

Diabetes New Zealand

Type 2 Diabetes – Outcomes Model Update

September 2008

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1 Summary of Findings

Scope

1.1 This project was commissioned by Diabetes New Zealand Inc. The purpose is to provide an indication of the potential level of government spending on health services for Type 2 diabetes under different assumptions about preventative interventions.

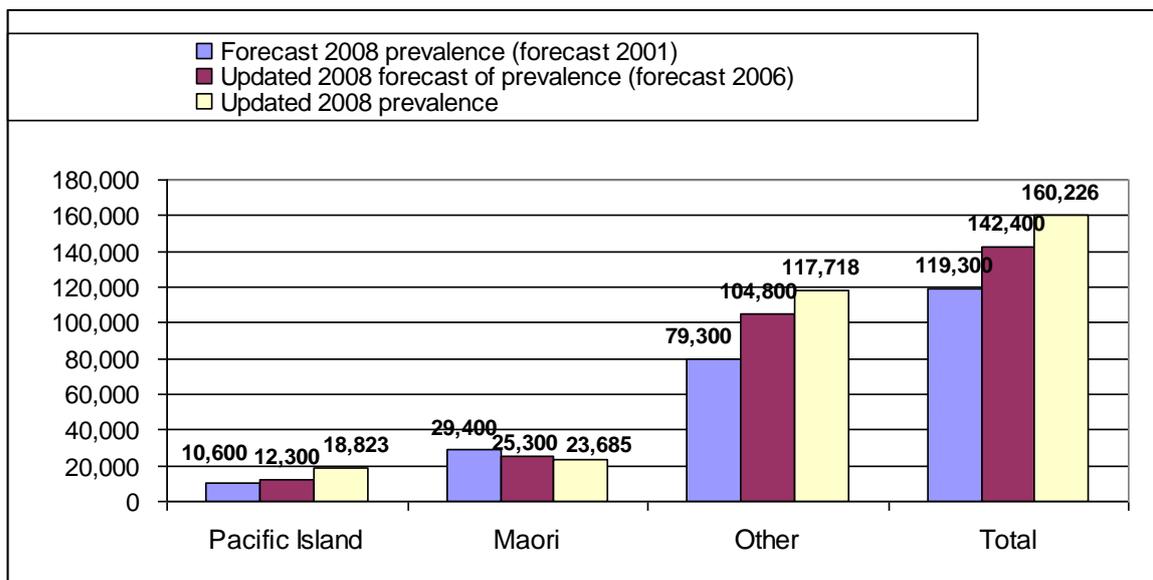
1.2 We have calculated these cost projections by updating the calculations in the 2001 report *Type 2 Diabetes: Managing for Better Health Outcomes* (“the 2001 Report”) and updated again in the 2007 report *Type 2 Diabetes Outcomes Model Update* (“the 2007 Report”), published by Diabetes New Zealand and prepared by PricewaterhouseCoopers, using the latest Ministry of Health (MoH) diabetes prevalence data.

1.3 Please note our disclaimer attached as Appendix A: Important Note.

Prevalence of Type 2 Diabetes

1.4 MoH has released new diagnosed Type 2 diabetes prevalence data for 2008. These prevalence rates are higher than the Ministry’s previous forecasts, as shown in Graph 1.

Graph 1: Ministry of Health Type 2 Diabetes Prevalence for 2008 by Ethnicity – Comparison of the MOH’s 2001 Forecasts and 2006 Estimates.



Source: Ministry of Health 2001-2021 Prevalence Projections and Ministry of Health 2006 and 2008 Updated Prevalence Projections.

Updated Cost Projections

1.5 We have used the MoH’s 2008 prevalence data to update the cost forecasts calculated by the Type 2 diabetes outcomes model developed for the 2001 Report. It is important to note that although the MoH has updated its prevalence projections for diabetes, it has not updated its diabetes services and treatment cost estimates.

1.6 As the Ministry's Diabetes and Cardiovascular Disease Quality Improvement Plan (QIP) is progressively implemented, there will be a gradual movement from 2000 service levels to the enhanced service levels forecast in 2001 and 2007. For this update of the model, we have assumed that diabetes services continue to improve so that the Enhanced Services level is expected to gradually become the baseline. An implication of this is that by 2022 there is no difference between the 2000 Service Level and the Enhanced service.

1.7 The outcomes model produces three scenarios of future government spending on services (treatment and prevention) for Type 2 diabetes under different assumptions about the level of preventative interventions. Scenarios 1 and 2 are intended to estimate the upper and lower range for existing Diabetes services.

- **Scenario 1: 2000 Service Level.** Forecasts based on services and treatments as described in the *Diabetes 2000* report from the former Health Funding Authority (gradually moving to the Enhanced Services level by 2022);
- **Scenario 2: Enhanced Services.** Forecasts the effect of additional funding (of \$20 – 40 million per year) for diabetes prevention, detection and treatment services; and
- **Scenario 3: Optimal Services.** Assumes a significant, immediate increase (of approximately \$60 million per year) in funding for diabetes prevention, detection and treatment services. The key focus of this scenario is the use of prevention initiatives.

1.8 The following table presents the forecast cost of Type 2 diabetes health services under the three scenarios based on prevalence data produced by the MoH in 2008.

