or other laboratory, where it is deemed prudent to do so (taking into account the principles outlined under section 10).

Services covered under this clause by one laboratory to the other shall be charged at actual or reasonable costs. The costing mechanisms shall be shared with the other laboratory in a transparent way.

8. Information systems

The parties agree to move to a common laboratory information system eventually, the timing being subject to usual business case processes. In the interim (which may be three to five years) the parties agree to develop an integrated laboratory clinical data repository from which results are easily accessible to both HVDHB and CCDHB clinicians. Where clinicians and laboratory staff at each DHB need access to each others laboratory information systems, this shall be facilitated.

9. Point of care

The two parties will work together to develop mutual point of care systems and policies. Where possible, the content of these policies shall be common between the two organisations. Point of care resources may be shared.

10. Ongoing Collaboration Processes

The laboratory managers and clinical leaders or their nominated representatives shall meet at least once a month (excluding December and January) to discuss the implementation of the above agreements and any other opportunities for collaboration. The group will also discuss each laboratory's annual service plan during preparation and align these where possible.

A steering group shall be established to guide this process. The steering group will meet twice yearly and include the laboratory managers, the Chief Operating Officers or their representatives, a clinical advisor and other members deemed appropriate. It shall be chaired by a representative chosen by the group.

In February each year the steering group will develop a set of concrete objectives to be achieved under this Memorandum of Understanding in that year, in addition to responding

to issues as they arise. A report will be prepared in November each year, outlining the progress made against the objectives and in any other areas, with suggestions for the following year's work programme.

If differences or disputes arise between the parties about an issue that is of importance to one or both parties, the parties agree that they shall use their best endeavours to resolve any differences or disputes between them by negotiation in good faith. If the parties are unable to resolve the differences or dispute within 15 business days, then the parties will refer the dispute or difference to the Chief Operating Officers together with the Chief Medical Officers, and the Chief Executive Officers if required.

The following principles shall guide the decisions of the steering group, laboratory managers and clinical leaders:

- Building quality and safety within the laboratories is the first priority;
- Appropriate levels of service to deliver quality healthcare to patients must be maintained;
- Considering the mutual needs of both laboratories;
- Efficiency of laboratory service provision;
- Clinical evidence based decision making;
- Consistency from request right through to report;
- The competency and satisfaction of staff;
- Ability to provide back up;
- Impact on turn around times; and
- Diagnostic effectiveness of testing.

Exclusions

Nothing in this agreement should be read to alter the fact that:

- On-site laboratories will continue to provide 24/7 testing at Wellington and Hutt Hospital; and
- Both laboratories will maintain separate ownership and management and remain with their parent DHBs.

Review

This document shall be formally reviewed every two years.

Definitions

Subregion: Capital and Coast DHB and Hutt DHB catchment areas.

ANNEXURE 6

Central Region Laboratory Project – Report of the Central Region Laboratory Working Party February 2005

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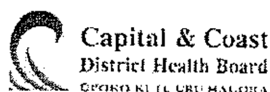
COPY

FINAL REPORT

Central Region Laboratory Project - Report from the Central Region Laboratory Working Party

For the Central Region Laboratory Steering Committee

Prepared by the
Central Region Laboratory Working Party
with assistance from LECG
February 2005



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1 Introduction

LECG was contracted to help examine the possible integration of laboratory services within Hawke's Bay, Hutt Valley and Capital and Coast District Health Boards. A steering committee, made up of Planning and Funding staff and other DHB managers, led the work, while LECG project managed and completed some of the analysis with assistance from the DHBs.

This paper brings together the work completed by LECG over the last year including:[1]

- The discussion paper - "*The future of laboratory services delivery in the central region*" released in September 2004.
- "*Central region laboratory project - Analysis of submissions*" completed in November 2004.
- A paper on governance and incentives issues prepared in November 2004.
- A presentation on IT issues given to the Central Region Chief Information Officers in November 2004.

It also draws on:

- The consultation material distributed to stakeholders in September 2004.
- The financial analysis of different possible laboratory configurations completed by the three hospital laboratory managers in February 2005.
- Presentations given at workshops held in 2004.
- Relevant Board papers.

This paper is designed to give an overview of the reasons for looking at change (or the problem definition); explain some of the background about laboratory services in the Central Region and the processes that have occurred in the Central Region Laboratory Project, so that it can be understood as a standalone document; discuss the key findings that have arisen; and describe the available options for change and decisions that need to be made. The also paper provides a view on a decision and implementation path.

1.1 Structure of report

The report is structured as follows:

Section 2: a series of high level recommendations and a proposed decision path

[1] Full versions of these documents are attached as an appendix to this paper.

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Section 3: background on the current configuration of labs in the three DHBs and the process taken to date

Section 4: a summary of the consultation undertaken and some of the major views that emerged from different groups

Section 5: IT issues

Section 6: an analysis of the benefits and costs of laboratory integration generally and in the three DHBs specifically

Section 7: the risks of integration and barriers to integration, and suggestions on preferred options

Attached are the following:

- The discussion paper - "The future of laboratory services delivery in the central region" released in September 2004.
- "Central region laboratory project - Analysis of submissions" completed in November 2004.
- A paper on governance and incentives issues prepared in November 2004.
- A presentation on IT issues given to the Central Region Chief Information Officers in November 2004.
- Business case analyses for each DHB.

The following have assisted in the preparation of this report and/or have been active in the working party; Ash Fitchett (Laboratory Manager, Hawke's Bay DHB), Stephen Wolland (Business Analyst, Hawke's Bay DHB), Stephen Silk (Clinical Support Services Manager and Former Laboratory Manager, Hutt Valley DHB), Paul Williams (Acting Laboratory Manager, Hutt Valley DHB), Peter Kennedy (Business Advisor, Hutt Valley DHB), Stephen Dee (Pathologist and Former Clinician, Hutt Valley DHB), Russell Cooke (Laboratory Manager, Capital and Coast DHB), Tim Blackmore (Clinical Leader of Laboratories, Capital and Coast DHB), Richard Steele (Capital and Coast DHB), Merrin Blight (Associate, LECG) and David Moore (Director, LECG). The steering committee also assisted.

2 Recommendations and decision path

We set out our final recommendation and pave the way for further decisions in this section.

2.1 Recommendations

The working party has completed its work and makes the following recommendations:

On a shared data repository for laboratory records

There is almost unanimous support for the development of a regional data repository for laboratory records and the working party recommends that regional CIOs should be requested to develop an implementation strategy as a matter of priority;

On sub-regional integration

The working party recommends that Hutt Valley and Capital and Coast DHBs should move to a collaborative arrangement using a memorandum of understanding or some other agreement where the hospital laboratories work in partnership. This would likely involve sharing pathologists, using common standards and a common laboratory information system or results repository, purchasing equipment and consumables jointly where possible, and working together on management and governance, while still operating with two sites. In future, it may be possible to share management and governance, as well as laboratory testing even further between the two DHBs.

These two DHBs may also decide to jointly tender for the provision of community services for both regions.

On integration of local laboratory services

There is evidence of the benefits of local integration of laboratory services in Hawke's Bay and in the Hutt Valley. In addition to the above, the working party recommends that both Hawke's Bay and the Hutt Valley DHBs consider local integrated provision of laboratory services, while recognising that the major barrier to inhouse provision may be space constraints and refitting costs, while the major barrier to a joint venture is the willingness of a community partner to participate. Local integration in Hutt Valley is consistent with sub-regional integration.

