CONTRACTING IN THE HEALTH SECTOR

Papers presented at a seminar held by the Legal Research Foundation at The University of Auckland on 6 July 1994
FOREWORD

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The health sector reforms brought about by the Health and Disability Services Act 1993 separated the hitherto intertwined roles of purchaser and provider of health services. The success of the reforms depends in large measure on whether the contracts between purchaser and provider produce efficient, effective and equitable health outcomes.

In July 1994 the Legal Research Foundation held a seminar at The University of Auckland on “Contracting in the Health Sector”, which was designed to examine the contracting experience in the health sector from a variety of perspectives.

The Foundation was fortunate to gather such an expert group of speakers, spanning a wide range of disciplines; each bringing a different perspective to bear on the topic. The papers disclose a diversity of views, and prompted much discussion from the large audience in attendance at the seminar. All the papers and official commentaries given at the seminar are included in this book, except that of Dr Tony Cull, CEO of Health Waikato.

It is hoped that the seminar, and now this record of the proceedings, advances discussion and evaluation of the role and efficacy of contracting in the reformed health sector.
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COMMENTARY

CONTRACTING TO PURCHASE HEALTH AND DISABILITY SERVICES: AN RHA PERSPECTIVE

COMMENTARY
VOICE AND EXIT IN NEW ZEALAND’S HEALTH CARE SECTOR

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Introduction

Evans describes health care reform as “the issue from hell”.¹ Recently, expanding budgets for health care and a recessionary environment have led governments worldwide to reassess the methods of financing and delivery of health care services.² Both the international movement towards privatization of public enterprises and concern over levels of government expenditure have led governments to consider why the funding and provision of health care services cannot be left to private markets. In 1991, the National government announced a dramatic restructuring of the health sector. Although the New Zealand reforms were not instances of privatization, they assume private markets are more efficient than public organizations and, if privatization is not a politically acceptable option, that public organizations should seek to mimic private firm behaviour. In contrast, we argue in this paper that, in addition to the demands of distributive justice, economic theory also supports substantial governmental intervention in the funding, regulation and provision of health care services.

Historically, New Zealand has prided itself on its state-funded health care system and its public hospitals. Here, as in countries such as the United Kingdom and Canada, universal entitlement to health care services stands as a symbol of altruism and richness of public spirit. In reality, despite the symbolic importance of universal entitlement, user charges for general practitioner care have dominated New Zealand’s health care system. Other features of the system prior to the most recent reforms included fragmented funding between treatment for illness and accidents and between primary and secondary care ³

² Evans, ibid, pp 35–36 notes that virtually every country in the Organization for Economic Cooperation and Development had proposed or launched major reforms of its health care system within the same time period, ie, Sweden, United Kingdom, Germany, the Netherlands, the United States and, of course, New Zealand. He also notes that in the five years preceding July 1993 every province of Canada had established a Royal Commission or other major inquiry into its health care system.
³ Salmond et al define primary care as “... the first level of contact people have with the health care system or other services provided in the community to support those basic services. Primary care services include doctors in general practice, nursing services such as domiciliary midwives and district nursing, accident and emergency services, laboratory services .... occupational therapists and community-based services”. They define secondary care as “...services available only on referral from a primary care provider”, and note that it is “... predominantly associated with hospitals although care may be
(which has resulted in perverse incentives for patients to consume more secondary services that, in real terms, are more expensive to produce than primary services), and the growth of the private sector and private insurance. New Zealanders on lower incomes have increasingly had to bear the cost of growing waiting lists for elective surgery in the public sector. Those with higher incomes have been able to receive faster treatment through the private sector and have benefited historically from tax breaks subsidising the cost of private insurance and from government subsidies for private hospitals. It is difficult to draw firm conclusions about a health care system’s effectiveness from available data indicating the “healthiness” of a population. However, in New Zealand, there are large inequalities in health care consumption among the various socioeconomic groups and between European and Maori peoples. At least one author has attributed New Zealand’s poor performance in this regard to the historically high levels of user charges for general practitioner care.

Prior to the reforms, the National government contended that the decline of the health system was not due to insufficient funding but organizational slack. However, in comparison with other OECD countries, New Zealand’s expenditure on health care, as a percentage of Gross Domestic Product, has been below the average since 1970. Most of the reforms have centered around the public hospitals whereas in fact this sector has seen a zero increase in government expenditure over the last decade—largely because of the fixed budgets allocated to the old Area Health Boards. Costs have increased in the area of primary care; however, the reforms do not directly attempt to reform this sector. The National government has also been criticized for neither acknowledging the potential of reforms that were undertaken during the 1980s nor allowing these earlier reforms provided either by admitting patients (inpatient) or through outpatient services—Salmond, Mooney & Laugeson, “Introduction to Health Care Reform in New Zealand” (1994) 29: 1 & 2 Health Policy, p 7.

4 Barr, “Economic Theory and the Welfare State: A Survey and Interpretation”, (June 1992) 30 J Economic Literature 741, p 781 notes that health care is only one factor in the production of good health; other factors include nutrition, environment, and lifestyle. Therefore, it is not only difficult to measure health outcomes (which are both subjective and relative) but also the contribution of health care services to the observed outcomes.

5 For example, Barr, ibid, p 788 refers to a study by Le Grand in 1987 that attempted to compare the health experience of different social classes. He estimated mortality inequality across all ages and classified countries into three groups: in the most-equal group were the Netherlands, Sweden and the United Kingdom; in the middle group were Australia, Canada, Germany, Japan; in the least-equal group were New Zealand and the United States.


8 The government announced that health care spending had increased by 27% more than the increase in the consumer price index in the period 1980–1991 with no real improvement in the number or quality of services produced. The Department of Health’s budget increased from NZ$1.1 billion to NZ$3.8 billion—Upton, Your Health and the Public Health—A Statement of Government Health Policy (Wellington: Minister of Health, July 1991), pp 7–8. Bowie has challenged the accuracy of this claim, and has argued that, on a per capita basis, and adjusted by the consumer price index, spending actually fell by 0.7%; Bowie, “Health Expenditure and the Health Reforms—A Comment” (1992) 105: 945 NZ Med Jnl, p 458.


This paper will not address those debates in depth and instead considers whether the recent structural reforms of the health sector have the potential to improve the efficiency, accountability and fairness of the health care system on the assumption that the pre-existing health care system was not as efficient, accountable or as fair as it should have been. In examining the efficiencies of the new system we examine both technical and allocative efficiencies and criticize the reforms on the basis that they aim to curb government expenditure on health care without analysing issues of allocative efficiency. "Technical efficiency" considerations go towards determining the most efficient instruments with which to achieve a government's goals once these are defined. "Allocative efficiency" essentially describes the overall efficiency and allocation of resources in an economy—and these considerations should be integral to a government's determination of spending goals.

First, we will outline the distributive justice arguments for ensuring that everyone is entitled to adequate health care and why private markets cannot efficiently achieve this objective. We will then describe the theories of the firm, agency cost, and public choice, which we will draw on in analysing instrument choices in the recent reforms in New Zealand. Twenty-three years ago, Albert Hirschman, in his book *Exit, Voice, and Loyalty*, described how economic and political processes can act as efficiency-enhancing mechanisms in both the private and public sectors. A major theme of this paper is how the economic concept of "exit" and the political concept of "voice" will operate in the newly reformed health sector. We will provide an overview of the recent reforms, and then analyse the reforms from both the demand side (which will include, for our purposes, methods of funding) and the supply side.

**Goals of a health care system**

Generally, only those who are in ill-health need health services (apart from preventative services), and there is often a correlation between ill-health and poverty. In other words, the very individuals who are most likely to benefit from health care services are least able to afford them. In attempting to reform the United States' system, which is predominantly privately funded and provided, the Clinton Administration has extracted political mileage from dramatic accounts of the inequalities and unfairness of a system that results in some 37 million being uninsured (14% of the population) and another 22 million lacking adequate coverage. Most of these people are the working poor, with government

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11 These reforms included the restructuring of twenty-nine elected hospital boards into fourteen Area Health Boards ("Boards"); the introduction of population-based funding for Boards in 1983; and the introduction of the New Zealand Health Charter in 1989, which required each Board to sign a performance-oriented accountability agreement with the Minister of Health. A set of "health goals and targets" was drawn up to provide guidance to the Boards in the setting of spending priorities. Ashton, "Reform of the Health Services: Weighing up the Costs and Benefits" in Boston & Dalziel, *The Decent Society* (Auckland, Oxford University Press, 1992) 146, p 150 (citing figures from Treasury, 1990) reports that the 1989 initiatives resulted in productivity improvements. For example, the average length of stay in hospital fell from 15.55 days in 1987 to 13.31 days in 1989, and the throughput of surgical patients increased by 10% between 1987 and 1990.


subsidies providing health care for the unemployed poor and the elderly. The Administration’s goal is to ensure that all American citizens are entitled to adequate medical services regardless of their ability to pay or of risk of ill health. Although we assume that distributive justice requires that this be the goal of any health care system, this vague and general proposition leaves many questions unanswered.

The quintessential problem of health care delivery has been summed up as “infinite medical needs exhaust finite resources”, what level of service must be provided to all to satisfy the demands of distributive justice while recognizing that resources are limited? Giving everyone in society an equal right to the best health care services available is problematic, as is preventing those who can afford to purchase more or better treatment from doing so. Lester Thurow has described the dilemma as follows:

Being egalitarians, we have to give the treatment to everyone or deny it to everyone; being capitalists we cannot deny it to those who can afford it. But since resources are limited, we cannot afford to give it to everyone either.

It is crucial to determine what “adequate” level of health care should be available to everyone in need that will efficiently satisfy social justice demands. The recent reforms in New Zealand provide for public consultation in order to define a list of “core health services”, ie the health services, given limited resources, that individuals and communities value the most.

Access to an adequate level of health care services is also supported on communitarian grounds. Dougherty has said:

... there is something more repugnant about unequal treatment in matters as intimate as life, death and the quality of life than in the general arena of consumer goods and services.

Moreover, to communitarians, universal access to health care services is important as it:

... draws people together in relationships of caring and response to the needs of others. This sense of sharing the burdens of illness and the general limits of the human condition is linked to notions of equal membership in a community.

Universal access can also be supported on the grounds of political necessity. If the middle
and upper classes do not feel a vested interest in the public health system, the system will deteriorate and will eventually collapse through lack of voter support.

**Instrument choice**

The reforms presume that the market is a more efficient allocator of health care resources than the government is or could be. The government’s goal through the reform process has been to improve the technical efficiency of the system. However, the overall goal of the system cannot be lost sight of. Assuming that, at a minimum, the goal of any health care system is to provide some adequate (and, as yet, undefined) level of medical services to everyone without regard to their ability to pay or risk of ill health, what is the best means to attain this goal? A government has a choice of a variety of instruments or means. There are three sets of considerations that bear on the question of instrument choice: (1) technical or efficiency considerations, ie, what instrument or method of obtaining the desired goal is the most cost-effective; (2) distributive justice considerations, ie, who should pay and how much should they pay for the realization of the goal; (3) political considerations—which may mean that the instrument chosen is not that which, objectively, is the most efficient and fair.\(^{21}\)

It will help, at this stage, to briefly outline the theories supporting private markets over public provision as we will refer to these again in analysing the recent reforms in New Zealand. The three theories we will discuss are agency cost theory, the theory of the firm, and public choice theory.