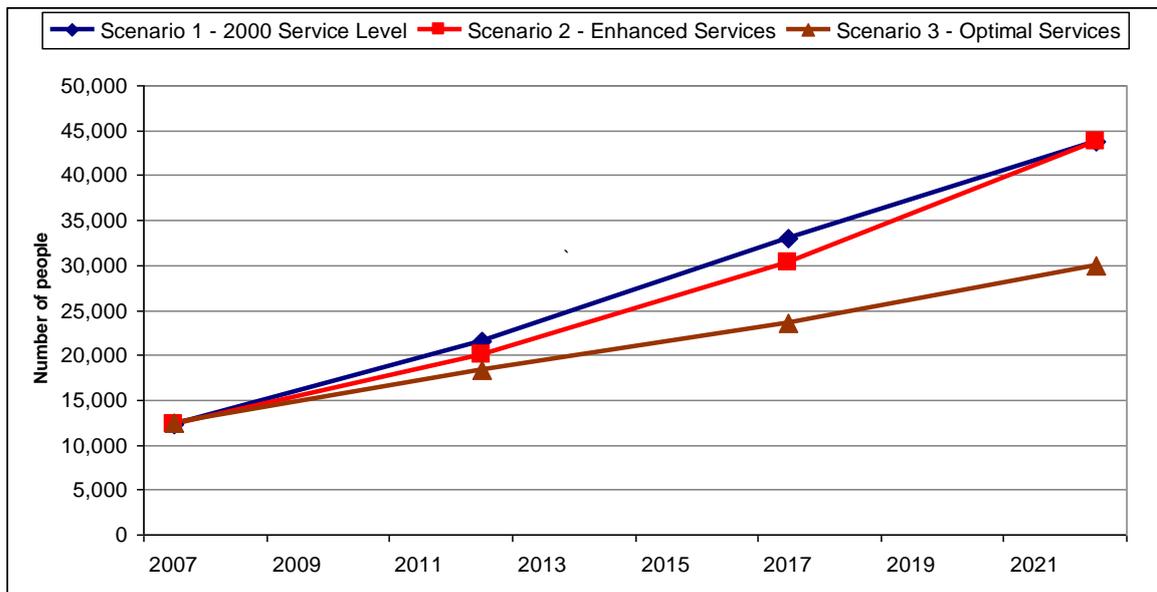
Table 1: Updated Forecast Cost of Type 2 Diabetes Using 2008 Prevalence Data (2008 dollars)

Cost of Type 2 Diabetes	2007/08 (\$m)	2011/12 (\$m)	2016/17 (\$m)	2021/22 (\$m)
2000 Service Level (Moving toward QIP)	600	920	1,310	1,770
Enhanced Services (QIP)	630	930	1,300	1,770
Optimal Services	650	910	1,170	1,510

Source: PricewaterhouseCoopers modelling (2008) based on Ministry of Health Diabetes Updated Prevalence Projections.

1.9 The results show that if MoH were to fund diabetes services (treatment and prevention) to a level envisaged under Scenario 3: Optimal Services, it could result in a cost saving against Scenarios 1 and 2. The key driver of this cost saving is the forecast reduction in the number of people with diabetes who develop serious complications as a consequence of these interventions. Graph 2 shows the forecast number of people with serious complications, caused by Type 2 diabetes, under the three scenarios.

Graph 2: Forecast Number of People with Type 2 Diabetes who Develop Serious Complications – Comparison of Scenarios.



Source: PricewaterhouseCoopers (2008) and Ministry of Health 2008 Type 2 diabetes Updated Prevalence Projections.

Conclusion

1.10 Based on the model assumptions, an increased investment of \$60 million a year (in 2008 dollars) in prevention, self-management and early detection services for Type 2 diabetes has the potential to reduce the government’s health expenditure, after increased spending on preventative services, by as much as \$260 million in 2022. As well as this reduced cost to the taxpayer, at the same time there will be increased services focused on improving the health and wellbeing of New Zealanders.

1.11 This update of the model reinforces the conclusion that there is potential to make significant savings through increased expenditure on prevention and early detection. The investment required is \$60 million to receive both a reduction and prevention of the conditions related to Type 2 diabetes.

1.12 Over the last five years, MoH has implemented a number of diabetes focused programmes, such as the Get Checked programme, aimed at improving the health and wellbeing of people with Type 2 diabetes. The MoH’s update of prevalence estimates has provided the opportunity to review what is known about the impact of these programmes on future health expenditure. This third examination of the implications of the MOH’s prevalence data shows yet again the health expenditure savings that can be generated.

1.13 From the latest 2008 prevalence figures, there is some early evidence that the government’s investment into diabetes prevention programmes is having a small effect, particularly within Maori communities.

1.14 The QIP, instituted by the MoH, is also expected to see an improvement in diabetes related health services over time, such that the 2000 baseline service level will move toward an enhanced service level as the baseline in 2008.