Capital and Coast is not able to integrate because of space constraints within the hospital. The working party recommends that in the short to medium-term Capital and Coast consider full local integration of laboratory services for 2008.

On a vehicle for the provision of integrated laboratory services in Hutt Valley and Hawke's Bay

The working party recommends that the DHBs use an RFP or tender process to seek more information prior to determining the appropriate vehicle for the provision of laboratory services. This will provide further information to compare and choose between hospital provision of all laboratory services or one of the other range of alternatives.

On options for Capital and Coast

The working party recommends that Capital and Coast issue an RFP for a short-medium term provider of community laboratory tests, leaving the option open for in-house, public provision of laboratory tests when hospital space is available. As indicated above, the working party's preference is that Capital and Coast undertake this jointly with Hutt Valley.

On implementation risks

The working party recommends that the three regions proceed under an alliance agreement (i.e. something more than regular meetings, such as a mutual undertaking to assist each other) that allows for the DHBs to share learning (and risks where appropriate) during the implementation stage.

2.2 Decision path

The working party has formed its view and is now presenting that view to CEOs and the steering group for consideration. Each DHB needs to consider the report in light of its own particular circumstances. We understand that regional CEOs and possibly regional chairs will further consider this report.

We recommend that the process of change is triggered by the DHBs giving the community laboratories the notice required to exit from the current contracts (due to expire on 30 September 2005). Even if DHBs wish to continue to contract with community laboratories, DHBs will wish to make significant changes to the contract.

Following this, we recommend that each DHB set out specific implementation steps and review them together.

3 Background and context

3.1 Problem definition

Integration of laboratory services has been considered as a possible answer to a number of problems and/or a missed opportunity in the laboratory sector.

A concern with growing laboratory testing volumes and expenditure was initially the key driver to look at change in the sector. However, this growth has slowed recently and there has been recognition that only growth from inappropriate drivers is a concern, rather than positive forces such as better screening programmes.

The discussion document noted that the laboratory sector had the following opportunities:

- Reduce waste and duplication;

- Strengthen the overall capability of laboratories in management, staffing and IT;

- Improve integration between primary and secondary care; and thus

- Reduce cost and improve health outcomes.

The discussion document also noted that the status quo was unacceptable, pointing to problems with:

- Retaining pathologists [although this isn't necessarily a driver of change and may limit some options that could result in fewer pathologists];

- Developing the medical laboratory workforce;

- Tougher accreditation standards requiring certain volumes of testing and levels of pathologist support (and associated difficulties of recruiting and retaining workforce);

- Perceptions of less than optimum value for tax payers' dollars in health service provision;

- Inefficient contracts, for example relying on schedule prices that don't necessarily reflect market conditions or relate to the costs of production;

- Payment mechanisms leading to incentives to increase volumes rather than driving down costs (already partly mitigated through capped budgets and risk sharing arrangements); and

- An observed inefficient industry structure.

Other drivers for change identified through the process included:

- Recognition that there is unnecessary duplication in laboratory testing due to lack of common data repositories and information systems;

- Test results being unavailable to clinicians as patients move between laboratories in primary and secondary care or between DHBs;

- Less than optimal demand management processes to educate referrers about evidence based, cost-effective testing;

- Calls for better standardisation of testing to improve consistency across the region; and

- The growing ability to process large numbers of automated tests together (in some specific laboratory specialities) to realise economies of scale.

3.2 Current laboratory configuration

The two tables below, taken from the discussion document, set out the main providers of laboratory services in the three DHBs and the approximate volumes of tests ordered and dollars spent last year.

Each DHB has a DHB-run hospital laboratory that performs inpatient and outpatient testing 24 hours a day, 7 days a week. They also perform some more specialist testing and after-hours testing for other laboratories. The strengths of hospital laboratories lie in their ability to offer urgent testing with fast turnarounds 24/7, and a wide range of tests including more specialised testing. They also provide education and clinical guidance within the hospitals.

Each DHB also has a contract with at least one private laboratory that performs community testing and provides a phlebotomy service. The strengths of community laboratories lie in their attention to service for GPs, cost efficiency and standardisation of process.

The table below shows the main laboratories in each region. Each laboratory also completes some tests on patients resident in other DHBs.

In addition, a large proportion of off schedule testing in the region is sent to Canterbury Health Laboratories. Canterbury Health provides a wide range of tests, a 24-hour service and fast electronic turnaround times.

	Capital & Coast DHB	Hutt Valley DHB	Hawke's Bay DHB
Hospital	Wellington Hospital (Newtown) Kenepuru (Porirua)	Hutt Hospital (Lower Hutt)	Wairoa Hawke's Bay Hospital (Hastings) Central Hawke's Bay Health Centre (Waipukurau)
Community	Wellington Medical Laboratory (Abano Healthcare Ltd) *Additional providers:* Valley Diagnostic Laboratories (Sonic Healthcare Ltd) Southern Community Laboratories (NZDG)	Valley Diagnostic Laboratories (Sonic Healthcare Ltd)	MedLab Hawke's Bay (MedLab Central – Sonic Healthcare Ltd) Southern Community Laboratories (NZDG)

The table below shows the approximate volumes of tests ordered and dollars spent (in thousands) in each DHB last year. The total level was $46 million. Issues such as the following mean that the statistics are not directly comparable although they do give a good measure of activity and cost:

- A lack of common counting of tests (i.e. the same test can be counted in different ways);
- Inclusion or exclusion of indirect overheads and blood products; and
- Inclusion of tests for patients from other DHBs.

	Capital & Coast	Hutt Valley	Hawke's Bay	Combined
Hospital	1,120 $10,040	482 $4,410	729 $3,934	2,331 $18,384
Community	1,480 $14,050	664 $6,331	752 $6,925	2,896 $27,306
Combined	2,600 $24,090	1,146 $10,741	1,481 $10,859	5,072 $45,690

3.3 Process to date

There has been a long history of review of laboratory services. Concerned with the efficiency and sustainability of laboratory services, the Central Region DHBs commissioned an evaluation of purchasing options for laboratory services. Enterprise Transformation Group Ltd completed this evaluation, *"Review of Purchasing Options for Laboratory Services"* in May 2003. Recognising a set of inappropriate drivers for laboratory spending, ETG recommended the laboratories be consolidated. As a result of the report, three of the DHBs, namely Hawke's Bay, Hutt Valley and Capital and Coast, decided to review the possibilities of integrating hospital laboratories.

The Central Region Laboratory Project was formed, sponsored on behalf of the Regional Chief Executive Group by the CEO of the Hawke's Bay DHB, with a steering committee made up of Planning and Funding, and other managers (including a Chief Operating Officer) from the three DHBs. The acting Planning and Funding Manager of Hutt Valley DHB chaired the steering committee. A team of hospital laboratory managers with analytical support, and some medical input, was formed to undertake further work. LECG, a firm of economic and financial consultants, was contracted to project manage and complete some of the analysis. Regular steering group meetings were held to direct the project and to receive advice from the working party.

All affected parties were offered the opportunity to submit on the discussion document. Further workshops and meetings were held particularly with community laboratory managers, pathologists and managers, but also with other parties.

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4 Extensive consultation

A major part of the process to date has been consultation with the laboratory sector. This has included requesting submissions, running workshops and holding more informal meetings.

4.1 Analysis of submissions

4.1.1 First round of consultation

In September 2004, the discussion document was released and laboratory staff were asked for written submissions on it. A feedback template was sent to staff in the hospital laboratories, community laboratories (via managers), unions and other stakeholders. 47 submissions were received in total, consisting of 21 from Hawke's Bay, 18 from Capital and Coast and 8 from Hutt Valley. Some were from individuals and some from groups. The full analysis of the submissions is attached.