1. **Agency cost theory**

Agency cost theory focuses on the costs associated with divorcing ownership of an organization from its management. In essence, the agency problem is how to ensure that the managers of a firm or organization act in the best interests of the firm’s owners or the organization’s beneficiaries.\(^{22}\) The number of professionally managed firms in existence shows that the benefits of such an arrangement generally outweigh the disadvantages.\(^{23}\)

Three principal factors have been identified in the private sector as helping to ensure that professional managers act in the best interest of shareholders in publicly-traded corporations. First, there is the employment market for professional managers—competition between and for good managers ensures greater efficiency and innovation.\(^{24}\) Second, there is the output market—if a firm faces competition, then unless it performs efficiently its customers will “exit” (a concept that will be discussed later in this paper) and it will lose profits and, at the limit, become insolvent.\(^{25}\) Third, there is the impact of private capital markets. This gives a manager an incentive to ensure that the firm acts efficiently as salaries of senior management are often related to stock performance and managers are


\(^{22}\) The problem, of course, is minimized where the owners are themselves the managers.

\(^{23}\) A professionally managed firm, as opposed to an owner-managed firm, may be better able to raise large amounts of capital, take advantage of scale, and take advantage of managerial expertise available through the use of professional managers—Easterbrook and Fischel, *The Economic Structure of Corporate Law* (Cambridge, Mass, 1991), p 11.


\(^{25}\) Fama, idem.
often evaluated in the job market on the basis of this performance. In addition, should the firm’s performance decline there is a higher risk of a corporate takeover and the consequent loss of incumbent managers’ jobs.26

In the public sector, the public are indirect owners of public enterprises, but they have no control over management. Taxpayers and voters form such a large and diverse group that no individual or group has a strong incentive to lobby for the public enterprise in question to act efficiently. Arguably, the public have delegated this responsibility to government, but this delegation raises its own agency problems. The agency problem is exacerbated in the public sector because the three factors mentioned above as affecting a manager’s behaviour in the private sector do not operate—or at least not to the same extent. Competition among managers of public enterprises is often muted by formal rules for promotion and because a manager’s performance cannot be measured by stock performance. Public enterprises may often not face competition in output markets and, in any event, since they are owned by the government, are unlikely to be left to become insolvent. Managers are aware of this. As shares in public enterprises are not traded on the stock market, managers do not bear the risk of displacement as a result of a takeover.

2 The theory of the firm

The theory of the firm helps explain why some production functions are undertaken within a firm or organization and others outside—the "make or buy" decision.27 The theory focuses on the transaction costs of a particular method of production.28 When a firm purchases goods or services (or "contracts out"), it incurs costs in acquiring information about their price and quality, and in negotiating, monitoring and enforcing supply contracts. There is also the risk that sellers (or "providers") will take advantage of the difficulty of specifying the product being contracted for or the quality thereof, and increase the price of the product or, if quality is difficult to monitor, skimp on quality (pecuniary forms of opportunism). On the other hand, internalizing production is not without its cost as one loses the valuable information that is contained in market price signals which indicates the real value and scarcity of production factors.29 Also, internal incentives for non-pecuniary forms of opportunism (organizational slack) may be created since remuneration is not directly linked to output.30

The relevance of the theory of the firm to public sector organizational arrangements is that a government must determine what activities should be performed "in-house" or be performed by others in the market.31 In general it seems that a government should choose

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30 For example, consumption of products or production inputs or slacking on the job.
31 Either by contracting out in its traditional sense, management contracts, licensing, franchising, or individual contracting—for a discussion of the incentive properties associated with these organizational options see Trebilcock, above, n 21, pp 14–20. On contracting out by public sector organizations see Cassidy, Contracting Out (Queen’s University: Government and Competitiveness School of Policy Studies, June 1994).
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market provision (or "contracting out") over "in-house" production if: (1) the desired product or service is easily described and its volume and quality can be specified in advance; (2) the costs of contracting (negotiating, monitoring and enforcement) are low; and (3) production involves few economies of scale and scope but large returns to specialization. As will be discussed, it is difficult to imagine examples for which these assumptions would be less applicable than that of most hospital (or secondary) services.

3 Public choice theory

Public choice theory illuminates how political processes impact upon a government's choice of both goals and instruments by which to realize these goals. This theory cynically assumes that, just as the actors in private markets are assumed to be motivated principally by self-interest, so too are voters, politicians, bureaucrats, regulators and the media. For example, politicians do not make decisions on the basis of what is in the public interest but rather on the basis of what will secure political support and enhance their prospects of election or re-election. Similarly, the decisions of bureaucrats and public servants are presumed to be motivated by a desire to improve their pay, power, and prestige.

Public choice theory has provided support for privatization programmes throughout the world. Governments have sold public sector organizations to private firms on the assumption that private firms will operate them more efficiently, since their decisions will not be distorted by political self-interest or be subject to manipulation by pressure groups. As Charles Shultze notes: 32

Under the social arrangements of the private market, those who may suffer losses are not usually able to stand in the way of change. As a consequence, efficiency creating changes are not seriously impeded.

However, that governments have chosen to undertake privatization programmes challenges the assumptions underlying public choice theory. If a government were primarily motivated by self-interest why would it privatize, which involves a reduction of its own powers and, at least in New Zealand, is unpopular amongst the voters? Although politicians and bureaucrats may be motivated by self-interest, it cannot be assumed that they operate according to self-interest alone. Moreover, public choice theory cannot be invoked to justify unqualified adherence to markets over government intervention. In the case of some goods and services the market is not the best allocator of resources because the assumptions upon which a market is presumed to operate are invalid and/or the free operation of the market results in unacceptable inequalities.

4 Failure of health service markets

The most commonly identified causes of market failure in health care are imperfect competition and externalities. To this should be added information asymmetry between patients and providers. Government can intervene to correct market failure by funding, regulating or providing health services or any combination thereof.

Positive externalities—that is the benefit to individuals within society in ensuring that

32 As quoted by Enthoven, "The History and Principles of Managed Competition" (1993: Supplement) 12 Health Affairs 24, p 40.
everyone receives health care services—is an argument often advanced to support government funding of public health care services. Generally, this line of reasoning supports services designed to inhibit the spread of contagious diseases. A “paternalistic” explanation for government funding of all health care services is the “merit goods” argument—members of society at large feel that individuals in need of care ought to consume effective care. This explanation does not of itself, however, justify universal entitlement nor government provision of health services.

There is imperfect competition in the supply of many secondary (or hospital) services in New Zealand due to the small and geographically dispersed population and the capital costs of maintaining hospitals. In order to avoid paying excessive prices to private monopolies a government would have to regulate both price and quality. If regulation is costly and difficult to enforce it may be more efficient for the government to provide health services itself.

Fielding and Rice argue that the market for health care services fails as the usual assumptions that goods and services produced are homogeneous and consumers and producers possess good information regarding the price and quality of alternative choices are invalid. Both Hutton and Wisner argue that the problem of imperfect information is the most powerful argument for government intervention. On the demand side, patients rely upon physicians to assess their health care needs and to tell them what health goods and services they should consume. It would be costly for patients to attempt to acquire this information themselves, and the cost to individuals of choosing badly may be very high. In other words, demand for health care goods and services is driven, at least to a significant degree, by the providers of health care. It is also almost impossible for individuals to accurately anticipate major expenditure on health care services. This information asymmetry supports the need for government regulation of the quality of health services and possibly is an argument for public provision. It also supports regulation of the number of providers in a system. An increase in the number of providers does not drive the costs of health care down but up. Providers are able to create their own demand for their services by the advice they give their patients—particularly in a fee-for-service

33 “Public health” is widely defined in the Health and Disability Services Act 1993 to mean the health of all of the people of New Zealand; or a community or section of such people. In practice, public health services include those designed to minimize the spread of contagious diseases, immunization programmes, effective sanitation programmes and public health-education programmes.

34 Although Evans notes that as there are many other forms of consumption that an individual may value more highly than health care and which are not paid for or provided by others, this cannot be true altruism. He suggests that the altruistic form of externality is not specific to any particular type of commodity or source of satisfaction and therefore, if really interested in someone's well-being, we should be as willing to subsidize gin as penicillin if that is what the recipient of our benefaction wants—Evans, Strained Mercy: The Economics of Canadian Health Care (Toronto, 1984), pp 61, 63.


38 Wisner, ibid, p 9.
regime such as exists in New Zealand with respect to the delivery of general practitioner care.\textsuperscript{39}

The case for government funding as opposed to private insurance rests upon the poor quality of the information that is available to insurers concerning the likelihood of any individual needing any particular health service.\textsuperscript{40} Insurers are likely to charge some individuals premiums that are higher than the real risk of future consumption of health services by those individuals would justify. This may cause these individuals to drop out of the health insurance market altogether—an "adverse selection" problem.\textsuperscript{41} This problem could be alleviated by a mandatory requirement that all have health insurance, but this may impose an unacceptable burden on those with lower incomes who generally have higher health risks. Government subsidies could be targeted at these low-income groups, but these subsidies would be vulnerable to cuts in government expenditures as the mass of voters would not have an interest in maintaining these subsidies. Also, experience in the United States tends to suggest that competition between multiple private insurers increases overall costs, particularly administrative costs.

Those individuals who are charged a lower premium than their risk of utilization warrants have a perverse incentive not to take preventative steps to insure that their consumption of health services is minimized—a "moral hazard" problem. Moral hazard, however, is also a potential problem in countries in which the government provides health services without user charges. We will discuss this problem further when we describe the role of user charges in the New Zealand reforms.

4 \textit{Comparing different health care systems}

Accepting a general case for government intervention for distributional reasons and to ameliorate market failure due to externalities, imperfect competition and information asymmetry, a survey of the various systems in use throughout the world shows that the forms of government intervention vary greatly. The United Kingdom ("UK") and New

\textsuperscript{39} Fielding & Rice, above, n 36, p 219 and see Evans above, n 34, ch 13.

\textsuperscript{40} In the United States, Enthoven (above, n 32, p 30) has described the failure of the insurance market for health services as follows:

First, insurers have a strong incentive to group their customers by expected medical costs and to charge people in each group a premium that reflects their expected costs. This practice is known as experience rating or underwriting. The consequence is that those people having high predicted medical costs face high premiums. Many sick people find such premiums unaffordable and may go without insurance, taking their chances they will receive free care. Second, healthy individuals face strong incentives to ride free, that is, to go without insurance or with minimal coverage until they get sick, at which point they seek to buy comprehensive coverage. Consumers are more likely than insurers to know more about their prospective medical needs. Third, partly because of the behaviours induced by these incentives and partly because of high marketing costs to reach individuals or small groups, the administrative costs of individual health insurance policies are very high—40\% of medical claims or more. This creates more of an incentive for relatively healthy people to go without insurance. Rather than bearing the risks and expenses of covering individuals who are sick, even at a high price that would cover their expected costs, most insurers choose not to cover them at any price. Fourth, health insurance contracts are extremely complex and difficult to understand and administer. Insurers deliberately make them even more complex to segment markets and make it difficult for consumers to compare prices.

Zealand both have predominantly government-funded systems and public hospitals but they allow private sector insurance and provision. New Zealand has a higher percentage of private expenditure for primary services, notably general practitioner care. Canada has a system dominated by government funding for secondary and primary services (although not pharmaceuticals) and it effectively prohibits private insurance for services that are provided by the public health insurance scheme. In Canada hospitals are a mixture of private and public not-for-profit organizations. Germany's system is one of decentralized social and private insurance combined with mixed public/private delivery. The United States relies more heavily on private insurance and private providers than any other developed country but the government subsidises health care for the unemployed poor and poor elderly.