1.15 Under all three scenarios modelled, expenditure on health services for Type 2 diabetes services rises significantly over the forecast period. The results demonstrate the benefits of the MoH leading a focused National Diabetes Strategy that addresses key issues including:

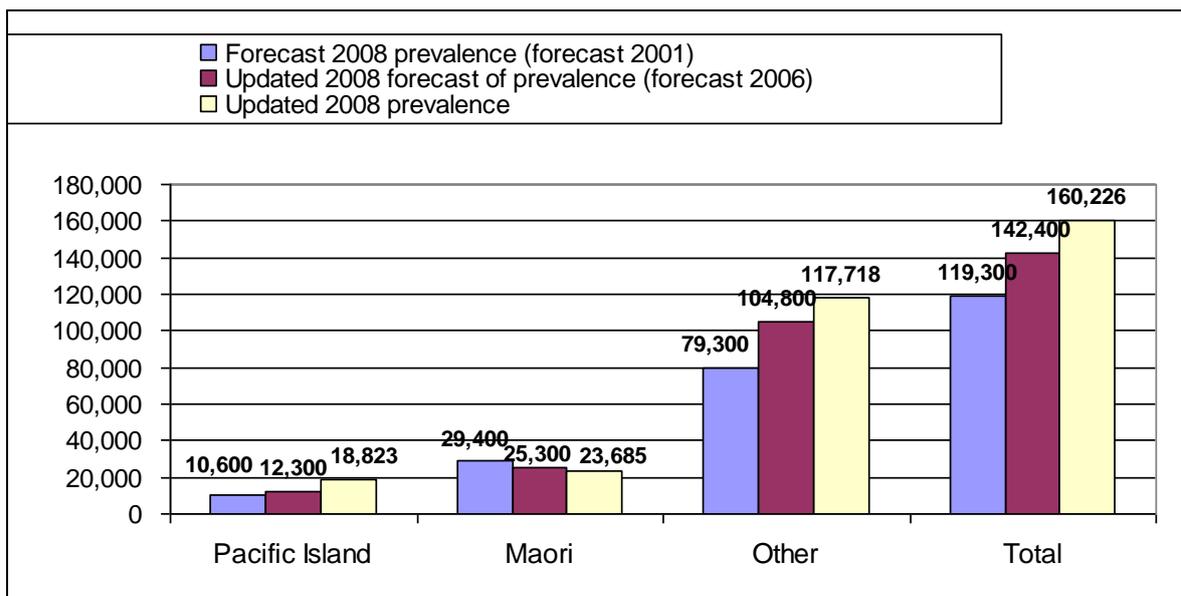
- annual updates of the prevalence of Type 2 diabetes (by age, ethnic group and DHB) by way of a national register;
- programmes for Primary Health Organisations to identify those in their populations with undiagnosed diabetes and engage them in appropriate care, including enrolment in the Get Checked programme;
- up-to-date and reliable data on utilisation rates and costs of health services and treatments for people with Type 2 diabetes, using an outcomes model to monitor the implications; and
- New Zealand-based research into the effectiveness of interventions and population-based programmes to prevent and manage Type 2 diabetes.

2 Prevalence of Type 2 Diabetes

Updated Ministry of Health Prevalence Data

2.1 MoH announced new diagnosed Type 2 diabetes prevalence estimates for 2007 in April 2008. These prevalence rates are higher than the Ministry’s previous projections, as Graph 3 shows.

Graph 3: Ministry of Health Type 2 Diabetes Prevalence for 2008 by Ethnicity – Comparison of 2001 Forecasts, 2006 Estimates, and 2008 Estimates.



Source: Ministry of Health 2001-2021 Prevalence Projections and Ministry of Health 2006 and 2008 Updated Prevalence Projections.

Forecast Total Population of People with Type 2 Diabetes

2.2 It is also important to take into account the number of people with undiagnosed Type 2 diabetes. People with undiagnosed Type 2 diabetes miss out on PHO preventative and self-management health care. As a result, these people have a much higher chance of developing serious complications, which can result in costly tertiary hospital care.

2.3 It is possible that the increased prevalence rate published by MoH for Type 2 diabetes reflects higher detection rates and that the proportion of people with undiagnosed Type 2 diabetes is reducing.

2.4 The implication of this is that government funded expenditure for Type 2 diabetes over the next 15 years would increase at a slower rate.

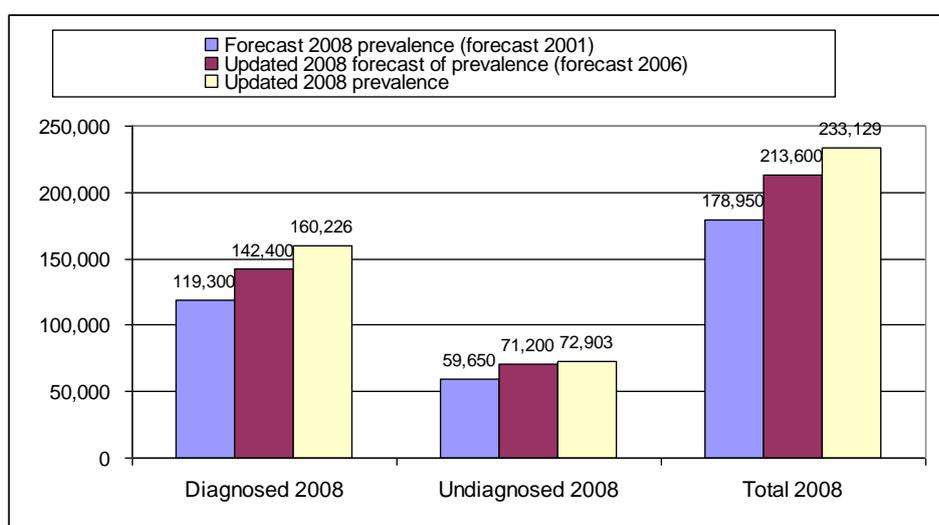
2.5 The number of people with undiagnosed Type 2 diabetes has been estimated using updated assumptions of the relationship between diagnosed and undiagnosed cases used in the 2001 Report. Previously this rate was assumed at a flat rate of 1 to 2, or one undiagnosed individual for every two diagnosed.