There was general agreement on many of the issues and concerns raised in the discussion paper, including broad agreement about the benefits of integration, and the need for change, but disagreement on some facts and the preferred option (e.g. disagreement between the private and public sectors over where the work could be done).

Submissions repeated a number of key issues. These included:

- Retaining qualified and experienced staff during shortages, and keeping workloads reasonable, and competence and morale up;
- Making sure there is adequate staff and equipment on a day to day basis and for back up/civil emergencies;
- Implementing demand side management through referrer education, an improved request form and an updated schedule;
- Introducing a single data repository or mechanism for all providers to access all results, regardless of the outcome of the project, to prevent duplication of testing, save money and assist patients;
- Introducing a region wide IT system; and
- Compliance with accreditation requirements.

Other comments received on the discussion document were as follows:

- Submissions noted a number of inappropriate drivers (for example ordering groups of tests when only an individual test is required) and appropriate drivers of growth (such as screening programmes).
- Suggestions were made on what should be considered when looking at laboratory services including patient needs, short-term costs versus long-term gains, the need for evidence, existing strengths and past experience.
- Comments were made on suggested levels of urgency and impacts on it like clinician's expectations; how to meet accreditation requirements; how to improve efficiency and quality and ways to manage demand.

- There was near unanimous agreement on the need to improve IT systems to solve many of the problems recognised in the discussion document, such as duplicated testing. Submissions noted that privacy issues should still be dealt with.
- Views differed on the current configuration, but ideas on how to improve it were similar such as integrating some non-urgent specialised tests and building on existing relationships.

A number of comments were made about the proposed integration options. Local integration showed through as the preferred option in the immediate term in submissions, with many suggesting sub-regional integration in the future. Others raised soft integration (sometimes as a means to work towards sub-regional integration). Regional integration was broadly misunderstood to mean centralisation - specifically, being run out of Wellington. Centralisation was not the intention of the regional integration option - there was, however, limited understanding of and feedback on regional integration. A major finding was that there was greater support for laboratory integration than that the team had considered likely, prior to consultation.

In general, the private laboratories considered that if there were integration that they would be the appropriate vehicles for laboratory services integration. While, the hospital laboratories disagreed - raising issues about commercial incentives leading to suboptimal outcomes in the health sector.

4.1.2 Second round of consultation

Hutt Valley DHB undertook a second round of consultation, ending on 31 January 2005. Opinions were requested on the strengths and weaknesses of the current Hutt laboratory services, the critical success factors for an integrated service and opinions on the three options proposed - hospital provision, a 50/50 joint venture or an enhanced status quo.

13 submissions were received by the deadline.

GPs made 9 submissions, largely supporting enhanced status quo and rejecting hospital provision (7/9) and a 50/50 joint venture (8/9). They commented on Valley's accessibility, reliable and quick electronic results, and the difficulty accessing hospital results. There is some concern that the quality of submissions received is mixed as a number of GPs made very similar comments - either suggesting a high level of agreement between GPs on the issues or some interference in the consultation process. There is also some indication of confusion of issues - GPs could be referring to problems within the whole hospital or with radiology services, not just medical laboratory services specifically. There is, however, little doubt that GPs in the region are generally happy with the service from private laboratories - this is not a surprising finding as the problem definition is not about the quality of service to GPs, but more about the cost of that service.

A union was concerned with workforce and employment issues for DHB employees, but still supported hospital provision. An individual hospital staff member supported hospital provision, pointing to benefits in the delivery and quality of service and positive attitudes of staff, while recognising that it would require a lot of work and the biggest change.

A private provider supported an enhanced status quo with a co-operative approach with sharing of results, experts and knowledge; minimal duplication and that meets all users

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needs. They were concerned with the current low volumes of testing, inadequate communication, sharing of test results, duplication of services and formalised backup between the hospital and community; as well as inadequate control of demand side and mechanisms to review the schedule. The submission commented that a standalone organisation may not be able to access the benchmarking, professional expertise and purchasing agreements that an international testing group has access to.

Hutt Hospital Laboratory staff made a collective written submission following a forum on 13 January 2005. Staff preferred the option of hospital provision of all laboratory services and noted benefits of: cost savings; transparency of costs; responsibility to medical staff and patients, not shareholders; using a data repository system that allows results to go to all Hutt Valley and Capital and Coast referrers (this change is due to be implemented in 2005 anyway); ability to recruit clinical specialist pathologists and less reliance on outside back-up. The risks mentioned were: that the hospital LIS is untested in the community setting; the potential inability to recruit anatomical pathologists; need to match community laboratory remuneration packages for anatomical pathologists; difficulty meeting expected turn-around-times for urgent tests when community volumes are included; accommodation requirements can't be met in the short term.

4.1.3 Workshops

A series of workshops were held to both inform and get opinions. All community and hospital laboratories were invited to the meetings and a number of community and laboratory managers spoke on various topics in the meetings. Key speakers were invited to talk on a number of topics such as laboratory IT.

Following is a list of the workshops and topics on the agendas:[2]

26 April

- Understanding the current laboratory environment
- Presentations by the laboratory managers on their laboratories
- Trends and costs by Marty De Boer of Hutt Valley DHB
- Overview of national activity by Rawinia Lewis of Hawke's Bay DHB
- Analytical framework
- Information needs
- Project planning

22 June

- Progress update
- Options, implementation and workforce capability
- Presentation by Andrew Coe on the importance of IT
- Presentation by Stephen Silk of Hutt Valley DHB and Russell Cooke of Capital and Coast DHB on urgency of different groups of laboratory tests
- Presentation by Cynric Temple-Camp of Medlab Central on lessons learned by Medlab Central

17 August

[2] These were held in the Capital and Coast DHB Boardroom in Wellington.

- Presentation by Stephen Silk on behalf of Grant Tunbridge – Q Lab – example of a hospital laboratory providing community tests
- Presentation by Peter Bethwaite of Medlab Wellington on rationalisation solutions for community labs
- Presentation by Win Bennett of Capital and Coast DHB on public/private partnerships and the funder perspective
- The 'preferred option'
- Human resources issues and advice

14 September

- Presentations by Margot Mains, Win Bennett and Kristine Kilkelly, all of Capital and Coast DHB, on background and the proposed consultation process
- Discussion by unions and union representatives

17 November

- Process
- Benefits of integration
- Whiteboard session on different options and major implications
- IT issues
- Governance

9 December

- Presentation by Peter Bethwaite of Medlab Wellington on behalf of themselves and Valley Diagnostics on governance
- Discussion of views on governance and incentives

The workshops have been extremely useful and have clarified the similarities and differences of the different parties. On the whole, community laboratories are extremely keen to retain the status quo, and are of the view that any arrangement that does not leave the private sector in control is likely to be sub-optimal, and are, generally, strongly dismissive of joint venture options. Hospital laboratories have been more open to a range of options and are clearly concerned but less closed about possible options. All agree on the need for improved IT, enhanced demand side management, etc – but there are substantial areas of difference in how fundamental shifts in the supply of laboratory services might happen.

4.1.4 Informal meetings

Each DHB ran meetings for laboratory staff, interested hospital staff, GPs and PHOs to inform them about the project and gauge feedback.

The project team met with the community laboratories in Hutt Valley, and Capital and Coast, but the Hawke's Bay laboratories were not available to meet and declined meeting invitations a number of times. There have been a number of in-depth meetings between Capital and Coast and the community laboratory in Wellington with the purpose of investigating soft integration options in some detail.