It is very difficult to compare accurately different health care systems, as measurements of health outcomes depend on a variety of cultural, economic and environmental factors, and not only the effectiveness of the health care system. In terms of expenditure, however, it seems that centralized single-payer systems (such as those in the UK and New Zealand) where health insurance is financed out of tax revenues and where, in general, the hospitals are public enterprises, have been better able than other systems to contain costs. In 1989, the UK spent 5.9% of Gross Domestic Product ("GDP") on health care and New Zealand spent 6.9%. At the other end of the spectrum, it is clear that the administrative costs associated with multiple private insurers and providers in the United States contribute to that system being the most inefficient and inequitable of all the OECD countries—leaving 37 million Americans uninsured, yet spending 11.5% of GDP on health care in 1989. Moreover, it is predicted that in the absence of reform the United States will be spending an enormous 19% of Gross National Product on health care by the year 2000. However, the relative efficiency of the UK and New Zealand systems may be over-stated by simply comparing expenditure as a percentage of GDP as there are hidden productivity costs in the long waiting lists for public hospitals in both the UK and New Zealand. Also, the UK system appears to achieve the goal of universal access more successfully than the New Zealand system, the latter being grouped in one study with the United States as having the most unequal mortality rates across social classes. This is likely due to the relatively high user charges for general practitioner care in New Zealand.

Canada spends substantially more on health care than New Zealand—8.6% of GDP in

42 Evans, above, n 34, p 160 notes that not-for-profit firms are of central importance to the overall functioning of the Canadian health care system. The leading example is the voluntary hospital, governed by a board of trustees on behalf of a voluntary society, municipality, or religious order who are the legal owners.
43 Wisner, above, n 17, p 20.
44 Muthumala & McKendry, above, n 9.
45 Muthumala & McKendry, ibid.
47 Prior to the most recent round of reforms there were an estimated 62,000 people on waiting lists for the public hospitals. The accuracy of this data is in doubt as historically the compilation of waiting list data has been haphazard. This figure is up 61.1% from an estimated 38,501 people on waiting lists in 1981—Upton, above, n 8, p 28.
48 Refer to discussion at footnote 5.
There are two possible explanations for this phenomena. Firstly, Canada has a higher number of physicians per capita. Because of the information asymmetry which exists between physicians and patients, physicians are able to influence to a significant degree demand for their services and in a fee-for-service regime such as exists in the primary and secondary sector in Canada and in the primary sector in New Zealand this translates into higher costs. Secondly, Canada’s higher expenditure may not necessarily be reflective of an inefficient system but of a system which delivers better quality service. For example, Canada has less of a problem with waiting lists than New Zealand. It is, however, difficult to empirically prove whether Canada’s shorter waiting lists are due to the additional 1.7% of GDP spent above that by New Zealand on health care and whether the cost is worth it.

Despite its single-payer system, Canada spends a similar proportion on health as Germany where there are multiple purchasers (some 1200 sick funds)—although it should be noted in this latter regard that the German government’s concern over rising costs has led to the sick funds being required to band together in regional purchasing groups, thereby enhancing their purchasing power. Pooling purchasing power through the creation of large regional health alliances is also the basis of the Clinton Administration’s proposals for health reform in the United States.

6  _Hirschman’s theory of exit and voice_

It is not obvious from this brief survey of different health care systems what the most appropriate instruments are for the funding and provision of health care except that the United States system is a glaring example of how not to organize a health system, that a concentration of purchasing power seems to assist in cost containment, and that those systems which provide universal free access to general practitioner care have better records than New Zealand in terms of access by different socioeconomic groups to health care services. It is our contention that whatever the instruments or mechanisms in place for the delivery of our stated goal (ensuring access for everyone to adequate medical services regardless of their ability to pay or of risk of ill health), they are more likely to be efficient and result in a more accountable system if there is an appropriate mix of “exit” and “voice”.

49 Muthumala & McKendry, above, n 9—ranked Canada third in terms of total health expenditure as a percentage of GDP in 1989.
50 Waiting lists are not as long in Canada as in New Zealand. Ashton, Beasley, Alley & Taylor, _Reforming the New Zealand Health System: Lessons From Other Countries—Report of a Study Tour Sponsored by Health Boards New Zealand_ (April 1991), p 18 notes that in British Columbia just under 1% (25,000) of the total population is on a surgical waiting list compared with about 1.7% (60,000) of the population in New Zealand. It appears that time spent on waiting lists is shorter in Canada than in New Zealand.
51 Germany spent 8.6% of GDP on health care in 1989—Muthumala & McKendry, above, n 9.
52 Barr, ibid, n 4, p 786 notes that government regulation seeks to control expenditure in Germany by: imposing a de facto ceiling on the pay-roll tax from which the sick funds derive their revenue which is reinforced by voluntary targets for hospitals; requiring that a hospital-specific per diem be negotiated between individual hospitals and the regional association of sick funds; and constraining physicians’ fee-for-service charges by a schedule of agreed fees and a global budget for all physicians in a region.
Albert Hirschman, in his book *Exit, Voice, and Loyalty*, described how economic and political processes can act as efficiency-enhancing mechanisms in both the private and public sectors.\(^{54}\) When a dissatisfied customer shifts from one firm to another (or “exits”), she or he not only seeks to protect or improve upon her or his own welfare, but also sets in motion market forces that may result in the firm from which she or he had defected remedying inefficiencies.\(^{55}\) This is because the revenue losses resulting from customers switching firms is a signal to the firm that its performance must improve in order to achieve its previous profit levels or even to remain solvent. “Exit” requires no direct communication between the dissatisfied customers and the firm and is often a relatively cheap option to exercise. However, exit does not function well as a mechanism where demand for the product or service in question is inelastic and/or there is no competition between firms. It is also not an effective recovery mechanism if demand is so elastic that exits occurs too rapidly, rendering a firm insolvent before it has had a chance to make efficiency improvements.

Hirschman defines “voice” as any attempt to change, rather than to escape (by “exit”) a firm or organization.\(^{56}\) Voice is most often thought of as a mechanism affecting political behaviour but it has a role in private markets. In comparison with exit, voice is “messy”,\(^{57}\) costly and “conditional on the influence and bargaining power customers and members can bring to bear within the firm from which they buy or the organization to which they belong”.\(^{58}\) The difficulty is that the customer or member who is very sensitive to declines in quality and would be likely to use voice to agitate for improvement will, where there are better quality substitutes (even at higher prices), be the first to exit.

Hirschman suggests that there may be a case for monopoly provision (ie, not allowing exit) where exit is ineffective as a recuperative mechanism.\(^{59}\) He gives the example of a public hospital where, because of government support, should the hospital decline in performance, there is likely to be an insufficient number of customers who exit to induce the hospital to improve its performance. Where exit does occur it is most likely to be of the more quality-conscious, alert and potentially active patients, ie, the patients most likely to use voice.\(^{60}\) In such a case, neither exit nor voice will operate effectively and the hospital will continue to operate inefficiently. Hirschman notes that those who hold power in a “lazy monopoly” may actually have an interest in creating some limited opportunities for exit on the part of those who are most likely to criticize and embarrass the monopoly.\(^{61}\) In New Zealand, the 1960s saw the advent of waiting lists for treatment in public hospitals. To relieve pressure, the National government of the day started paying private hospitals bed subsidies and private insurance premiums were made tax deductible. This assisted quality-conscious consumers on higher incomes to exit to the private sector. Their voice was consequently muted and they did not have the same incentive to agitate for significant improvement in waiting times in the public hospitals.

\(^{54}\) Hirschman, above, n 12.  
\(^{55}\) Hirschman, ibid, p 15.  
\(^{56}\) Hirschman, ibid, p 30.  
\(^{57}\) Hirschman, ibid, p16.  
\(^{58}\) Hirschman, ibid, p 40.  
\(^{59}\) Hirschman, ibid, p 55.  
\(^{60}\) Hirschman, ibid, p 47.  
\(^{61}\) Hirschman, ibid, p 60.
To proscribe exit completely (for example, through monopoly provision) in cases such as that of a public hospital, where exit does not operate effectively as a recuperative mechanism, is not appropriate. Voice is less effective if not supported ultimately by the threat of exit. Hirschman suggests that in order for voice to be effective there needs to be the possibility of exit but that exit should not be too easy or too attractive where deterioration in the performance of the firm or organization occurs.\(^6^2\) Loyalty is one mechanism that can impact on the readiness of quality-conscious customers or members to be the first to exit.\(^6^3\) Other mechanisms for achieving the same result include institutional barriers, which raise the cost of exit.

**Summary of the recent reforms of New Zealand’s health care system**

The 1991 July budget proposed a restructuring of New Zealand’s health care system in order to improve both the efficiency and accountability of the existing system. The original version of the reforms was set out in the government’s Green and White Paper.\(^6^4\) The nine most important changes are outlined below. We do not address all the important reforms. Apart from discussing user charges we largely only examine the reforms affecting the delivery of hospital services for illness and accident as this is where the most radical changes have occurred. The changes of most significance for the purposes of this paper are described in detail when we analyse the reforms from both demand side and supply side perspectives.

**Demand side reforms**

1. A regime of targeted user fees that included introducing, for the first time since 1938, partial user charges for public hospital care.

2. The disbandment of the predominantly elected members of the fourteen Area Health Boards, which had previously been responsible for the purchase of most hospital care and had also managed the major public hospitals. The proposals provided for the separation of the Boards’ purchaser and provider roles.

3. The establishment of four Regional Health Authorities (RHAs) to act as purchasing agents with available government funds of primary and secondary care for illness, accident and disability suffered by citizens residing within their respective regions.

4. Provision for the eventual establishment of private health care plans as alternatives to the services offered by the RHAs to which individuals could shift their allotted portion of government funding, which would otherwise be spent by an RHA.

5. Public consultation by a government appointed committee to define a list of “core health services” that must be available without charge or at “affordable” prices. RHAs and private plans must purchase core health services as a matter of priority for those individuals for whom they are responsible.

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\(^{62}\) Hirschman, ibid, p 83.

\(^{63}\) Hirschman, ibid, p 79.

\(^{64}\) Upton, above, n 8, p 9.
The separation of responsibility for the purchasing of public health services from other types of health services, and the establishment of a Public Health Commission to purchase public health services from public and private providers. 65

The transfer of responsibility for the purchasing of disability support services from a variety of government departments to the RHAs. 66

Supply side reforms

The restructuring of public hospitals (approximately 100) into 23 special government-owned companies known as Crown Health Enterprises ("CHEs"). CHEs will compete with each other and private secondary care providers for supply contracts with the four RHAs.

The 1991 proposals for reform provided that, subject to economic viability and government approval, small hospitals would be run as community trusts. 67

Demand side analysis

User charges

Since 1941, government subsidies have failed to keep pace with the fees charges by general practitioners. Prior to the reforms, the real value of the General Medical Services Benefit had fallen on average from around 75% of the total fee when it was first introduced to less than 20%. 68 In addition to the 1991 structural reforms, the National government introduced a regime of targeted user charges, which abolished subsidized general practitioner visits for many New Zealanders, increased pharmaceutical charges and introduced for the first time since 1938 partial user charges for care received in public hospitals. 69 This latter reform led to such a public outcry that it was eventually abandoned. 70 Targeting of subsidies and charges for general practitioner fees and pharmaceutical costs on the basis of income status survived the public furore. In order to avoid paying the highest rate of charges for these services, "low and modest income earners" must now

65 See the definition of "public health" at footnote 33.
66 Although a significant innovation, due to constraints of time and space this paper will not discuss this particular reform. Although there may be benefits flowing from this particular reform we note that it would have been possible for this reform to have been implemented within the confines of the old system i.e. making the old Area Health Boards responsible for the purchase of disability services. For a discussion see Carter, "Disability Support Services and the Reforms" (1994) 29:1 & 2 Health Policy, p 25.
67 These trusts, once established, have to compete equally with CHEs and other providers for contracts with the RHAs or private plans. For a discussion of the operation of community trusts see Malcolm & Barnett, "New Zealand's Health Providers In An Emerging Market" (1994) 29:1 & 2 Health Policy 85, p 95.
68 Ashton, above, n 11, p 149. Primary care for some groups has continued to remain completely subsidized. For example, pregnant women receive free general practitioner care for matters relating to their pregnancy. Also, prior to recent reforms of the accident compensation system, accident victims received free general practitioner care. The usual cost of a consultation is approximately NZ$35 and accident victims must now pay between NZ$10 and NZ$15 thereof.
69 For a description of the new user-fees regime see Ashton, "Charging For Health Services—Some Anecdotes From The Antipodes" in Malck et al (ed), Strategic Issues in Health Care Management (Great Britain, 1993), p 9.
70 The newly appointed Minister of Health, Bill Birch, with a national election looming, announced the abandonment of user charges for public hospitals on 1 April 1993.
present an entitlement card—the "Community Services Card". We argue that user charges do nothing to improve the efficiency or fairness of a health system.