2.6 The new assumption has seen an improvement in this rate due to health screening programmes beginning to have some effect. This rate is also expected to continue to improve modestly into the future.

2.7 These assumptions are based on data from New Zealand surveys¹ and are still conservative by international standards (i.e. a relatively low ratio of undiagnosed to diagnosed).

2.8 Graphs 4 and 5 present the estimated number of people with diagnosed and undiagnosed Type 2 diabetes in 2008 and 2021 respectively (based on prevalence figures published by the MOH in 2001, updated in 2006 and then 2008).

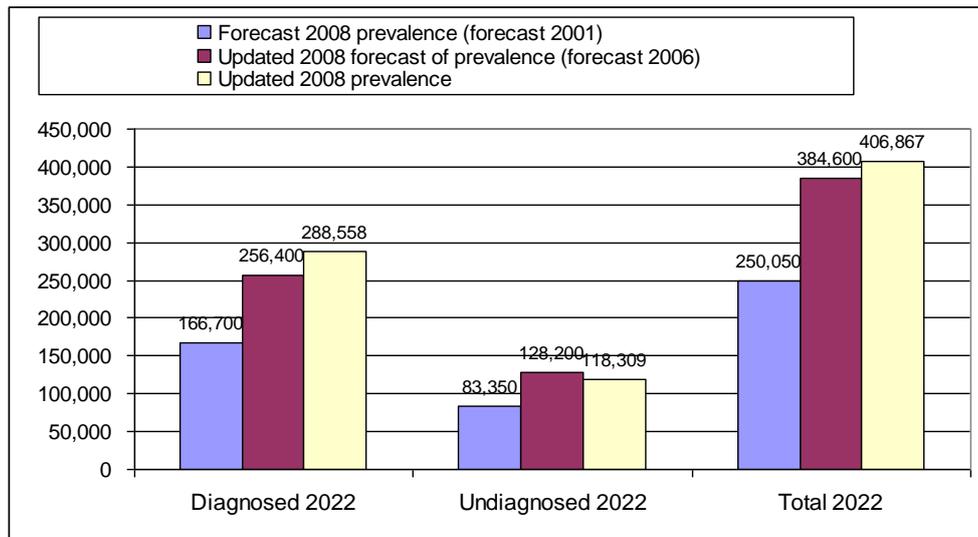
Graph 4: Implications of the Ministry of Health Type 2 Diabetes Prevalence Estimates for 2008 – Comparison of 2001 Forecasts, 2006 Estimates and 2008 Estimates of the Numbers of Diagnosed and Undiagnosed.



Source: Ministry of Health 2001 – 2021 Prevalence Projections and Ministry of Health 2008 Updated Prevalence Projections. Key Assumptions: 2:1 diagnosed to undiagnosed ratio (50%) moving from 45% (European 2:1, Maori 3:1, Pacific 5:1) to 41% as of 2022.

¹ Sundborn, G. et al (2007) Ethnic differences in the prevalence of new and known diabetes mellitus, impaired glucose tolerance, and impaired fasting glucose. Diabetes Heart and Health Survey (DHAH) 2002-2003, Auckland New Zealand, New Zealand Medical Journal 2007: 120-1257. Joshy, G, Simmons, D. (2006) Epidemiology of diabetes in New Zealand: revisit to a changing landscape, New Zealand Medical Journal 2006; 119-1235.

Graph 5: Implications of the MOH Type 2 Diabetes Prevalence Estimates for 2022 – Comparison of 2001 Forecasts, 2006 Estimates, and 2008 Estimates of the Numbers of Diagnosed and Undiagnosed.

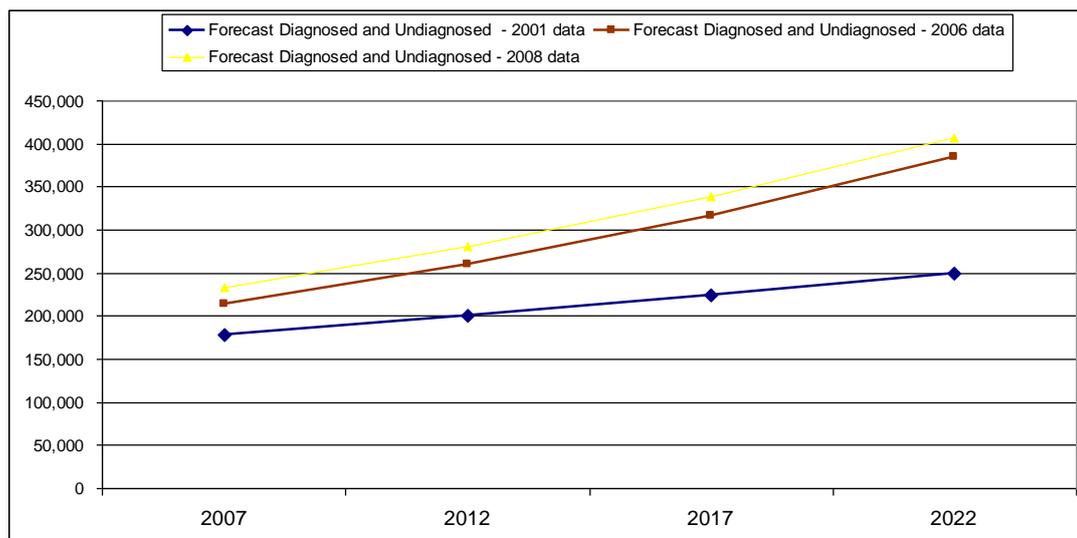


Source: Ministry of Health 2001 – 2021 Prevalence Projections and Ministry of Health 2008 Updated Prevalence Projections. Key Assumptions: 4% p.a. growth in the number of people with Type 2 Diabetes; 2:1 undiagnosed to diagnosed ratio (50%) moving from 45% to 41% as of 2022.