The two community laboratories in Hawke's Bay approached the DHB with an informal offer of a 20% reduction in the cost of their services. A 20% reduction would amount to approximately $1.46m. A letter confirming the general nature of the offer has been solicited and received. However, the letter notes a range of benefits (some of them important) but does not cover all of what we understand to have been discussed more informally – in particular, there is no discussion of substantial price discounts.

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The Planning and Funding teams of each DHB also met with the community laboratories. Overall, the project team through both formal and informal processes has been able to gain a very good understanding of the both the issues at hand and the mutual positions and views of stakeholders.

4.2 Summary of views of stakeholders

We summarise the conclusion of the formal and informal consultation process below.

Those who made **submissions** generally agreed that:

- Integration a good idea;
- Local integration is the preferred form of change in the short term; and
- A mechanism to electronically share results between testers/primary and secondary care and DHBs is required.

The views that emerged from **community laboratories** included:

- They are already highly efficient and acceptable to GPs;
- A longer term view is needed for them to make the large investments required;
- Joint venture proposals are not acceptable for them;
- They are willing to change their practices to meet DHB needs; and
- Expressed interest in working jointly with other community laboratories.

The views from **GPs**:

- Generally satisfied with current providers and service levels - described as responsive, efficient etc; and
- Some indifference as long as service levels are preserved.

The views from **providers in other areas** who have tried change:

- It takes time to see benefits;
- Concerns about any transition and expectations of benefit (i.e. don't reduce staffing too much at the beginning - need more staff initially); and
- Any new laboratory should consider rebranding itself - with a new name, uniform, image etc.

5 Data repository is a priority

The need for more compatibility and uniformity in the information systems of laboratories in the region is an issue that stands out as both high priority for all in the sector and feasible. The issue falls in two levels, as follows:

- Laboratory data repositories (LDRs); and
- Laboratory information systems (LIS).

The view of the project team is that Chief Information Officers (CIOs) within the region need to make the investigation of a common LDR a high priority. The laboratory test record is an important part of the patient's electronic health record. The implementation of LDRs is not a laboratory matter, rather one for the whole of the clinical community within the region, and one that can be addressed within the existing IT frameworks and initiatives with relative ease, and with considerable benefit. It will, however, require DHBs to step out of their individual IT viewpoints and take a regional perspective.

Our views on laboratory information systems are more circumspect. Integration is difficult and expensive – but any change to a system needs to be in a direction that allows for greater integration. Lack of integration is a major obstacle to some local integration options.

5.1 Laboratory data repositories

The major driver for uniformity in laboratory data repositories is from a clinical perspective for a clinician to be able to view the entire relevant laboratory results on a particular patient wherever those results have been produced. The laboratory test may have been produced in the home laboratory, a neighbouring DHB laboratory, or another community laboratory. Currently, tests results are held in different repositories with different levels of access, and with different levels of integration with a core patient record. The generally agreed solution, and the solution that has been implemented in a number of regions and DHBs, is to set up a common LDR. Common data repositories sit over the top of existing laboratory information systems, and are relatively cheap and easy to implement.

Input of results from the community sector to local or regional LDRs is a must and if this cannot occur in a voluntary fashion it should be part of any future community contract. Privacy concerns need to be dealt with appropriately but have been dealt with elsewhere – such concerns present no real barrier.

Most DHBs now have some form of electronic medical record (EMR). This record will display such items as laboratory results, radiology reports, outpatient letters and discharge summaries. Specifically, within each EMR is embedded a laboratory data repository, either integral with the larger database or able to be called from the EMR to display the relevant laboratory results.

The Auckland DHBs have set up a common laboratory result repository (Delphic Éclair), which contains all the laboratory results produced by the DHB laboratories and the outpatient results produced by the community laboratories. This repository in turn feeds

the EMRs of the three DHBs enabling results from any of the DHBs to be viewed by a clinician seeing a patient at a particular DHB.

Within the central region, there has been some progress on EMRs although we are not as developed as the Auckland region. An EMR (supplied by the medical software company, Orion) has been installed within Hutt Valley and is highly likely to be installed with Capital and Coast, and Wairarapa DHB, and possibly in Hawke's Bay DHB. In contrast Mid-Central DHB has an Éclair database into which both community and hospital results are fed.

The project team met with regional CIOs in December 2004. At the meeting, there was a level of agreement within the group that a common LDR would be useful. There was less clarity and some dispute over which LDR would be suitable across the region. While the Orion EMR has an LDR within it, there is no experience with that LDR being shared across DHBs, while there is considerable experience with the alternative major supplier, Éclair. This discussion is the limit of the work undertaken to date but it is clearly an easy step to prepare a business case (we suggest, at a relatively high level) and then to implement an agreed solution, with regional CEOs as the escalation point if any differences of views need to be aired. We recommend that the business case should be undertaken promptly.

5.2 Fragmented laboratory information systems (LIS)

Laboratory information systems (LIS) are increasingly crucial to the operational effectiveness of all clinical laboratories. The LIS underpins the registration of samples, the collation and entry of results and the production of reports.

The LIS is of crucial importance, involved in all aspects of laboratory operations. Within the wider region we have a greater diversity of LIS than in any comparable area within New Zealand (see table below).

Laboratory information systems within wider region

Organisation	LIS
CCDHB	QuadraMed (Détente)
Wgtn Medlab	Lab. Solutions
HVDHB	IBA Health (formerly DMS)
VDL	Triple G
Masterton Hospital	Gaelen
HBDHB	Delphic
Southern Community HB	Triple G
MedLab Central	Delphic

The major drive for compatibility in LIS is the ease of operational integration of laboratories from a processing perspective. For instance, the LIS for the hospital laboratory in Hawke's Bay is closely integrated with the LIS in Canterbury hospital – this close integration and compatibility allows good access to the results of send-away tests, reduces duplication of entry, etc. On the other hand, the lack of integration between community and hospital laboratories means that any forms of weak integration are

extremely difficult, as samples transferred between sites may need to be entered into the two different systems. This duplication of entry is expensive and likely to mitigate other benefits of integration.

Lastly, IT is an area that can generally be considerably leveraged by standardisation of approach and consequent reductions in staff and development costs. At present, the cost of integration of LIS appears to be too great but, as systems come up for review, further integration and reduction in variety is extremely desirable.

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6 Analysis of integration benefits

In this section, we set out the benefits and costs that might come about through integration of laboratories at a local level. Benefits at a sub-regional or regional level include the integration benefits identified below, and open up pathways in the future to releasing further benefits. The section is structured as follows:

- The process of analysis and review;
- General conclusions on benefits and costs; and
- Specific DHB analyses.

In addition, in the discussion document of September 2004 we identified a number of other changes that could occur, other than integration that would bring benefits. These include:

- Pursing demand side initiatives;
- Investigating common IT within the region;
- Reshaping the test schedule; and
- Managing non-schedule tests.

6.1 Processing of establishing benefits

The process of establishing benefits and costs was designed to ensure that there were checks, balances and oversight of the analysis as much as was possible. The process was as follows:

- A common base of information was established from the laboratory data warehouses, although we note that there are substantial data issues, and that the data appears to differ depending on source;
- DHB specific analysis was undertaken in each DHB independently of the other regions. The laboratory managers were responsible for this analysis;
- Information was exchanged with community laboratories where they were willing to participate - there was only active engagement by one community laboratory, namely Wellington Medical Laboratory; and
- The analyses were shared with the two other DHBs, and were quality controlled and peer reviewed for assumptions, calculations and results.