The introduction of user charges may seem justifiable in simple economic terms. The introduction of part or full charges should operate as a rationing mechanism informing patients, to some extent, of the real cost of health care services they want to consume. Patients will restrict their demand for health care services to those they value the most. It is argued that a "moral hazard" problem arises if health services are free—patients will consume services that are not cost-efficient and consume more services than needed, resulting in an explosion of health care expenditure. Moral hazard is, however, ameliorated in the health services market by virtue of the information asymmetry factor, which as we discussed earlier, exists between patients and providers. There are very few patients that enjoy consuming unneeded health services and, in general, a patient will only consume health services advocated by his or her physician. The difficulty is that with third-party payers (whether private insurers or the state) providers have no incentive to choose the most cost-efficient treatments for patients. The imposition of user charges does not affect this phenomenon as most of the costs of utilization (at least those incurred by those on higher incomes) are passed on to private insurance companies.\textsuperscript{71}

Stoddart and others argue that patient-initiated abuse does not comprise a large proportion of total health care expenditure as patients are not able to initiate many expenditures, ie, call-back visits, referrals, hospital admissions and prescriptions.\textsuperscript{72} They note that, in Canada, physician services make up about 16–20% of all health care expenditures, and a patient may initiate access (without referral), to about half of those services. Of that 8–10%, however, some of those visits will be return visits (initiated by a practitioner) and most of the patient-initiated first visits are in response to a genuine need. They speculate that the percentage of total health care spending generated by patient-initiated abuse is less than 1%.\textsuperscript{73}

Stoddart and others also note that because patients do not have sufficient information to make correct judgements about service needs, user charges are likely to result in a fall in consumption of both necessary and unnecessary services—patients engage in self-diagnosis.\textsuperscript{74} A United States study by the RAND Corporation supports this claim.\textsuperscript{75} The patients most likely to reduce consumption of both necessary and unnecessary services are those that are "price-sensitive", who are most likely to be the poor.\textsuperscript{76} Stoddart and others refer to the imposition in Saskatchewan between 1968 and 1971 of a flat fee user charge of Canadian $1.50 (about $6.00 in today's prices) for a physician office visit. The charge reduced the annual per capita use of physician services by 6-7%, but for low-

\textsuperscript{71} Differential premiums (based on consumption of services) may provide an incentive (although somewhat muted) for patients to demand from their physicians the most cost-effective treatment.


\textsuperscript{73} Stoddart et al, ibid, p 6.

\textsuperscript{74} Stoddart et al, ibid, p 7.

\textsuperscript{75} Lohr, Brook, Kamberg et al, "Use of Medical Care in the Rand Health Insurance Experiment: Diagnosis and Service-specific Analyses of a Randomised Controlled Trial" (1986 Supplement) 25 Medical Care, p 531 as cited by Stoddart et al, ibid, p 6.

\textsuperscript{76} Stoddart et al, ibid, p 7.
income people the reduction was around 18%. Since 1941, New Zealanders have had to pay an increasing proportion of the cost of a visit to a general practitioner. These user charges for primary care, impacting as they seem to do mostly upon the utilization of health services by low income groups, explain New Zealand's poor record in securing equal access for different socioeconomic groups and the relatively poor health status of Maori. User charges for general practitioner care provides an incentive for poor patients to delay seeking treatment which may result in greater overall costs if the ailment or injury worsens as a result of a delay in seeking treatment. While the government can reduce health expenditures in the short term through user charges, it must consider the impact of user charges in terms of allocative efficiency. User charges are likely to increase overall expenditure on health care and reduce the effectiveness of the system. Inconsistent levels of user charges for different kinds of health care results in perverse and inefficient incentives. For example, patients still have an incentive to utilize hospital care at an average real cost of NZ$600 per day (but free to the patient) rather than general practitioner care which costs much less to produce but for which the patient must pay.

In order to reduce the burden of user charges on the poor, the 1991 proposals for reform provided for the population to be divided into three income categories: low (Group 1), modest (Group 2) and high (Group 3). It should be noted that although “low and modest” income earners now pay lower user charges than “high income earners”, all patients no matter how sick or poor are required to pay a proportion of the cost of a visit to a general practitioner and for pharmaceuticals. “High income earners” include any family not eligible for family support, most of the elderly earning private income and single people earning over NZ$17,500 pa. Under the new regime these “high income earners” receive no subsidy with respect to the cost of visiting a general practitioner (unless a child or diagnosed as chronically ill in which case a partial subsidy is paid) and have to pay up to NZ$15 per prescription item (unless diagnosed as chronically ill in which case the charge is NZ$3 per prescription item) up to a maximum of 20 prescription items per annum.

Ashton argues that the criteria for qualification for the category of “high” income earners is set too low, and accordingly problems of access and utilization have been shifted slightly up the scale from the very poor to the not so poor. Issues of distributive fairness arise, as a single person earning NZ$17,500 pays the same for health care services as a single person earning NZ$60,000, and user charges in general result in the sick paying more than the healthy. An estimated 45% of the total population has private insurance. The expansion of private insurance in New Zealand in recent years has had negative distributional consequences. Whereas about half of households with incomes in the top quarter are covered, fewer than 20% of those in the bottom quarter have private insurance. User charges will have a small impact on the purchasing decisions of those on higher incomes with “gap” insurance (that is, insurance compensating for the

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77 Refer to footnotes 5 and 6.
78 Ashton, ibid, n 69, p 12. Originally “high income earners” were required to pay NZ$20 per prescription item. Concern over access encouraged the National government to lower this charge to NZ$15 per item from 1 February 1993. However, at the same time the maximum number of times an individual could be charged for prescriptions per year was increased from fifteen to twenty.
difference in cost between the government subsidy and the actual charge).  

Although all New Zealanders will have to continue to pay some level of user charges for general practitioner care and pharmaceuticals, the brunt of user charges will be felt by those on low incomes who do not qualify for the government’s Community Services Card and who cannot afford private insurance.

Serious consideration should be given to abolishing user charges for general practitioner care. The focus should not be upon attempting to restrict demand for health services by user charges, but to provide incentives for providers to choose the most cost-effective treatments through more innovative reimbursement arrangements than the current fee-for-service regime. If the government were the sole funder of needed primary and secondary care then not only would the system be fairer but the government’s purchasing power would be enhanced. Experience in other countries would tend to suggest that, therefore, total health care costs would be contained and fairness enhanced. Although total government expenditures would increase, total health care expenditures would be reduced, and the overall efficiency of the system improved.

2  Core health services

In 1991, the National Advisory Committee on Core Health and Disability Support Services (“the Core Services Committee”) was appointed. The government’s goal in establishing the Core Services Committee was to receive independent advice on the health and disability support services that should be purchased by the RHAs and private plans in order that people have access to effective services on fair terms with due regard to the government’s limited fiscal means. It was proposed that core health services be available to everyone on affordable terms and without unreasonable waiting times.

In the past, resource allocation and rationing decisions with respect to secondary services have been made by individual providers on a case-by-case basis. Concern has been expressed that providers treat patients in a manner that satisfies the provider’s own professional judgement—whether through the use of expensive technology or expensive drugs—without regard to the costs and benefits of the treatment. There is also concern that the more articulate, influential and wealthy are able to use their influence to persuade providers to let them queue-jump waiting lists for New Zealand’s public hospitals. Identification of the core services is important not only as a mechanism for rationing in the face of seemingly unlimited demand for health services but also, in the event of private plans being established, to help clarify the differences between competing plans and to prevent health plans from varying available services to avoid high-risk patients.

Attempting to define the core services is not without its perils. The Core Services Committee is a bureaucracy comprised of government-appointed officials who, accord-

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80 Heylen Survey conducted in July 1989. As a proportion of total health expenditure private insurance expenditure rose from 1.1% in 1980 to 3.5% in 1991 and private out-of-pocket expenditure rose from 10.4% in 1980 to 14.5% in 1991—Muthumala & McKendry, above, n 9, pp 11, 29.


82 Upton, above, n 8, p 75.

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ing to public choice theory, are assumed to make decisions which further their own self-interest. Mandatory public participation in the decision-making process may help ameliorate this problem. Appointment of committee members for one fixed term could also reduce the risk of committee members making decisions with a view to reappointment or unduly favouring particular interest groups.84

Defining the core services is a difficult process requiring a balancing of enormously variable and culturally driven factors. Defining health entitlements in a broad fashion brings into focus the dilemma of how a health system draws a line between an approach which concentrates on individual suffering and need and the utilitarian approach of ensuring the greatest health to society as a whole.85 Brahms notes that defining the services that the RHAs must purchase from providers may impact upon clinical freedom and that defining the core involves making implicit statements about the value and worth of the aged, chronically ill, infirm and mentally impaired.86 There are complex ethical problems involved in trading off competing interests in order to define the core. Despite these difficult ethical problems, if one accepts that rationing decisions were being made previously by providers on a case-by-case basis without concern for larger issues relating to the most appropriate allocation of limited resources, then as difficult and as hazardous as defining the core is, it surely must be an improvement over the previous situation.

The state of Oregon has attempted to rank priorities for its Medicaid programme. In order to ascertain the preferences of citizens about the relative value of medical treatments, Oregon officials conducted a public survey and held eleven public hearings and forty-seven town meetings.87 The end result was a comprehensive list of medical conditions and treatment each ranked according to costs and benefits. This process was quite controversial, but the initiative has been praised as recognizing that decisions about priorities and the balance between the public and private good must be arrived at through the political process.88 However, because the services being defined as "core" by the broader community were for consumption of those on Medicare (ie, the non-working poor) a cynic may query whether the broader community would find it as feasible to define core health services for consumption by the community as a whole.

In its first report of 31 October 1992, the Core Services Committee recommended that those health services provided by Area Health Boards and private organizations prior to implementation of the structural reforms be simply rolled over for the first year of operation of the new system (1993/1994). The Committee made some other very broad recommendations including that more emphasis should be placed on ensuring that Maori receive effective primary care services; regional differences in consumption of health services be examined to ensure consistency and equity; waiting lists be scrutinized to ensure fairness; health information and statistics be collected and standardized databases

84 Bergthold, ibid, p 108.
87 Bergthold, above, n 83, p 107.
88 Callahan, above, n 85, p 10.
be adopted by all RHAs; and, in the long term, more emphasis be placed on quality rather than quantity of life.\textsuperscript{89} No specific list of services has been compiled nor have services been prioritized. The Committee did make recommendations as to the guidelines to be used by the RHAs in purchasing decisions within ten clinical service areas. Some of the recommendations were quite specific, making hard decisions as to who is to have priority in terms of receiving health services.\textsuperscript{90}

Borren and Maynard suggest that the reforms should have provided for the size of the core to be determinative of the public budget for health care as this would provide a more rational basis for determining what government funds are provided to the RHAs. Attempts to define the core may be beset by the problem that more and more services may be included in the core. This problem may be reduced if the core were ranked in order of importance (at least at the margin) so that available government funding is used to purchase core services in the order in which they are prioritized—those that are of relatively low priority may not be purchased but this would be a decision made by government and subject to public scrutiny.