2.9 When the 2001 and 2006 Type 2 diabetes prevalence forecasts are compared with the updated 2008 projections, prevalence is expected to be significantly higher than originally estimated. By 2022, the total number of people with Type 2 diabetes (combining diagnosed and undiagnosed) is predicted to be approximately 407,000. This is more than 150,000 above the prediction based on the 2001 prevalence projections (see Graph 6).

2.10 The forecast based on 2008 prevalence data shows the implications of the improvement in the undiagnosed rate. Those undiagnosed falls by about 10,000 by 2022.

Graph 6: Forecast Type 2 Diabetes Prevalence 2006 - 2021 – 2001, 2006, 2008 Forecasts Compared.



Source: Ministry of Health 2001 – 2021 Prevalence Projections and Ministry of Health 2008 Updated Prevalence Projections. Key Assumptions: 4% p.a. growth in the number of people with Type 2 Diabetes; 45% moving to 41% diagnosed to undiagnosed rate.

3 Basis of the Cost Projections

3.1 MoH's 2008 Type 2 diabetes prevalence data has been used to estimate government spending on health services for Type 2 diabetes. This has been done by updating the prevalence assumptions in the Type 2 diabetes outcomes model that was developed for the 2001 and 2007 Reports.

3.2 This section provides an overview of the model and summarises the key assumptions. Further information about the structure and assumptions behind the model can be found in the 2001 Report.

Basis of the Model

3.3 As developed in the 2001 Study, there are two key underlying assumptions (and the parameters ascribed to them) driving the scenarios that are modelled:

- the onset of Type 2 diabetes and its complications can be delayed and in some cases are preventable; and
- additional expenditure on preventive services will result in higher detection and lower later complication rates.

Limitations

Validation of the 2001 Model

3.4 There is limited data available to validate the accuracy of the 2001 model forecasts. It is assumed that the model produces reasonable forecasts of the government health costs of Type 2 diabetes.

Updating Cost Inputs

3.5 Descriptive data for costing diabetes services is buried within other data sets collected about health services and treatments. The exercises carried out by experts in 2000 and 2001 to describe and cost diabetes services provide the most reliable information at this time. Therefore, to update costs for this report, the 2001 base cost assumptions were increased using Statistics New Zealand's consumers price index (CPI). In particular, the health group CPI for the period 2001 to 2007 was applied. It had a growth rate of 25.8%, which represented an average annual growth rate of 4.3% which was above the general CPI over this period.

Base Assumptions

3.6 The following table summarises the base assumptions in the model.

Table 2: Base Case Assumptions

Description	Value
Number of people with Type 2 diabetes as a % of total diabetes population	85%
Number of people with undiagnosed Type 2 diabetes as a % of diagnosed (this % changes over time to reflect the improvement in undiagnosed)	45%-41%
% of people with Type 2 diabetes who develop serious complications per annum	3.0%
% of recorded diabetes hospital costs attributable to serious complications	90%
% of people with Type 2 diabetes who develop other complications per annum	6.6%
% of recorded diabetes hospital costs attributable to other complications	10%
Hospital Care	\$000
Average cost per patient of treating serious complications	\$25.1
Average cost per patient of treating other complications	\$1.3
Average cost per patient of specialist diabetes services	\$1.3
Average cost per patient of hospitalisation due to undiagnosed diabetes	\$12.6
Primary Care	\$m
Estimated total primary care costs for diabetes	\$91
Estimated total hospital costs for diagnosed diabetes	\$113
Estimated total inpatient costs for diabetes	\$100
Estimated total outpatient costs for diabetes	\$13
Estimated total hospital costs for undiagnosed diabetes	\$138

Please note: All costs are in 2008 dollars.

Source: PwC (2001) Type 2 Diabetes: Managing for Better Health Outcomes – based on the available literature and workshops with experts on Type 2 diabetes.

Scenarios

3.7 The 2001 model estimated potential government spending on services for Type 2 diabetes under three scenarios. These scenarios (including the assumptions and parameters ascribed to them) as described in detail in the 2001 Report. The three scenarios are now converging to two scenarios because of QIP: A key difference between the scenarios is the cost of primary care per new diagnosis. This is lower (0 then \$500 per new diagnosis in 2016/17) under Scenario 1: 2000 service level than under Scenario 1 for later years and Scenario 2 (\$1000) to reflect the increase in GP visits and other preventative primary care services provided under QIP.

1. Scenario 1: 2000 Service Level

This describes the base-line services and treatments consumed by people with Type 2 diabetes, on average, and is based on the *Diabetes 2000* report from the former Health Funding Authority.

2. Scenario 2: Enhanced Services

Incorporates the effect of additional funding (\$20 million per year from 2008 rising to 40 million by 2022) for diabetes prevention, detection and treatment services.