6.2 Benefits of integration

The following benefits were identified at a general level:

- There are substantial savings (in staff, reagents, etc) in the more automated, less labour intensive tests such as:
    - Routine biochemistry

COPY

- Routine haematology
- Haematology coagulation

More labour intensive areas will see fewer saving in staff costs as there is a proportional relationship between the number of tests and the number of staff required. For example, in routine microbiology or anatomic pathology.

- Clinical benefits through calibration/standardisation of tests meaning that there is greater consistency of test results through the region.
- Concentration of IT competency and standardisation of LIS over time. Both allow clinicians to access results for patients seen in the hospital, community and in different DHBs - giving them fuller information to provide better care and reduce duplicate testing - and means running one IT system not two or more.
- Rationalisation of phlebotomy (blood collection) services.
- Potential to decrease some turn around times in tests by increasing the number of production runs.
- Potential to better integrate and improve demand management by better detailed oversight of test volumes - helping to reduce unnecessary or inappropriate testing e.g. by improving request forms, educating referrers, controlling off schedule testing (depending on the contract and type of integration chosen).
- Possible savings on machine calibration costs (a minor benefit).

6.3 Costs of integration

The costs of local integration are as follows:

- Change management and transition costs, which differ based on how the integration is undertaken.
- Physical refurbishment costs, which may be substantial.
- Possible capital expenditure on IT systems.
- Potential litigation by incumbent community laboratories against any change.
- Increased expenditure on pathologist salaries to match community levels or to attract new pathologists to the area, and possible spill-over to other clinician groups.

6.4 DHB specific business cases

The three DHBs developed business cases for the proposition that there were substantial cost savings from local integration. Short papers explaining findings and assumptions are included as an appendix. Findings are summarised below.

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Development of business cases

As discussed above, the businesses cases were prepared by the DHBs, then discussed with lab managers who have experienced change in other regions to validate their findings, question staffing numbers etc. As part of this process, the three DHBs had a series of teleconferences going into depth on the spreadsheets - questioning assumptions and figures, answering each other's queries etc. For example, the lab managers discussed the appropriate salaries that would be needed to bring pathologists into the region, a common figure was agreed on after some discussion, and this agreed figure was used in the analysis.

Other questions raised were the number of phlebotomy stations required and opening hours needed, whether staff would be paid over time, whether provision was made for training costs, whether staffing costs would fall over time as laboratories became more efficient etc. The lab managers also shared their spreadsheets, using each others' helpful sections.

Conferences within each DHB with Planning and Funding, other DHB management, accountants, analysts, outside experienced lab managers, and community laboratories where possible were also held to make sure that assumptions such as availability of space were agreed by all.

It should be noted that while the lab managers used their knowledge and experience to make the best estimates they could - they are just estimates. The options analysed in each DHB are also not necessarily the lab managers' personal view on the best option.

This process of analysis and peer review gives DHBs possibly the best understanding of potential costs and benefits of integration that DHBs have been able to gain to date.

As a cautionary note, when considering these options, they should be compared with the counterfactual or next best option. As it has been agreed that the status quo is unacceptable the counterfactual is a form of enhanced status quo - with an improved contract etc.

6.4.1 Significant integration benefits in Hawke's Bay

Hawke's Bay DHB prepared an analysis of the costs of the Hawke's Bay Hospital laboratory providing 100% of hospital and community testing in the Hawke's Bay. Some of the calculations are based on estimates due to lack of access to community laboratories' information.

Summary points are as follows:

- Estimated savings of $1.56 million p.a. or 14 % of combined spend last year.
- Includes $500,000 set aside for unforeseen costs.
- Excludes anticipated savings from:
    - shifting the community test request form from a tick box with groups of tests to a blank request form
    - reducing duplicate testing
    - reducing avoidable non-schedule testing.
- Calculated on marginal test cost basis (and validated against Hutt Hospital laboratory costs). Used high marginal costs for histology should it need to be contracted out if pathologist recruitment is delayed.
- Based on HealthPAC Christchurch data for private laboratory claims for 2003/2004, which appears consistent with DHB payments.

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- Staffing requirements agreed with senior laboratory staff and Clinical Head of Department. This included significant additional staffing for microbiology and histology manual work, specimen reception, community phlebotomy collection, clerical staff and GP liaison. Additional staff will also allow for an enhanced service to hospital clinical areas.
- Allows $225,000 per additional pathologist (a figure reached in consultation with Hutt Valley DHB).
- Requires a building extension.

The levels of savings broadly align with the level of savings that we understand to have been indicated to the DHB chairman in a conversation with a community laboratory.

The steering committee notes that Hawke's Bays calculations may be too ambitious, given that Hawke's Bay has a similar population to Hutt Valley DHB, but appears to be able to make much greater savings. The figures have been reviewed and appear to be sound. Possible explanations for the differences include:

- Fewer pathologists in Hawke's Bay.

A different medical laboratory scientist to medical laboratory technician ratio (which could lessen the total salary package).

- The use of penal rates, inclusion of ACC levies etc may be different.

6.4.2 Significant integration benefits in Hutt Valley

Hutt Valley DHB prepared an analysis of the costs of the Hutt Hospital laboratory providing 100% of hospital and community testing in the Hutt Valley.

Summary points are as follows:

- Estimated savings of:

  $612,000 in year one (or 6% of combined spend last year)

  $581,000 in year two (5%)

  $663,000 in year three (6%)

  $757,000 in years four and five (7%)

  a total of $3,370,000 over five years.
- Includes $500,000 to outfit an expanded laboratory - due to space constraints on the Hutt Hospital campus this could involve either altering the existing hospital laboratory space or altering a new space leased elsewhere in Lower Hutt. Another option is building a new area on the Hutt Hospital campus, but this would require a longer-term view and more capital.
- Includes one additional clinical specialist FTE for demand side management (paid $170,000). The FTE would probably be spread over a number of specialists, as a high level of expertise is required to encourage doctors to alter their practices. This could potential be spread over Capital and Coast as well. This resource could also handle GP requests for advice.

- Includes costs of 47 staff, their training, computers, further rental space etc. These staff will largely already be employed by the community laboratory (with 73 staff), and would be offered the opportunity to move into the hospital laboratory.
- Allows $225,000 per additional pathologist (a figure reached in consultation with Hawke's Bay DHB).

6.4.3 Limited integration benefits at Capital and Coast

Capital and Coast is unable to integrate the community laboratory on its site until 2008. Rather Capital and Coast has undertaken a review of the benefits and costs of limited integration (alternatively called enhanced status quo or soft integration) with the help of the local private laboratory.

This analysis is particularly interesting both because of the close sharing of information with the community laboratory and because it gives a clear expression of the counterfactual – namely, two laboratories seeking to integrate. One of the observations is that the two different LIS significantly hinder the efficiencies of joint processing over two sites. The savings are relatively minor and include savings that other DHBs have excluded, such as eliminating GP phlebotomy payments.

The summary findings are as follows:

- Estimated *gross* savings of $465,000 p.a. (or 2% of combined spend last year).
- Estimated *net* savings of $391,000 p.a. (after redundancies, building changes etc).
- Savings will be made through stopping phlebotomy payments to GPs (which could happen anyway), changing phlebotomy service levels, and managing demand for certain tests (such as folate).
- An estimated 2% of tests will be saved through the use of a common data repository (at a one off capital cost of $200,000 and annual cost of $40,000).
- The two labs would swap samples for clinical efficiency.
- On call urgent testing between 2100 and 0800 hours could be done at the hospital laboratory, leading to savings in overtime.