It now seems that the Core Health Services Committee will not complete the process of defining the core services. In our opinion, the process of defining the core services was one of the most important reforms with the potential to help improve the fairness with which resources are allocated. This importance is no less diminished by the absence of private plans. The Committee has shied away from specifically defining and prioritizing core health services—which leaves both purchasers and providers with more flexibility but does nothing to ensure a consistent range and quality of services across the nation.\textsuperscript{91} Moreover, without a list of core health services it will be difficult for the performance of the RHAs and CHEs to be compared.\textsuperscript{92}

3 Dissolution of Area Health Boards and the splitting of the purchaser and provider functions

On budget night in July 1991, the predominantly locally-elected members of the Area Health Boards were summarily disbanded. The Area Health Boards had previously not only decided what hospital services to “purchase” with available government funding but had also, through the control of the public hospitals, provided most of these services. One of the problems identified in the system prior to the 1991 reforms was the tendency of Area Health Boards to purchase their own services rather than those of private providers who, objectively, may have been more efficient. The Area Health Boards had no incentive to contract with private providers as this could result in under-use and eventual closure

\textsuperscript{89} The Core Committee Report, above, n 81, p 12.
\textsuperscript{90} The Core Committee Report, ibid, pp 13–14. For example, it was recommended that in “usual circumstances” people over 75 years of age should not be accepted for “end stage kidney failure” services nor should children under five years, unless there is a reasonable prospect of a kidney transplant from a live donor. It was recommended that individuals be excluded from the kidney programme if they are likely to continue serious substance abuse, or are violent or exhibit other “major antisocial behaviour that causes difficulty with treatment and for staff and other patients”.
\textsuperscript{91} Scott, “Reform of the New Zealand Health Care Sector” (1994) 29: 1 & 2 Health Policy 25, p 27.
of the Boards' own hospitals. Essential to the 1991 reforms was the notion that the purchasing and providing roles of the Area Health Boards be split and performed by independent entities.

The National government envisaged that this change would lead to transparency, so that the true costs of production inputs could be revealed. It was also thought that this would create incentives for providers—particularly the public hospitals—to operate efficiently in order to secure contracts for the supply of health services with purchasers (the Regional Health Authorities ("RHAs") or, if established, private plans). However, efficiency-enhancing incentives will only exist if the RHAs can either abstain from purchasing health services (which seems unlikely given their statutory mandate) or purchase services elsewhere in the event that existing providers do not perform efficiently—ie, to exploit competition in the provider market. Because of the geographic spread and small size of the New Zealand population, in many areas and in respect of many services, there are no effective competitors to the incumbent public hospitals nor are effective competitors likely to emerge because of the economies of scale involved in the operation of an efficient hospital.93

It is interesting to note that while New Zealand is setting in place a system where the purchaser and provider functions are split irrespective of efficiencies, the United States is beginning to appreciate the benefits of integrating the purchaser and provider organizations through “Health Maintenance Organizations”.94 Borren and Maynard argue that an indiscriminate purchaser-provider split will increase management and administrative costs and is unlikely to result in any real changes in the services provided by hospitals or their respective market shares.95 Intuitively, one can agree that the establishment of twenty-seven new entities (four Regional Health Authorities and twenty-three Crown Health Enterprises) is likely to result in higher administrative costs than fourteen Area Health Boards. The establishment of the RHAs adds another layer of government bureaucracy to the system, which according to public choice theory expands the opportunity for misallocation of resources. Moreover, as will be discussed below, there will be significantly higher transaction costs involved in negotiating, writing, monitoring and enforcing contracts of supply.

4 Private health care plans

It was originally envisaged that once the four Regional Health Authorities ("RHAs") were established, private health care plans would also be established, and would compete with RHAs to provide services to patients. The proposal to establish private plans had now been put aside by the National government because of public opposition to what was perceived as the "Americanization" of the health system. It is, however, important to

93 Ashton, above, n 11, p 155.
discuss this proposal, as there is the prospect that it will be resurrected in the future, and there is provision for the establishment of private plans in the Health and Disability Services Act 1993 ("the Act").

Originally it was proposed that citizens would be allowed to exit their RHA and take their entitlement to government funding with them to pay the annual fee of their preferred private health care plan. Those who had a higher risk of needing to consume health care services would take a larger entitlement to funding with them in order to encourage private plans to enroll these individuals. The prospect of losing funding by way of "exit" of disgruntled patients would be an incentive for RHAs to act efficiently and to be accountable. Private plans would have to offer all those who chose to shift from the RHA to their (particular) plan at least the core health services and could charge premiums in addition to the government funding received.

The establishment of private plans was an integral component of the 1991 structural reforms. Without the threat of exit by individuals within a region from their relevant RHA (and, more importantly, the loss of government funding consequent upon such exit), there would be less incentive for the RHAs to operate efficiently and to respond to patient demand. In a post-election briefing to the incoming government in 1990, Treasury stated: "A separate funding agency would face less pressure to place institutional or employee interests ahead of the interests of patients". However, Treasury went on to note:

... if the separate funding agencies are the monopoly purchasers of publicly funded hospital services for the community, they present the same difficulties as existing arrangements. They too face the problems of establishing communities' demand for services through administrative and political processes.

The raison d'etre for the split of provider and purchaser roles was to foster competition at both the provider and purchaser levels. Competition between RHAs and private health plans would ensure competition at the provider level as purchasers would have to ensure that they were contracting with the most efficient providers. As we shall discuss, however, contracting out is not necessarily the most efficient means to provide health care services. RHAs are prohibited under the Act from producing health care services, even though this may be the most efficient means of production. Private plans will have a competitive advantage if established as it was not proposed that private plans be forced to split the purchaser and provider roles.

The National government proposed that private plans would be responsible for purchasing not only elective surgical services but also all core health services. It was thought that by making the private sector responsible for the provision of all services—including those involving high-risk and high-cost, and not only elective surgery—this would result in some of the costs and risks associated with the delivery of the less profitable, yet necessary, services being shifted to the private sector.

96 Pursuant to s 20(c) of the Health and Disability Services Act, the Minister of Health could sanction the establishment of private plans without further legislation although, in reality, a great deal of regulation would have to be put in place before private plans could be a viable option.

97 Upton, above, n 8, p 61.
The original proposals for private plans did not provide for regulation to require private plans to accept every individual who wished to enrol in their particular plan, and therefore there was a risk that private plans would seek to cut costs by enrolling only individuals with good health status and/or high incomes ("cream-skimming"). It was hoped that this problem would be alleviated by allocating high-risk individuals larger entitlements to government funding, in order to encourage private plans to accept such individuals. However, such entitlements would presumably be set in large part according to sex, race, income, and age criteria, as opposed to actual health status (which would be administratively very difficult), and there would be nothing to stop the private plans “cream-skimming” the healthy, as opposed to those with a personal or family history of ill health, from the pool of those with higher funding entitlements. The individuals that the private plans would try to attract would be the very individuals less likely to utilize the high-risk and high-cost services of the public hospitals. Their entitlement to funding would be shifted away from the RHAs, which would then have fewer resources to maintain the large capital outlay required to operate major surgical wards. In other words, the public sector would no longer benefit from the good health status of the wealthy—the private sector would.

Ashton and others criticized the government’s proposals to establish private plans on the basis that competing private plans would:

... increase administration costs, weaken the bargaining power of RHAs, introduce additional problems concerning equality of access to care, and undermine any long-term service planning.

Moreover, as noted by Ashton, empirical studies showed that selective contracting was more effective in containing costs where a large proportion of a provider’s revenue was sourced from a single dominant purchaser.

Ashton contends that, in light of this evidence and the cost pressures associated with multiple purchasers in the United States, the replacement of demand-side competition by regulatory reporting requirements for RHAs was an appropriate decision. The National Government eventually acknowledged the strong public opposition to the creation of private plans and agreed that the issue would be set aside.

In the absence of the possibility of exit by dissatisfied individuals to private health care plans, patients cannot use exit as a mechanism to force the RHAs to behave efficiently and they will have to rely on the voice of those quality conscious individuals who have the time and political influence to agitate for improvement. The wealthy and the insured are able to contract with private providers independently of the government-financed system, but the RHAs do not lose any entitlement to government funding as a result. The wealthy and the insured are not forced to use their voice to agitate for improvement within the government financed system. Those on lower incomes will likely continue being trapped in a progressively deteriorating government-financed system. To improve the reformed

98 Ashton, above, n 35, p 12.
99 Ashton, idem.
100 Hon S Upton reported in Hansard, Health and Disability Services Bill—Introduction, 20 August 1992, 10773, p 10776.
system either exit and/or voice must be enhanced. Enhancing either exit or voice within
the present structure of the reforms arguably requires the establishment of private plans.
If one relies on exit, then the existence of private plans is crucial. If one relies on voice,
then the possibility of exit to private plans should be an option, for without the possibility
of exit, voice is not as effective as an efficiency-enhancing mechanism. On this basis,
serious consideration should be given to establishing private plans and mitigating some
of the problems identified by Ashton and others in their establishment.

Given that RHAs do not bear the same risk of insolvency as a private firm, one may
consider that “exit” would not work as an efficiency-enhancing mechanism to the same
degree as it would if RHAs were private firms. “Exit” can still work as an efficiency-
enhancing incentive, however, if management contracts are designed to measure and
reward performance on the basis of the number of patients the RHAs service and if
managers know that unless they perform they will be replaced.

There is a justifiable concern that private plans would cream off healthy patients.
Undoubtedly, there would be an incentive to do this but regulation could help to
ameliorate the problem. For example, regulation could require that private plans accept
all those who apply. Concern that private plans will attempt to cream off “the wealthy and
the healthy” by the types of services offered and extra charges made could be alleviated
by insisting that private providers offer a basic package of core health services without
user charges to everyone enrolled in the plan. One of the problems of introducing private
plans is that they may try to compete with each other and the RHAs by offering more and
artificially-differentiated services which may make it difficult for patients to compare
alternatives and may result in higher premiums. Regulation requiring a basic package
of core health service with “no-frills” would also help alleviate this problem. Fielding &
Rice note that private plans could still attempt to disenroll the more costly patients. They
suggest that plans should be made to report and publish the use and cost experience of
disenrollees, which could alert patients as to which plans have a tendency to “dump” sick
patients. Of course, this proposed regulation would not be without cost. Moreover, as
Field & Rice note: “History provides the clear lesson that all regulation has unintended
effects”. However, regulation is necessary to ensure that the creation of private plans
spurs efficiency-enhancing competition (where appropriate) at both the purchaser and the
provider level. Without private plans the reforms seem likely to generate more inefficien-
cies and result in a less accountable system than that which existed previously.

It is true that multiple purchasers are often associated with inflationary cost pressures. The
addition of many private plans may aggravate the problem of fragmented funding and
make it more difficult to implement a seamless approach between primary, secondary and
public health care for illness, accident and disability. However, the number of private
plans that come into existence could be indirectly controlled by regulation specifying
minimum levels of assets and shareholder funds. Given that private providers would have
to undertake to provide core health services for all citizens within one of the four regions
for which an RHA would otherwise be responsible (by way of in-house production or

101 Fielding & Rice, above, n 36, p 218.
102 Fielding & Rice, ibid, p 222.
contracting with CHEs or private providers), the size of this undertaking would tend to suggest that relatively few private plans will actually come into existence.

Expenditure on health care is likely to be contained irrespective of the development of private plans provided that the government is the single dominant purchaser of health care. Although there may be four RHAs and a number of private plans, the government can set a limit on monies spent by requiring that RHAs and private plans purchase all core health services on behalf of the individuals enrolled within their respective plans and prohibiting user-charges for the core health services. As discussed below, currently, the government is not a single dominant purchaser of health care, as there is a large component of private expenditure, particularly on general practitioner care. The best way to contain escalation of health spending may be for the government to take responsibility for funding all core health services, whether primary or secondary. This would both pool purchasing power and set an upper limit on health expenditure for those services.