3.8 These two scenarios are intended to estimate the upper and lower range for existing diabetes services.

3.9 As the Ministry's Diabetes and Cardiovascular Disease Quality Improvement Plan (QIP), is progressively implemented, there will be a gradual movement from 2000 service levels to the enhanced service levels forecast in 2001 and 2007. For this update of the model, we have assumed that diabetes services continue to improve so that the Enhanced Services level is expected to gradually become the baseline, so that by 2022 there is no difference between the 2000 Service Level and the Enhanced service.

3. Scenario 3: Optimal Services

Assumes a significant, immediate increase (of approximately \$60 million per year from 2007) in funding for diabetes prevention, detection and treatment services. The key focus of this scenario is the use of prevention initiatives.

3.10 The following table outlines the assumptions used in the three scenarios.

Table 3: Scenario Assumptions

Description	2007/08	2011/12	2016/17	2021/22
Scenario 1: 2000 Service Level				
% of new diagnosed - screening	5%	5%	10%	20%
% increase in serious complications	2.5%	2.5%	2.0%	1.8%
% increase in other complications	2.0%	3.0%	0.5%	0.7%
% specialist diabetes services	13.4%	15.4%	22.0%	33.4%
Primary care per new diagnosis (\$)	0	0	500	1000
Base diabetes primary care (\$m)	11	11	19	29
Scenario 2: Enhanced Service Level				
% of new diagnosed – screening	5%	10%	15%	20%
% increase in serious complications	2.5%	1.8%	1.8%	1.8%
% increase in other complications	2.0%	0.9%	0.8%	0.7%
% specialist diabetes services	18.4%	23.9%	27.1%	33.4%
Primary care per new diagnosis (\$)	1,000	1,000	1,000	1,000
Base diabetes primary care (\$m)	23	29	29	29
Scenario 3: Optimal Services				
% of new diagnosed – screening	30%	50%	70%	85%
% increase in serious complications	2.5%	1.0%	0.5%	0.3%
% increase in other complications	2.0%	0.0%	0.0%	0.0%
% specialist diabetes services	18.4%	33.9%	47.1%	63.4%
Primary care per new diagnosis (\$)	1,000	1,000	1,000	1,000
Base diabetes primary care (\$m)	49	49	49	49

Please note: All costs are in 2008 dollars.

Source: PwC (2001) Type 2 Diabetes: Managing for Better Health Outcomes – based on the available literature and workshops with experts on Type 2 diabetes.

4 Updated Cost Estimates

4.1 Table 4 presents the forecast cost of Type 2 diabetes, updated for the MoH’s 2008 prevalence data.

Table 4: Updated Forecast Cost of Type 2 Diabetes Using 2008 Prevalence Data (2008 dollars)

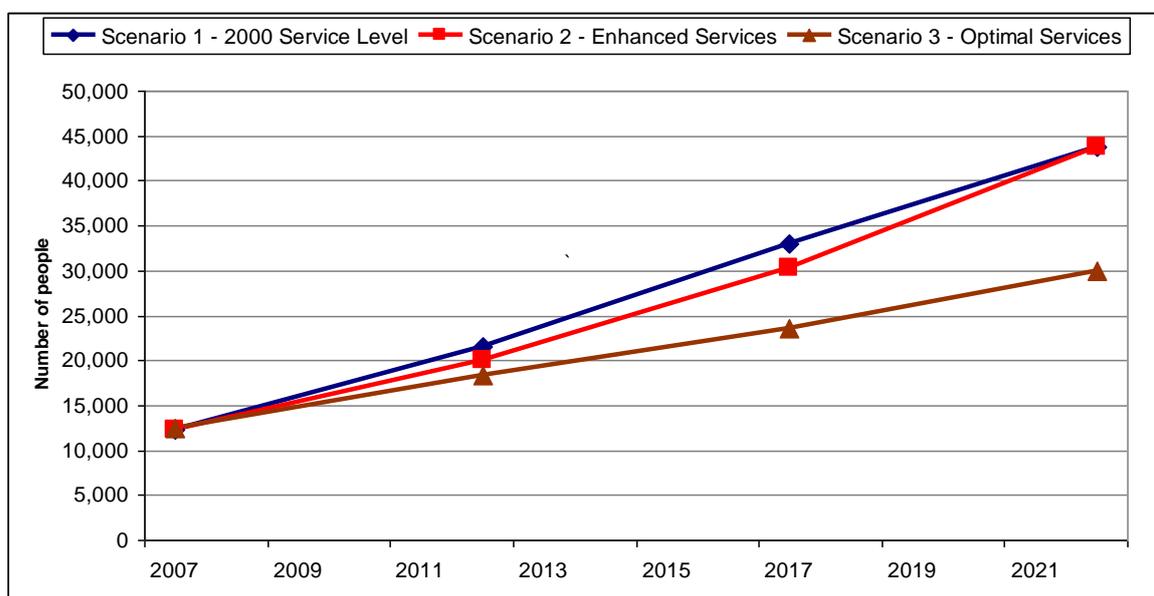
Cost of Type 2 Diabetes	2006/07 (\$m)	2011/12 (\$m)	2016/17 (\$m)	2021/22 (\$m)
2000 Service Level	600	920	1,310	1,770
Enhanced Services	630	930	1,300	1,770
Optimal Services	650	910	1,170	1,510

Source: PwC modelling based on MoH Diabetes Updated Prevalence Projections.

4.2 The results show that if MoH were to fund diabetes prevention services to a level envisaged under Scenario 3: Optimal Services, it could result in a cost saving against the Scenario 1 and 2 cost forecasts.