The community contract would need to be exclusive (but capped) – which is a significant issue.

7 Risks, barriers to integration and options

There is clear evidence of the benefits of integration, although weaker forms of integration produce more modest benefits.

There are a number of residual issues that we address in this section, as follows:

- Risks and barriers
- Regional and sub-regional integration
- Public or private provision, and the possibility of joint ventures
- Options for Capital and Coast.

7.1 Risks and barriers

7.1.1 Barriers to integration

There are two levels of barriers - the tangible and the intangible. The tangible barriers are the issues around the need for space for integrated laboratories. This barrier needs to be resolved before any progress can be made.

The second set of barriers is more intangible, and is about the motivation and the will to move forward with change, both within the DHBs and within the governance of DHBs. The project is now at the point that most laboratory projects fail - through the inability to move forward and implement. The effort to implement will be considerable and DHBs will need to feel secure that they are able to make that effort.

7.1.2 Risks are significant, but manageable

There are risks to implementation that are non-trivial. The risks that we have identified are as follows:

- Lack of support from pathologists and other medical staff and an inability to retain/hire pathologists (particularly anatomical and clinical specialist pathologists) required - particularly if those pathologists in the region that currently work in community laboratories are unwilling to work for the hospital provider, or vice versa, and others cannot be brought into the region. This would impact on the ability to retain IANZ accreditation.

- Unforeseen difficulties in reconfiguration.

- Difficulties in existing entities taking on new roles - for instance, either hospital or community laboratories would have to develop new competencies, and deliver to a new client group.

7.2 Regional and sub-regional integration supported

These topics were not popular in the consultation process but are strongly supported by the working party.

Clearly, each region would retain a laboratory, but some of the higher order functionality of the laboratories could operate across the region - particularly between Hutt Valley, Wellington and the Wairarapa.

A model of sub-regional integration has been suggested for Hutt Valley and Capital and Coast. This could involve the two hospital laboratories signing a memorandum of understanding to work in partnership. The laboratories would continue to operate from the separate hospital sites and retain their own identities, but work together in certain areas. This could involve sharing pathologists, using common standards and a common LIS or results repository, purchasing equipment and consumables jointly where possible, and collaborate on decisions about management and governance, where appropriate. In future, it may be possible to share management and governance, as well as laboratory testing even further between the two DHBs.

The working party strongly supports this level of sub-regional integration and expects that it would bring clinical benefits such as improved clinical consistency and improved patient care. It could also be a way to help share the risk of implementing other laboratory changes, rather than going it alone - for example, by one DHB providing anatomical pathologist support if the other has difficulty hiring one during a change process.

While some of this partnership occurs already, it is on an ad-hoc basis, dependent on the goodwill of the current laboratory managers and clinicians. It would be useful to make this relationship formal, so that any future new staff follow these same practices.

A further development of this model of sub-regional integration could be for the two DHBs (Hutt Valley and Capital and Coast) to issue an RFP asking for tenders for a single provider to perform the residual community laboratory work. The contract would give exclusive coverage, be capped, build in demand management and require results to go into a common data repository. This allows sectors to "stick to what they know", capture gains from agglomeration of community laboratories and builds on existing regional cooperation. The DHBs may want to put this option to the test (by asking for RFPs, but not guaranteeing to let the contract unless a suitable option is found) before taking a final decision.

This model could also be extended to one of regional integration - where Hutt Valley, Capital and Coast and Hawke's Bay work in partnership - although there is less gain in integrating between the proposed sub-region and Hawke's Bay.

7.3 Public sector provision is a popular option

Our views are strong about the need for some form of integration of laboratory services. Local integration has emerged as a popular option (particularly if sub-regional integration is rejected), while the choice between public and private sector provision is less clear cut. This is a comparative problem and there is no right answer. A working paper is attached on the subject and was used as part of the background for a workshop with hospital and community laboratories.

We now summarise our view as follows:

There are three options for local integration - private provision by community laboratories taking over and providing hospital services, public provision by hospital laboratories providing services for the region, or a public/ private sector partnership.

- Private sector laboratories argue that there is clear evidence of long run efficiency of the community laboratory system, and that, therefore, private laboratories would be the best provider. Alternatively, they argue that the status quo should remain.
- The private sector argument is considerably muted by the reality of the laboratory services. First, there are only two major and one moderate laboratory network in the country. There is an increasing trend to agglomeration of those interests and, therefore, a reduction in competition. There is in other areas, such as Auckland, a significantly dominant provider. Secondly, once contracted out, there is significant lock-in from the private sector to an essential hospital service. From experience, the extent of this lock-in appears to be highly problematic. DHBs are likely to find themselves short of both information and negotiating leverage. Private sector provision is the least preferred option of the working party.
- There is limited support for partnership arrangements from the private sector.

There are issues about DHBs extending themselves to provision of community laboratory services but, from the perspective of the working party, this is a popular option. If there is doubt in the minds of DHBs, then we would recommend an RFP to compare hospital provision with a public/private partnership or private solution, prior to taking the final decision. Private sector laboratories are well briefed and the process for the RFP could be rapid. Our other recommendation is to look at the timing of the solution - an interim option could be followed if space constraints, lack of capability etc mean that hospital provision isn't manageable currently, and could be reconsidered in 3 to 5 years time.

7.4 Capital and Coast options

An integrated laboratory service is not possible in Capital and Coast at present. Neither hospital provision of all tests nor a public/private partnership out of one site are possible due to space constraints. It is possible, however, for the DHB to move in that direction, and prepare for change in three years time. In the mean time, if benefits of soft integration between the hospital and a community partner are to be captured, we recommend that the process of offering that contract should be contestable, particularly if the community provider is to have exclusive rights to all community testing in the region, to meet Capital and Coast's administrative requirements.

ANNEXURE 7

Map showing location of collection centres in Capital & Coast and Hutt Valley DHB regions

CAPITAL & COAST DISTRICT HEALTH BOARD

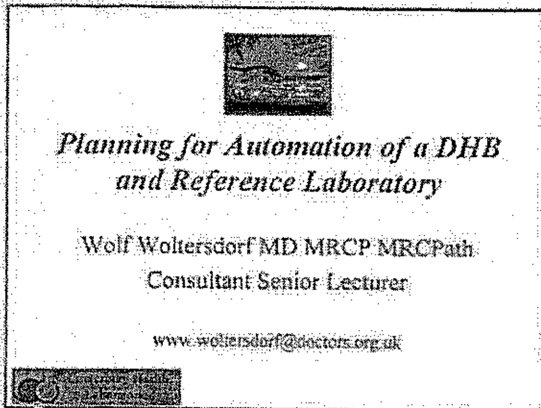
Waikawa Beach
Kuku
Manakau
Otaki Beach
Otaki
Te Horo Beach
Te Horo
Waikanae Beach
Waikanae
Otaki Forks
Paraparaumu Beach
Reikorangi
Raumati Beach
Raumati South
Paraparaumu
Paekakariki
Cloustonville
Pukerua Bay
Plimmerton
Porirua
Tawa
Totara Park
Upper Hutt
Featherston
Trentham
Silverstream
Kelson
Stokes Valley
Whitemans Valley
Pigeon Bush
Belmont
Naenae
Makara Beach
Johnsonville
LOWER HUTT
Waterloo
Petone
Makara
Wainuiomata
Eastbourne
WELLINGTON
Miramar
Brooklyn
Seatoun
Tuhitarata
Pirinoa
Lake Ferry