"Voice" should also be encouraged as a mechanism for ensuring the efficiency and accountability of the RHAs and private plans and, indirectly, the public hospitals and private providers they contract with. One possible mechanism for enhancing voice would be to prohibit private insurance and user charges for the core health services. Although it may seem inconsistent that on the one hand we are advocating private plans and on the other recommending regulating against private insurance, this arrangement would encourage quality conscious citizens to lobby for improvement within the publicly funded health system. Dissatisfied patients could shift their share of government funding from RHAs to private health plans and vice versa, but the absence of private insurance would discourage them from contracting out of the publicly funded system—at least for core health services. It is important that the core services (to be paid for by government) be defined so that the public know what services they can expect to be provided by the RHAs. This will help the public to use "voice" to ensure efficient performance on the part of the RHAs. Other possible mechanisms that the government could put in place to enhance voice include: establishing (as already proposed) a health commissioner and a code of health consumers' rights. In this latter regard the code could be extended to a right to receive core health services where it is considered medically necessary. Other potential mechanisms for enhancing voice include encouraging patient advocacy groups; requiring RHAs and private plans to establish regular public meetings and publication of the steps proposed to be taken as a result of public consultation; and requiring that some or all of the members of the RHAs be elected by citizens within the region.

Regional Health Authorities

The 1991 proposals for reform of the health sector provided for New Zealand to be divided into four regions. Four Regional Health Authorities ("RHAs") were established as bodies corporate under the Health and Disability Services Act 1993. With the government funding they receive, RHAs must purchase primary and secondary health services. covering illness, accident and disability from Crown Health Enterprises and

103 The Health and Disability Commissioner Bill was originally introduced in 1990, held-over, and passed through its second reading on 16 June 1994. It was enacted on 20 October 1994.
104 See definition of primary and secondary health care services, above, n 3.
private providers (private hospitals, general practitioners, community trusts, etc) for the citizens within their respective regions. The funding that a particular RHA receives from government depends upon the number of people in its region, and the likely health status of these citizens. Our discussion of RHAs will be divided into three parts: RHAs as monopsony purchasers; the independence and accountability of the RHAs; and contracting by the RHAs.

(a) RHAs as Monopsony Purchasers and the Integration of Primary and Secondary Care
Within their respective regions and in the absence of private plans (discussed above), it is assumed that RHAs will have monopsony buying power that will enable them to negotiate advantageous contracts with public (Crown Health Enterprises) and private providers. Earlier we identified a government's monopsony buying power as helping to contain costs in single-payer systems such as New Zealand and the United Kingdom. However, RHAs will not be monopsony purchasers of some crucial health services as they will not have control over the significant proportion of private expenditures on primary health care services nor expenditures on public health care services. It also seems likely that the RHAs will have difficulty controlling expenditures by the Accident Rehabilitation and Compensation Insurance Corporation which administers New Zealand's no-fault accident compensation scheme.

First, unlike the proposed regional health alliances in the United States, the RHAs will not co-ordinate or manage the purchase of health services paid for privately—either out of patients' own pockets or through private insurance. For the year ending June 1991, of the total spent on institutional (or secondary) care in both private and public hospitals, 3.68% was paid for by the private sector. This percentage seems low but is artificially so, as the figure for total expenditures include expenditures on long-stay geriatric and mental health care (23.47%) which would not be covered by private insurance. Those who receive treatment in private hospitals generally have private insurance, are on higher incomes, and statistically are in better health. Although those on higher incomes may have no cause to utilize private hospitals, they have the security of knowing that private care is available if they need it and thus have less of an incentive to lobby for improvement in public hospitals.

While private expenditure on secondary care may not be appear high in New Zealand, the same is not true of primary care. For the year ending June 1991, of the total spent on

105 For example, see Sharp, "Health Policy, Quasi-Markets and Purchaser-Provider Contracts" (unpublished and undated paper, Dept of Economics, The University of Auckland), p 3.
106 For a discussion of how competition within the United States' health care system was originally envisaged as being managed by regional health alliances, see Enthoven, above, n 32, p 24. For a criticism of the concept of "managed competition" as interpreted by the Clintons, see Butler, Unhealthy Alliances: Bureaucrats, Interest Groups, Politicians, and Clintons' Health Alliances—a draft paper prepared for the American Enterprise Institute Conference on Budget and Regulatory Aspects of the Clinton Health Care Plan, 22 February 1994.
107 NZ$2,974,085,000 was spent in total on institutional care and NZ$109,334,000 was paid for by the private sector—Muthumala & McKendry, above, n 9, p 55, Appendix 4J.
108 Of the NZ$2,974,085,000 spent in total on institutional care, NZ$697,936,000 was spent on institutional care for older people and the mentally ill—Muthumala & McKendry, idem.
“community care” (or primary care), 42.85% was paid for by the private sector. The former Minister of Health, Simon Upton, cited the integration of funding and coordination of primary and secondary care as one of the major reasons why the 1991 structural reforms should be supported. However, it is clear that integration extends only as far as primary and secondary services are paid for out of government funds. The RHAs will not control approximately 36.5% of all monies spent on general practice. This figure increases to 48.5% if funds spent by the Accident Compensation and Rehabilitation Corporation are taken into account. In addition the RHAs will not control 91.9% of monies spent on miscellaneous specialist services and 27.5% of monies spent on medicaments. The RHAs may have some leverage with respect to the type of purchasing decisions made by private consumers by making the purchase of certain primary care services from certain providers more attractive through the use of subsidies. The degree of leverage will depend to a large extent on what percentage of the actual cost of service in question the subsidy will cover. The abolition of subsidies for general practitioner care for the majority of New Zealanders defined as having “higher incomes” means it will be difficult for the RHAs to integrate and coordinate secondary and primary services consumed by those individuals.

The simplest way to integrate primary and secondary care would be for the government to purchase all primary as well as secondary care (ie, abolish user charges). Purchasing power would be pooled, which would assist in containing costs and the RHAs and private plans would receive funding that would allow them to produce or purchase from groups of providers an integrated package of health care services. This purchasing power could be reinforced by prohibiting user-fees for core health services—thus preventing cost escalation by providers. The integrity of the publicly funded core health services system could be protected by prohibiting private insurance for core health services so ensuring that more quality-conscious individuals remain within the publicly funded system and lobby for improvement where necessary. Within the publicly funded system, citizens could still have the choice of the RHAs or private health plans.

Unlike the old Area Health Boards, RHAs are not responsible for purchasing public

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109 NZ$1,959,802,000 was spent in total on community care of which NZ$839,750,000 was paid for by the private sector. “Community care” includes expenditure on general practitioner’s services, specialist services (diagnostic, physiotherapy, laboratory, and other), dental services and medications—Muthumala & McKendry, above, n 9, p 55, Appendix 4J.

110 Hon S Upton as reported in Hansard, Health and Disability Services Bill—Introduction, 20 August 1992, 10773, p 10775.

111 In the year 1990–1991, of the NZ$600.8 million spent on general practitioners fees 51.5% was paid for by state subsidies, 12.0% by the Accident Compensation Corporation, 26.5% by patients, and 10% by private insurance refunds—Muthumala & McKendry, above, n 9, p 32.

112 In the year 1990–1991, of the NZ$267.8 million spent on miscellaneous specialist services, 76.5% was paid for by patients, 15.4% by private insurance refunds, 5.2% by the Accident Compensation Corporation and 2.9% by state subsidies—Muthumala & McKendry, idem.

113 In the year 1990–91, of the NZ$710.9 million spent on medicaments (defined as including all substances used in curative treatment including medicines, dressings, syringes, other medical equipment and artificial limbs supplied by pharmacists or medical practitioners and excluding such items as sanitary towels, sun-glasses and cotton wool used for ordinary toilet purposes), 72.3% was paid for by state subsidies, 24.7% by patients, 2.8% by private insurance refunds and 0.2% by the Accident Compensation Corporation—Muthumala & McKendry, idem.
health services,\textsuperscript{114} which account for a small (3.3%) but important component of total health expenditure.\textsuperscript{115} The reforms, while attempting to integrate government funding of primary and secondary care, separated out responsibility for public health yet again.\textsuperscript{116} The Public Health Commission is now responsible for purchasing public health services for all New Zealanders. The National government considered that prior to the reforms not enough emphasis was placed on public health, the benefits of which may only occur in the medium or long term, and that public health expenditures were being squeezed by more immediate demands upon the Area Health Boards for more expenditures on hospital care. This concern could have been more effectively addressed by ear-marking government funding given to the Area Health Boards for public health expenditure and requiring annual reports as to the services purchased with those funds and the effectiveness of those services.

A problem that had existed in the delivery of health services prior to the 1991 reforms had been the fragmentation of funding for health services, particularly between the government and the Accident Rehabilitation and Compensation Insurance Corporation (“the Corporation”). Prior to the 1991 reforms the Corporation had an incentive to pay the private sector for care of accident victims to avoid the long waiting lists in the public sector, for the longer an individual was out of work, the higher the total income compensation paid to that individual from the Corporation’s funds. Funding by the Corporation of private institutions rose from NZ$3 million in 1982 to NZ$32 million in 1990\textsuperscript{117} before dropping to an estimated NZ$28 million in 1991.\textsuperscript{117} The Corporation’s contribution to total expenditures increased as a proportion of total health expenditures from 0.7% in 1980 to 4.2% in 1991.\textsuperscript{118} Individuals who suffered the misfortune of an accident received not only prompt and free secondary care (via private hospitals) but also free primary care, and so there was an incentive for both patients and doctors to expand the meaning of the word “accident”. The National government’s solution was to integrate funding for both sickness and accidents through the operations of the RHAs, so enabling the RHAs to have the benefit of a total purchasing programme.\textsuperscript{119} While prima facie the integration of funding for sickness and accidents seems logical, it is not clear that this change will alter the distorting incentives existing in the old system. For example, the Corporation will still have an incentive to purchase secondary care (albeit via the RHAs), which is available to patients without waiting, for otherwise it has to pay income-maintenance compensation for a longer period. Unless the performance of the public

\textsuperscript{114} See definition of public health at footnote 33.
\textsuperscript{115} Muthumala & McKendry, above, n 9, p 12 notes that this figure is down from the 6.5% spent in 1980. They note that these figures should be treated with caution given that they exclude public health activities undertaken by hospital boards and, subsequently, area health boards and that certain public health responsibilities were transferred from the Department of Health to area health boards in 1989.
\textsuperscript{116} Prior to the recent reforms, funding for some public health strategies within regions was a component of Area Health Boards’ bulk funding. This had not historically been the case, but had occurred as part of the transition from the hospital boards to the Area Health Boards.
\textsuperscript{117} Muthumala & McKendry, above, n 9, p 29 who also noted that the reduction from 1990 to 1991 may be attributed to the enactment of regulations in 1990 that generally limited the Corporation’s funding of health care.
\textsuperscript{118} Muthumala & McKendry, above, n 9, p 25.
\textsuperscript{119} Rt Hon B Birch as reported in Hansard, Health and Disability Services Bill—Second Reading, 1 April 1993, 14612, p 14616.
hospitals improves dramatically under the reformed system, it is likely that this care will continue to be purchased from the private sector where there are no waiting lists.

In summary, RHAs will not be monopsony purchasers of general practitioner care nor of elective surgical services. Given the incentives in the reformed system, the promised integration of primary and secondary care and illness and accident seems unlikely to eventuate. It is widely agreed that one area with scope for efficiency improvements is that of the primary care sector. However, the RHAs have agreed to retain fee-for-service payments for general practitioners at least until December 1995. RHAs will have to make a substantial commitment to integrating primary and secondary services and to reforming the primary care sector if significant efficiencies are to be realized. It is far from clear that RHAs are any better equipped for this task than the old Area Health Boards would have been if they had been given responsibility for the funding of primary as well as secondary services.

(b) The independence and accountability of the RHAs

The summary removal of the predominantly democratically elected Area Health Boards was characterized as the loss of a meaningless right. According to the then Minister of Health, Simon Upton: 120

> You could choose every three years some of the board members by way of an election, but one vote every three years, plus endless consultative committees and the potential for political paralysis, doesn’t add up to choice in my vocabulary.