4.3 The key driver of this cost saving is the forecast reduction in the number of people with Type 2 diabetes who develop serious complications as a consequence of prevention services. Graph 7 shows the forecast number of patients with serious complications, caused by Type 2 diabetes, under the three scenarios.

Graph 7: Forecast Number of People with Type 2 Diabetes who Develop Serious Complications – Comparison of Scenarios.

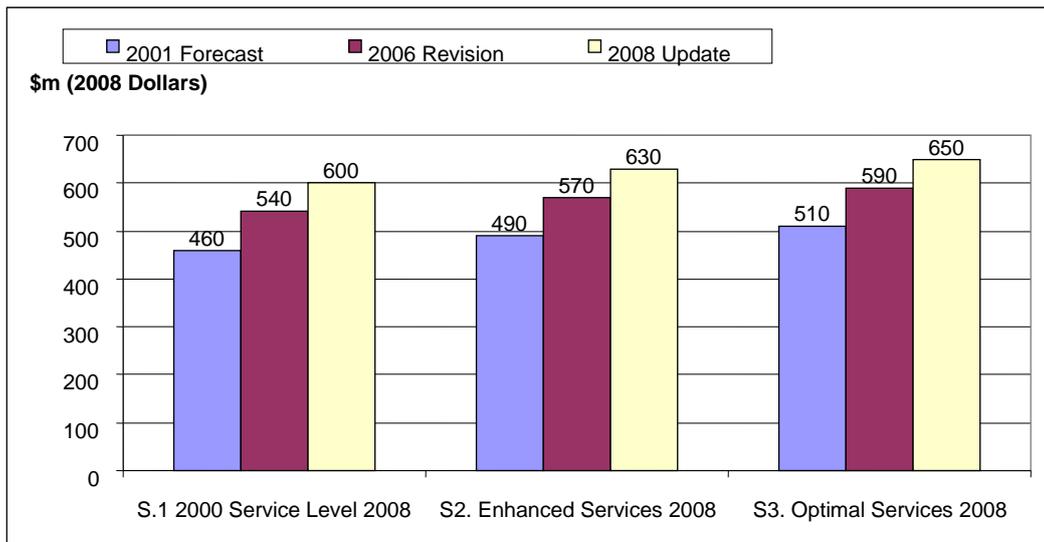


Source: PwC (2008) and MoH 2008 Type 2 Diabetes Updated Prevalence Projections.

5 Comparison of 2008 with 2001 and 2006 Forecasts

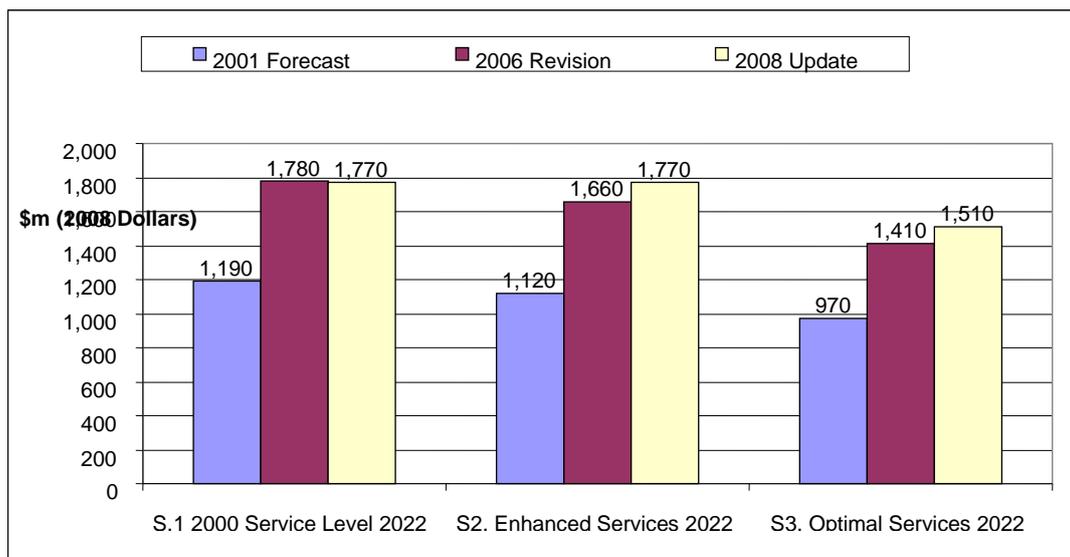
5.1 The higher Type 2 diabetes prevalence rates in 2008 have significantly increased the Type 2 diabetes cost estimates above the levels forecast in the 2001 and 2007 studies. The following graphs present the forecast cost of Type 2 diabetes based on prevalence data produced by the MoH in 2001 and the updated cost of Type 2 diabetes based on Ministry of Health 2006 prevalence data for 2006, 2008 and 2021/22.

Graph 8: Forecast Cost of Type 2 Diabetes in 2008 – Comparison of 2001 Forecast, 2006 Estimates and 2008 Update (2008 Dollars).



Source: Ministry of Health 2001 – 2021 Prevalence Projections and Ministry of Health 2008 Updated Prevalence Projections. Health prevalence data for 2006/07, 2008 and 2021/22.

Graph 9: Forecast Cost of Type 2 Diabetes in 2022 – Comparison of 2001 Forecast, 2006 Estimates, and 2008 Update (2008 Dollars).



Source: MoH 2001 – 2021 Prevalence Projections and MoH 2008 Updated Prevalence Projections.