WELLINGTON PATHOLOGY

ANNEXURE 8

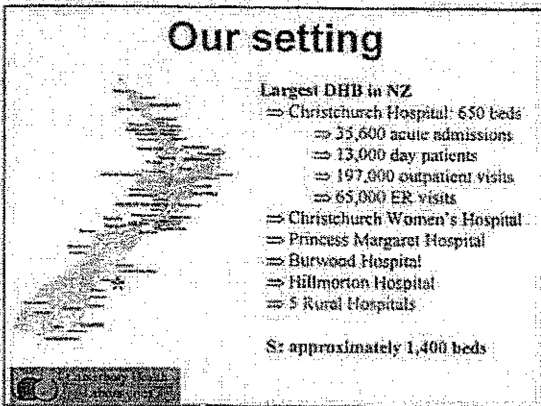
CHL powerpoint presentation – "Planning for Automation of a DHB and Reference Laboratory"

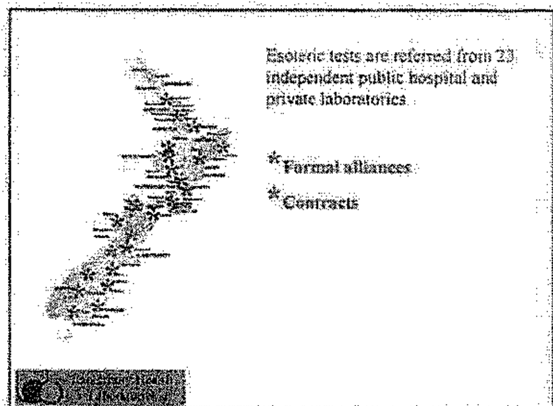
Canterbury Health Laboratories

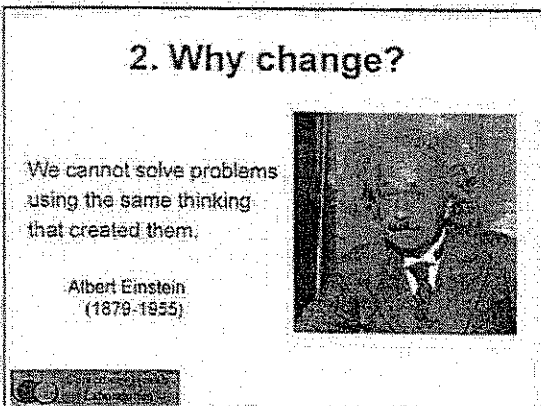


1. Overview

- 355 staff (255 FTE)
  - 20 pathologists + 15 registrars
  - > 20 PhD and research scientists
  - >100 registered laboratory scientists
- 3.1 million tests 2004/2005
- >1,000 different tests
- External revenue increasing by 15%







Why change?

- Change in the work force
- Consolidation
- Clinical requirements (TAT)
- Net working / informatics
- Change of traditional reporting (paperless)
- To become future proof (7% growth per year)
- Net savings

Canterbury Health Laboratories

Change in the workforce

→ 1998
- 16 permanent staff
- 20 rostered staff

→ 581 samples per weekday

→ 2003
- 14 permanent staff
- 11 rostered staff

→ 800 + samples per weekday

more check out and commenting

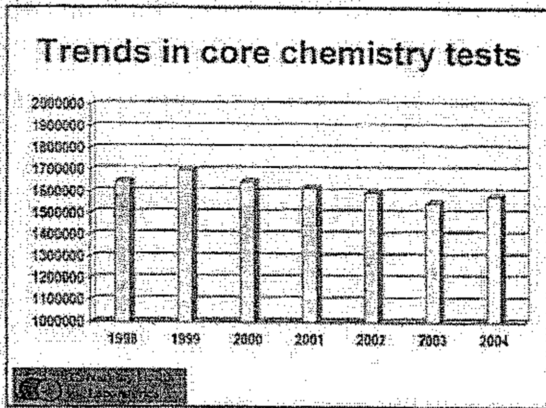
added value results

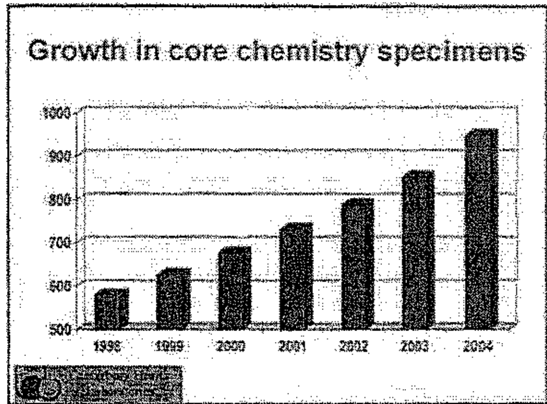
Effects of Utilization of FE500 on Specimen Processing Errors*

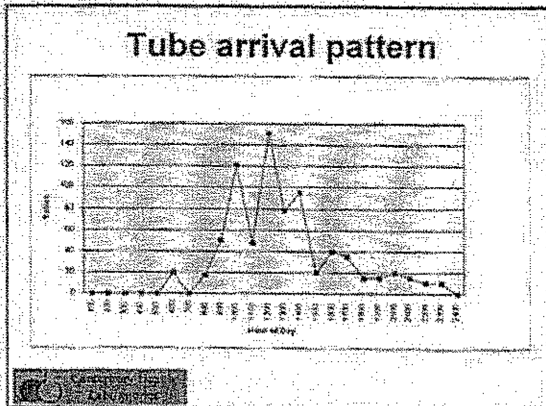
Clin Chem 48(3):540-548, March 2002.

	Number of Errors / Events per Month**		
Error / event classification	Pre FE500	Post FE500***	% Reduction
Sorting and routing errors	10,192	2,038	80.0
Pour-off errors	3,072	614	80.0
Labeling errors	9,011	1,800	80.0
Biohazard exposure events	3,126	24	99.3

* Study performed at Milton S. Hershey Medical Center, Pennsylvania State University.
** Estimated for one month's period of data collection.
*** Errors recorded in this category were from manually handled samples for STAT testing plus those samples processed for microbiology and virology testing







Clinical lab trends

- Labour / overheads currently represent approximately 85% of overall laboratory costs.
- Further decreased tests/sample will have negligible impact on overall costs..... # of sample tubes are a key driver of overall costs.