However, the reforms as implemented in the Health and Disability Services Act 1993 provide little choice. Purchasing decisions are made by government appointed bureaucracies as opposed to democratically elected Area Health Boards. Patients cannot signal their displeasure with purchasing decisions by voting the decision-makers out of power or (at least in the interim) by shifting their allotted share of government funding from a RHA to a private plan. In circumstances where needed health services are either not provided by the RHAs or, if provided, are not of sufficient quality or not available without waiting, there are two choices available. The first is that patients can use their political voice to lobby for change within their RHA. This process is both costly and time-consuming. Few would be prepared to stay within the public system in an attempt to improve it while their health deteriorates. The second option is to pay for private care with savings or from private insurance (this is to be distinguished from the situation where an individual is able to shift her or his share of government funding from an RHA to a private plan). As a consequence, practically the only patients with real choice under both the old and the reformed health care system in New Zealand as it currently stands are those who can either afford to pay for private care or able to afford private insurance.

The RHAs were originally intended to be independent decision-makers who would, unlike the old Area Health Boards, not be tempted to make decisions favouring their own or institutional or employee interests as opposed to the best interests of patients. 121 Each RHA has a board of no more than seven directors. The Minister of Health appoints the

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121 See Treasury, Post-Election Briefing to the Incoming Government (Wellington, 1990), p 120.
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directors for a term of not more than three years but reappointment is permitted. The board of an RHA determines its directors' salaries up to a maximum set by the Minister of Health. The members of the RHAs therefore have an incentive, with a view to their own reappointment or other job opportunities within the public sector, not to make decisions that are politically unacceptable. Public choice theorists would not consider the transition from Area Health Boards to Regional Health Authorities to be helpful in mitigating the problem of government and bureaucratic inefficiency.

The Health and Disability Services Act 1993 provides specific opportunity for political input into the RHAs' decision-making processes. The government has to date issued two sets of guidelines to be followed by the RHAs in their purchasing decisions. The most recent set of guidelines provides (vaguely) that RHAs are "expected to develop processes of change and improvement", yet still they must obtain the Minister of Health's approval before making any significant changes to the existing range of services or the way they are delivered, or if they plan to change the level of user charges.

One reason why government delegated responsibility to the RHAs was to make it easier to rationalize the delivery of health care services: ie, closing hospitals and services in areas where, on a per capita basis, their continued operation is inefficient and using funding liberated as a result to provide services in other areas. The political principle of "do no harm" means that politicians are reluctant to be seen to be directly closing hospitals or cutting back on services in an area, even if resources are then able to be allocated to where they are more needed. Enthoven believes that only impersonal market forces can close down unneeded, inefficient activities. The RHAs, however, are not perceived by the public or the government to be so independent that their decisions have no political repercussions for the government. It has already been demonstrated that RHAs are far from immune from political manipulation. The government has directed the RHAs that in the first year of operation of the reformed health sector, the newly established Crown Health Enterprises (CHEs) are to receive at least 98% of the funds they received as public hospitals under the old system. While this action is understandable in terms of giving CHEs some comfort in planning, it largely undermines the whole basis of the reforms. The

122 Section 35(2) and the Second Schedule of the Health and Disability Services Act 1993.
123 Section 8 provides that, prior to entering into a funding agreement with a "purchaser" (the definition of which includes a RHA), the Minister of Health must give written notice of the Crown's objectives in relation to:
   (a) The health status of the communities served by the purchaser:
   (b) The health services or disability services, or both, to be purchased by the purchaser:
   (c) The terms of access to those services; and the assessment and review procedures to be used in determining access to those services or such of those services as are specified in the notice:
   (d) The standard of those services:
   (e) The special needs of Maori and other particular communities or people for those services.
The notice is required to be published in the Gazette and a copy laid before the House of Representatives—s 8(5) of the Health and Disability Services Act 1993.


125 Shipley, ibid, pp 4–5.
126 Enthoven, above, n 32, p 43.
127 Ashton, above, n 35, p 4.
reforms were designed to remove comfort buffers and inject tautness into the health sector, so encouraging providers to behave efficiently.

Unlike the old Area Health Boards, voters will not be able to manifest their dissatisfaction with RHAs’ decisions in the polls. Meetings of the new RHAs are closed to the public and the press, enhancing concerns over the democratic accountability of these institutions. This prompted one commentator to state that the health reformers had been: 128

... seized by a misconception that an absence of election removes any justification for Regional Health Authorities to work in the open. The more secretive regional health decision-making becomes, the more it will be suspected that the new authorities are mere instruments of Wellington’s direction. The suspicion will probably be right.

There are inherent conflicts in the mandate given to the RHAs. They are meant to be independent of politics when they are not. Moreover, the RHAs are expected to act both as the “government’s agent in securing universal access to publicly funded health and disability support services” and be the “champion of the people within their regions”. 129

In practice these dual objectives may conflict.

An RHA must consult with the residents of its region to determine what health services to purchase. 130 It is not clear from the Act what status these consultations have if an RHA concludes as a result that it should be providing a service that conflicts with the government’s objectives for the region of which it has been notified under s 8. As there is no actual requirement that the RHAs purchase those services that are suggested as a result of consultation, the government’s objectives will likely prevail in the event of conflict.

Presumably, the rationale for having four RHAs (as opposed to one central purchasing body) was to improve accountability to local health care users. Arguably, it is easier for RHAs than for one central organization to obtain public input about the purchasing decisions being made and the quality of care received. However, unless there are effective mechanisms for voice so enabling accountability to be improved, the administrative costs of running four RHAs may not be justified.

In short, there is an agency problem between the RHAs and the public within the regions that they represent. This problem is exacerbated because the public does not hold shares in the RHAs nor does it elect the members of the RHAs. Patients therefore have little meaningful opportunity to signal their dissatisfaction with the operation of their local RHA. One possible way would be for patients to shift their share of government funding

129 Upton, above, n 124, p 1
130 Section 34 of the Health and Disability Services Act 1993 provides that every RHA, in accordance with its statement of intent, is to consult on a regular basis:
in regard to its intentions relating to the purchase of services with such of the following as the authority considers appropriate:
(a) Individuals and organizations from the communities served by it who receive or provide health services or disability services:
(b) Other persons including voluntary agencies, private agencies, departments of State, and territorial authorities.
from an RHA to a private plan ie, “exit”. Currently this is not an option. The other option open to the public is to use political voice to agitate and lobby for improved performance on the part of the RHA. Earlier we suggested some ways of improving voice. Notwithstanding the implementation of mechanisms to improve the operation of voice, the more quality conscious individuals (who would be more likely to use their political voice to lobby for improvements within the RHAs) are the very individuals who are likely to hold private insurance. In the event that the services purchased by the RHA do not fulfil their quality criteria, the wealthy and the insured will obtain needed health services from the private sector with their own funding or with private insurance. The RHAs will have no financial incentive to improve their performance as, in the absence of private plans (to which patients can shift their allotted share of government funding), they will not lose any entitlement to government funding as a result of any particular individual obtaining health services with private funds from the private sector. The RHAs and the CHEs will in fact have a perverse incentive to encourage patients to spend private funds in the private sector as there will then be less demand for government-subsidized services and it will then appear that waiting lists are being reduced.

Responsibility for the supply of quality health services is now diffused between the Ministers of Health and CHEs, the Ministry of Health, the RHAs, the Public Health Commission and the CHEs. It is not clear who is responsible and, in the absence of an adequately defined core, what they are responsible for.

(c) Contracting by the RHAs with public and private providers

Unlike the old Area Health Boards, the RHAs are prohibited from owning hospitals or employing medical staff and are not permitted to provide medical services directly to the public. Referring to our earlier discussion of the theory of the firm and the “make or buy” decision, we can see that the government has removed that option from the RHAs. RHAs have to “buy” all health care services and cannot produce services themselves. Our earlier discussion of the “theory of the firm” suggested that contracting out (which the RHAs must do) is likely to be more efficient than “in-house” production where the desired service is easily described and the volume and quality thereof is able to be specified in advance; where the costs of contracting are low; and where production of the service involves few economies of scale and scope but large returns to specialization. The advantages of “contracting-out” also hinge on competition amongst providers of the services, for without competition providers may be able to extract monopoly profits from purchasers. These preceding requirements are often not satisfied in health service markets—particularly hospital services, and “in-house” production is, in general, likely to be more efficient than is contracting out. As Smith and Lipsky note:

... the problem of providing human services of high quality on a sustained basis is so different from the problem of producing standardized products at a fixed price (such as automobiles) that it calls into question the simple proposition that government could increase its general effectiveness by stimulating competition by purchasing services.

Williamson finds two problems with the prospect of government contracting out a natural monopoly through a competitive bidding process. First, there is the difficulty of designing a contract that accounts for unforeseeable future changes in service objectives, technology, input costs, and other factors. Building needed flexibility into a contract gives opportunities for abuse of monopoly power. The second difficulty is that incumbent contract holders have an advantage over competitors at contract renewal junctures as there will be a reluctance to cause disruption of supply by switching contractors. RHAs may be reluctant not to contract with CHEs even in the face of more efficient competitors. This is because CHEs may not survive without winning a substantial number of contracts from the RHAs and it would not generally be politically acceptable or in the RHAs’ interest to let the CHEs become insolvent. Also, a current contract holder already owns or has access to the relevant assets, has a specialized staff and is better informed about operating costs. Smith and Lipsky note that contracting out will not be efficient where it is important that there be a continuing relationship between the provider and the patient, ie, long term therapeutic care—such as AIDS clinics, and residential placement—particularly mental health services. They also note that where a long-term relationship is required, the public agency (in this case the RHAs) will forge close ties with the private providers. In this scenario the government’s vision of two independent entities periodically contracting in the market on the basis of price and quality alone looks implausible.

The quality of a health service and its appropriateness as a treatment for any particular patient is crucially important. However, it will be very difficult for RHAs to monitor providers so as to ensure that the quality of health services provided is high and the services provided are appropriate for the particular patient given his or her needs. As Smith and Lipsky note:

...most services cannot be judged on the basis of decisive client outcomes. They cannot be standardized in their treatment approaches, nor can auditors effectively intrude into the interactions between workers and clients to determine whether decisions were made appropriately and consistently with existing policy.

Donabedian has defined three components of health care quality: (1) structural measures, ie, the actual buildings, technology, and skilled labour required; (2) process measures—appropriateness of steps taken during a consultation or treatment; and (3) outcome measures—which address whether the treatment results in a desirable patient outcome. RHAs will tend to stipulate structure and process measures in contracts with Crown Health Enterprises and private providers as outcome measures are difficult to specify and to monitor. This may result in providers being able to reduce quality and lead to a lack of innovation as providers are reluctant to change practices that satisfy the RHAs’ stated quality standards.
The costs of contracting will not be low in the New Zealand health care system as RHAs do not have information about the costs of production faced by providers—particularly for hospital services. This is not as severe a problem where there is competition in provision but, as discussed earlier, there is unlikely to be competition in the provision of many hospital services. Monopoly providers will be able to extract profits by taking advantage of this information asymmetry and all providers will have an incentive to cut quality where this is difficult to detect.

The funding contracts between the government and the RHAs and the specific requirements of the Health and Disability Services Act 1993 effectively impose a statutory mandate that means the RHAs do not have a real option of abstaining from purchasing certain basic services. Therefore, the RHAs may have no bargaining leverage with providers who hold a monopoly on the provision of medical services in a particular region as it is not credible for the RHAs to threaten to abstain from purchasing certain necessary services.