6 Conclusions

6.1 This assignment models the implications of the MoH's updated prevalence estimates. The government's District Health Board (DHB) expenditure on services and treatments for people with Type 2 diabetes is estimated to rise even more steeply than previously projected. This is likely to be the case if further investment into preventive strategies, is not made.

6.2 DHB strategies, Ministry of Health and PHO activities have shown greater awareness of the requirement to address the increasing prevalence of Type 2 diabetes since the beginning of this century.

6.3 As a result of this greater awareness and more focused service delivery in response to Type 2 diabetes, some modest improvement in detection rates and the rates of undiagnosed to diagnosed cases has been made.

6.4 Nevertheless, the assumptions and parameters modelled by Scenario 3: Optimal Services shows that increased funding for prevention strategies has the potential to provide even greater benefits than calculated in the 2001 and 2007 Reports. The onset of Type 2 diabetes and its complications can be delayed and when services support lifestyle changes, many of the conditions resulting from Type 2 diabetes are preventable. Services designed to prevent or delay the onset of Type 2 diabetes and its complications will result in lower net health costs (the reduction in chronic care costs more than offsetting the increased cost of preventative services). At the same time, there will be improved health and well-being for New Zealanders.

6.5 The implications of the MoH's 2008 updated Type 2 diabetes prevalence projections are:

- Government health spending to treat Type 2 diabetes could increase to approximately \$1,500 – \$1,800 million per annum (Scenarios 1 and 2) over the next 15 years (2008 dollars), in the absence of any further prevention initiatives;
- if the resources required to provide health services to people with Type 2 diabetes rise to this level, diabetes treatment costs will represent approximately 16% of Vote Health (compared with 4% of Vote Health in 2008), potentially crowding out other government funded health treatments and services.

6.6 An increased investment of \$60 million a year (in 2008 dollars) in prevention, self-management and early detection services for Type 2 diabetes (based on more evidence-based research about what works best) has the potential to reduce the government's health expenditure by as much as \$260 million in 2022.

6.7 The important result of this investment, however, is that it means that the health and wellbeing of those who would otherwise have experienced the complications associated with Type 2 diabetes and its pre-conditions, is better.

6.8 Over the last five years, the MoH has implemented a number of diabetes focused programmes, such as the Get Checked programme, aimed at improving the health and wellbeing of people with Type 2 diabetes. The MoH's update of prevalence estimates has provided the opportunity to review what is known about the impact of these programmes on future health expenditure.

A Focused National Diabetes Strategy

6.9 Under all three scenarios modelled, expenditure on health services for Type 2 diabetes services rises significantly over the forecast period. The results demonstrate the benefits of the MoH leading a focused National Diabetes Strategy that addresses key issues including:

- annual updates of the prevalence of Type 2 diabetes (by age, ethnic group and DHB) by way of a national register;
- programmes for Primary Health Organisations to identify those in their populations with undiagnosed diabetes and engage them in appropriate care, including enrolment in the Get Checked programme;
- up-to-date and reliable data on utilisation rates and costs of health services and treatments for people with Type 2 diabetes, using an outcomes model to monitor the implications; and
- New Zealand-based research into the effectiveness of interventions and population-based programmes to prevent and manage Type 2 diabetes.

Appendix A: Important Note

In preparing this report and forming our views, we have relied upon, and assumed the accuracy and completeness of all information available to us from public sources, or furnished to us by Diabetes New Zealand and the Ministry of Health. We have evaluated that information through analysis, inquiry and review but have not sought to verify the accuracy or completeness of any such information.

The diabetes outcomes model (“2001 Model”), which is used to forecast the health costs of Type 2 diabetes in this report, was developed for the 2001 report *Type 2 Diabetes: Managing for Better Health Outcomes* (“the 2001 Report”), published by Diabetes New Zealand and prepared by PricewaterhouseCoopers. The model’s approach to estimating diabetes health costs, assumptions and inputs are set out in detail in the 2001 Report.

We have tested the updated 2001 Model by performing a number of checks to assess the reasonableness of the calculations. However, it is not practical to test a computer model to an extent whereby it can be guaranteed that all errors have been detected, and accordingly we give no such guarantee. If you wish to rely upon the information derived from the 2001 Model you do so entirely at your own risk. Regardless of the form of action, whether in contract, in tort or otherwise, in no event will PricewaterhouseCoopers be liable to any third party for any direct, indirect, special, consequential, or other loss or damages resulting from the use of or the inability to use the 2001 Model, even if PricewaterhouseCoopers has been informed of the possibility of such loss or damages.

In addition, we will not accept responsibility to any other party other than to Diabetes New Zealand, to whom our report is addressed, unless specifically stated to the contrary by us in writing. We will accept no responsibility for any reliance that may be placed on our report should it be used for any purpose other than that for which it is prepared.

The statements and opinions expressed in this report have been made in good faith and on the basis that all relevant information for the purposes of preparing this report is true and accurate in all material aspects and not misleading by reason of omission or otherwise. Accordingly, neither PricewaterhouseCoopers nor its partners, employees or agents, accept any responsibility or liability for any such information being inaccurate, incomplete, unreliable or not soundly based, or for any errors in the analysis, statements and opinions provided in this report resulting directly or indirectly from any such circumstances, or from any assumptions upon which this report is based proving unjustified.

We reserve the right, but are under no obligation, to revise or amend our report if any additional information (particularly as regards the assumptions we have relied upon) which exists on the date of our report, but was not drawn to our attention during its preparation, subsequently comes to light.