Percent distribution of $'s spent*

90, 80, 70, 60, 50, 40, 30, 20, 10, 0

Labor/Overhead | Rgts/Equip

■ Reagents/Equip
□ Overhead
■ Labor

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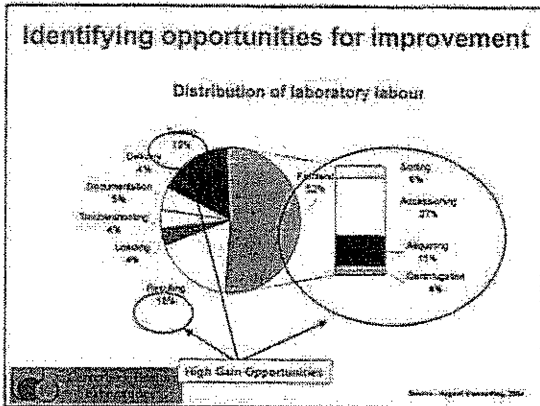
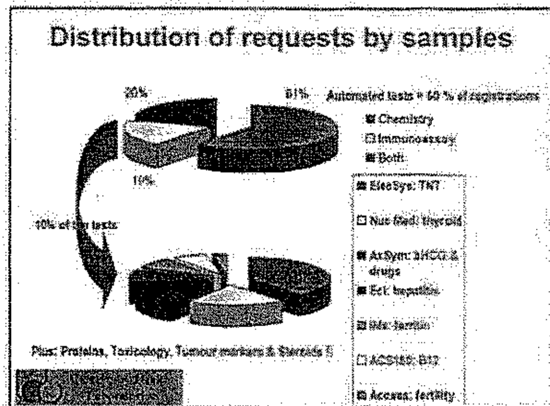
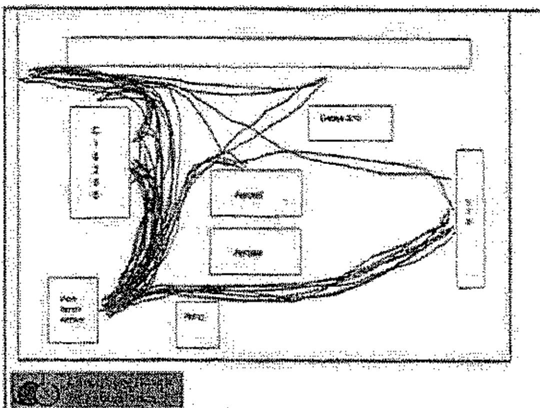




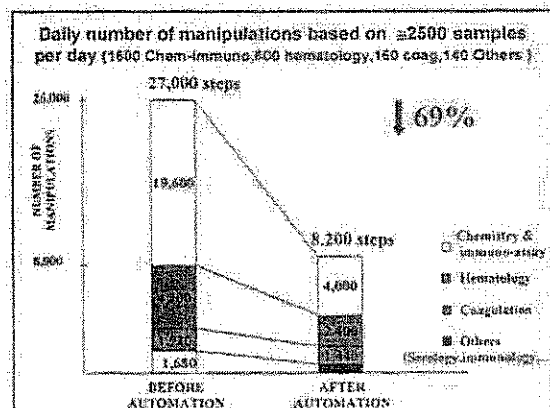


Immunoassay systems in use in Christchurch October 2005

- → Access x 2
- → ACS180
- → AxSym
- → Beckman Array
- → Behring BN II
- → Dade Xpand
- → ElecSys x 3
- → IMx x 4
- → TDx
- → Manual Elisa assays
- → Manual RIAs
- → ECi
- → ?? others

MANUAL STEPS INVOLVED IN CHEMISTRY: Before Automation - Phase 1 – Phase 2

	Before Auto	Phase 1	Phase 2
Reception	✓	■	○
Sorting	✓	■	
Scan bar-codes	✓	■	
Transport tubes to centrifuge	✓		
Load samples to centrifuge	✓		
Unload tubes from centrifuge	✓		
Split samples for several workstations	✓		
Visualise serum indices	✓		
Decap tubes	✓		
Transport racks to analyser	✓	■	○
Load equipment	✓	■	○
Store	✓	■	○
TOTAL NUMBER OF MANUAL STEPS	12	6	4



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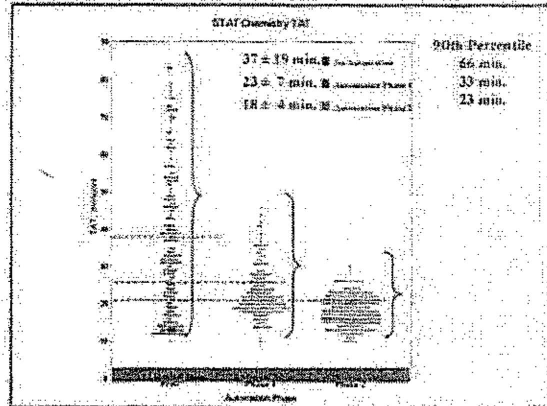
Why change?

- → Change in the work force
- → Consolidation
- → **Clinical requirements (TAT)**
- → Net working / informatics
- → Change of traditional reporting (paperless)
- → To become future proof (7% growth per year)
- → Net savings



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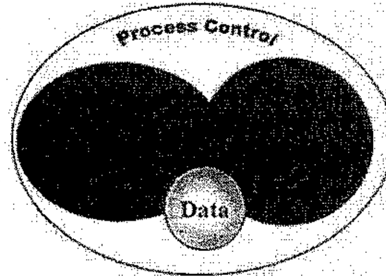
Workflow Management



Consolidation via informatics

Improves connectability

- ✓ Connects all analyzers within the lab
- ✓ Only 1 LIS interface required
- ✓ Can interface with any equipment or system across the laboratory network

Reduces errors, labour, and Turn-Around-Time

- ✓ Algorithms consistently applied across all results
- ✓ Automatic re-run of suspicious results and reflex to additional tests
- ✓ Delta checks and automatic release of technically correct results
- ✓ Immediate delivery of released results to physician (fax, e-mail, pager)

Consolidation via informatics

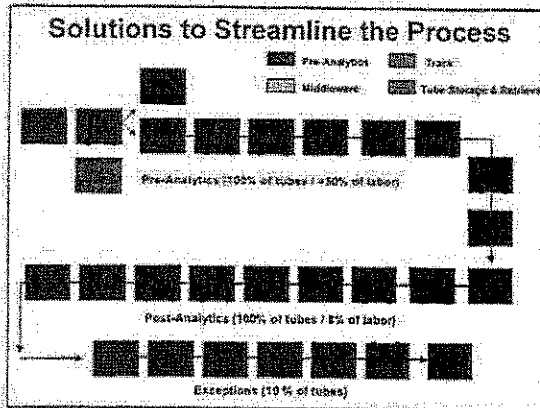
Improved efficiency and focus on exceptions

- ✓ Previous results viewable
- ✓ All images accessible from one screen
- ✓ Out of range values flagged
- ✓ Haematology & immunochemistry results in one screen

QC: detection and reduction of analyser errors

- ✓ QC rules evaluated in real time (Westgard and user defined)
- ✓ Visual alarms generated by QC violations
- ✓ Statistics compared across analyzers

Canterbury Health Laboratories



3. Preparing for automation

- → Identify specific goals that must be met by automation at your lab
- → Analyse your institution's clinical laboratory work load from a sample type point of view
- → Identify the steps (from reception to retrieval) to be included in the automation process
- → Prepare the list of essential questions to ask vendors about their products
- → Ask colleagues, visit sites, attend meetings
- → Communicate with staff, do not reduce FTE too early

4. Narrow the choices

- → Requests for Proposals (RFPs)
- → Decision matrix
- → Involve all staff who are directly involved in this process

- → Updated RFPs
- → Make a choice

Our key decision criteria 2004/05

- → Proven chemistry and IA performance & menu
- → Support and engineering
- → Ability to handle multiple tubes types *simultaneously*
- → Paediatric sample volume requirements
- → Sample archiving
- → Ability to prepare sample aliquots
- → Informatics
- → Price

'Progressive' installation overview

Installation completed in three main stages:

- STAGE ONE: A second ci8200 is installed into the existing core biochemistry lab.
- STAGE TWO: Installation of INPECO front-end, providing pre-analytical automation including input/output module, Centrifuge module and decapping.
- STAGE THREE: Introducing tracking system linking the two ci8200's with the front end automation modules and installing tube storage/retrieval module. This ultimately will be located in the existing Haematology Lab.

Share your experience with others

- → What worked, what didn't work
- → What you would do again / differently
- → What goals were met / not met
- → What advantages did you discover that you didn't expect (unexpected gains)
- → What disadvantages did you discover that you didn't expect (unexpected losses)
- → What was the worst / best part of the process