We suggest that the purchaser/provider split is unlikely to be very successful. We simply raise the possibility here of allowing RHAs to provide health services by reamalgamating RHAs and Crown Health Enterprises into public health plans if they so choose. To ensure the honesty and efficiency of such public health plans and that contracting out occurs where this is more efficient than in-house production, mechanisms should be put in place (as discussed earlier) that enhance voice and that allow exit (with an individual’s share of government funding) to private plans. To ensure exit works as a recovery mechanism the remuneration of decision-makers within the RHAs should in part reflect the number of people exiting to a private plan.

Supply side analysis

1 Crown Health Enterprises

The 1991 proposals provided for approximately one hundred public hospitals together with other clinics and diagnostic centres (all formerly under the control of fourteen Area Health Boards) to be restructured into twenty-three special companies in order to mimic private firms’ behaviour and to improve efficiency. These new entities are known as Crown Health Enterprises ("CHEs"). In essence, CHEs are expected to be the “providers” of secondary health care services. They are expected to compete with other CHEs and private providers and to seek and negotiate contracts with RHAs (and private plans if they are subsequently established) for the delivery of health care services.

The National Interim Provider Board, appointed in August 1991, advised that it was crucial to the success of the health reforms that CHEs operate according to key principles used by all good business-like organizations, whether privately or publicly owned. Those principles were said to be: (1) clear commercial objectives; (2) high quality directors, replaced expeditiously if they fail to perform; (3) performance objectives set by shareholding ministers; (4) an arm’s-length relationship between the government and

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136 For example, s 10 of the Act provides that, in addition to meeting the Crown’s objectives, RHAs must, to the extent enabled by their respective funding agreements with the Crown:

... promote the personal health of people; promote the care or support for those in need of personal health services or disability services; and promote the independence of people with disabilities.
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operational management; (5) transparent subsidies where the government wants to provide extra assistance to purchase services that would otherwise not be commercially viable; (6) a competitively neutral environment in which public hospitals have no advantage or disadvantage over alternative suppliers, and win their contracts through the efficient delivery of quality health services; (7) managers with the autonomy to make effective use of resources; (8) mechanisms that hold them strictly accountable on a performance basis, measured against the Minister’s goals and targets.137

The shares in the CHEs are held by Ministers of the Crown.138 The directors of the CHEs are appointed by the shareholding minister.139 In response to fears of privatization of the public hospitals, s 38 of the Health and Disability Services Act 1993 specifically prevents the shareholding ministers from selling or allotting shares other than to each other. However, there is nothing to stop a CHE selling assets to private interests—for example its buildings, plant, supply and service contracts—thus leaving the legal shell of a CHE without substance.

In terms of agency theory, the establishment of CHEs will not help in ensuring that the directors and managers of CHEs are more accountable to the New Zealand public (their ultimate owners) or more efficient than the old Area Health Boards. Possibly surrogate types of mechanisms could be used to encourage managers of CHEs to operate them efficiently. In particular, efficiency-enhancing incentives could be build into management contracts. However, these contracts are likely to measure managerial performance on the basis of cost-reduction and throughput, and it will be unlikely that they will help to ensure the quality of health services which, as discussed earlier, is difficult to measure. Tying performance bonuses to the result of patient satisfaction surveys could be considered but, because of the information asymmetry existing between patients and providers, would likely be a very rough indicator of quality.

We have already discussed how the RHAs are subject to political influence. Despite the National Interim Provider Board’s stipulation that CHEs operate in a competitively neutral environment and at arms length from government, it already appears that in practice this will not be the case. Given the National government’s express commitment to competition amongst providers, it would have seemed likely that CHEs would be subject to the anti-trust laws existing in New Zealand, ie, the Commerce Act 1986. However the government, through the Commerce Commission, granted all service providers immunity until 30 June 1994 because of their “lack of exposure to market conditions”. This move was criticized on the grounds that private providers will have little opportunity of challenging CHEs if they abuse their dominant position in the market.140 Arguably, such anti-competitive behaviour could undermine private operators’ ability to win long-term RHA contracts awarded in the first year of operation of the health reforms, and consequently inhibit competition in subsequent years.141 As another example of how

138 Minister of CHEs and the Minister of Finance, s 37 of the Health and Disability Services Act 1993.
139 Section 39 of the Health and Disability Services Act 1993.
141 Hunt, idem.
the CHEs will be subject to political influence, the Minister of CHEs announced in May 1993 that the government would underwrite troubled hospitals to bring them back to a “commercial position”. This was criticized on the basis that CHEs would “start life” in the knowledge that they can “overspend with impunity”.

The National Interim Provider Board’s expectation that CHEs compete on the same basis as private providers seems unrealistic given that CHEs have been given additional statutory obligations reflecting the public nature of their ownership that private providers do not have. Section 11 of the Health and Disability Services Act 1993 stipulates a number of disparate objectives for the CHEs to aspire to:

(1) The principal objective of every Crown health enterprise shall be to —
(a) Provide health services or disability services, or both; and
(b) Assist in meeting the Crown’s objectives under s 8 of this Act by providing such services in accordance with its statement of intent and any purchase agreement entered into by it —
while operating as a successful and efficient business.
(2) Without limiting subsection (1) of this section, every Crown health enterprise shall have the following objectives:
(a) To exhibit a sense of social responsibility by having regard to the interests of the community in which it operates:
(b) To uphold the ethical standards generally expected of providers of health services or disability services, or both, as the case may be:
(c) To be a good employer:
(d) To be as successful and efficient as comparable businesses that are not owned by the Crown.

A number of comments can be made about the range of these objectives. CHEs are entitled to provide health or disability services and may provide either primary, secondary or public health care. There is no requirement that CHEs maintain the traditional role of public hospitals as providers of secondary care or provide services to patients in their locality. The objectives listed in s 11(1) are subject to the constraint that CHEs operate as successful and efficient businesses while achieving these objectives. However, striving to fulfil these objectives may be the cause of a CHE’s failure to operate as a “successful and efficient business” as that concept is understood in the private sector. There appears, however, to be a distinction between the requirement, in s 11(1), that a CHE operate as a “successful and efficient business”, and s 11(2) that requires a CHE to be “as successful and efficient as comparable businesses that are not owned by the Crown”.

Of more concern is that a CHE’s obligation to uphold ethical standards is subservient to the primary objective of providing health services while operating as a “successful and efficient business”.

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143 One CHE, Healthcare Otago, proposed earlier this year to manage three hospitals in Saudi Arabia as a revenue raising venture. This proposal was subsequently put aside, probably because of adverse publicity in the media.
144 Presumably this distinction recognizes that a CHE can only operate as a successful and efficient business to a limited extent, given that it has to assist in fulfilling the Crown’s social policy objectives under s 8. In other words, the concept of a “successful and efficient business” is not that which is normally understood in the private sector.
efficient business”. The required rate or return to be earned by CHEs is fixed by the shareholding ministers. Sharp notes that if the ministers set excessively high rates of return it will be likely that CHEs will target their business at high net-revenue earning activities.\textsuperscript{145} However, as Neutz notes, often the most cost-effective and ethically correct approach to a health problem is to seek the “simplest, most natural, least intrusive remedy”.\textsuperscript{146} CHEs will not have a financial incentive to provide this kind of care unless it is as profitable as more intrusive forms of treatment. Because of the difficult of providing for and monitoring the quality of health services, CHEs may have an incentive to enhance profit margins by making cuts in quality that the RHAs will find difficult to detect. In particular, CHEs will have an incentive to cut the quality of services received by those without political “voice”—those who are least likely to be successful in complaining to the RHAs or to the government. This perverse incentive is exaggerated by the absence of the ability to bring an action for medical malpractice as a result of New Zealand’s no-fault accident compensation scheme.\textsuperscript{147}

While the ethical duties that regulate individual practitioners, such as the Hippocratic oath, may restrict the CHEs’ ability to cut the quality of services or to only supply profit-generating services, capped budgets will likely fuel the tension between what a practitioner perceives as his or her ethical duties and the CHEs’ obligation to operate as a successful and efficient business. This problem will be exacerbated by the fact that very few of the directors of CHEs are health professionals.\textsuperscript{148}

Unlike private providers, s 40 of the Act allows the shareholding Ministers to require a CHE to provide a particular health or disability service.\textsuperscript{149} A reasonable price is to be paid (presumably by a RHA or the Public Health Commission) for the service but, regardless,

\begin{enumerate}
\item \textsuperscript{145} Sharp, above, n 105.
\item \textsuperscript{146} Neutz, “Health Reforms and the Public Hospitals” (1993) 106: 948 New Zealand Medical Jnl, p 17.
\item \textsuperscript{147} Although the recently enacted Consumer Guarantees Act 1993 must be read subject to s 14 of the Accident Rehabilitation and Compensation Insurance Act 1992, which prohibits proceedings for damages for personal injury covered by that Act, some commentators speculate whether service failure that arises from inadequate hospital facilities (as opposed to a doctor’s negligence) would give rise to a claim under the act—Miller & Rennie, “Common Law Damages Claims” in a supplement to Brooker’s Accident Compensation in New Zealand (1993) as cited by Fraser, “The Liability of Service Providers Under the Consumer Guarantees Act 1993” (1994) 16: 1 New Zealand Universities Law Review, p 23.
\item \textsuperscript{148} A dental surgeon with a masters degree in business, a nurse who works as a banker and a physician with managerial experience are the only directors with health experience out of a total of twenty-four appointments made to the three Auckland CHEs—Holdom, “Emphasis On Enterprise As Health Boards Picked”, New Zealand Herald, 30 November 1992.
\item \textsuperscript{149} It is interesting to compare the objective of CHEs with the objectives of state-owned enterprises (“SOEs”) under the State-Owned Enterprises Act 1986 (“the SOE Act 1986”). Section 7 of the SOE Act 1986 provides that where the government wants a SOE to supply goods or services of a non-commercial nature, the government must agree to reimburse the cost to the SOE of providing that service. Taggart, Corporatisation, Privatisation, and Public Law, (Auckland: Legal Research Foundation, Publication No. 31, 1990), p 2. notes that the prevalence of mixed commercial and social objectives in the running of public enterprises prior to corporatization suggested that a good number of s 7 agreements would be entered into. In fact, however, the total number of s 7 agreements entered into by the Labour government in four years appears to be only two. Taggart hypothesizes that the reason few reimbursement arrangements were entered into is because ministers do not believe that state enterprises should perform social objectives. The formal separation of commercial and social objectives envisaged in the SOE Act 1986 has resulted, in practice, in the negation of social objectives. Given this evidence, there is a possibility that the government will rarely invoke its powers under s 40 of the Health and Disability Services Act 1993 to require CHEs to provide health services.
\end{enumerate}
the CHE is not entitled to withhold provision of that service. Therefore, CHEs (in the absence of private plans competing with the RHAs) may find themselves having no choice but to contract with the RHAs and may be forced to do so by ministerial order. Theoretically, there is the possibility that RHAs could undermine the viability of even the most efficient CHEs by using their monopsony power to contract for services at a price that is less than the marginal cost of production. This possibility must be discounted by the fact, however, that CHEs will possess information about the real value of production inputs that the RHAs do not have, and that in many areas and in respect of many services CHEs will be the monopoly supplier—thus yielding a bilateral monopoly, with indeterminate bargaining outcomes.

It was the objective of the National government that CHEs compete on an equal basis with private providers. We have already mentioned some of the reasons that the RHAs will tend to prefer contracting with CHEs as the incumbent providers. CHEs are treated like other companies for income tax purposes. However, while this prima facie seems reasonable, it has to be viewed in light of the fact that the main private competitor of the CHEs is the Southern Cross Medical Society ("Southern Cross"), which as a charitable trust does not have to pay income tax. Other private providers include religious organizations such as the Auckland Adventist and Mercy Hospital. The surplus earnings of these organizations do not attract income tax and they are exempt from goods and services tax.

Stone notes that in the United States:

If we have learnt anything from two decades of competition in health care it is that providers and insurers will compete on everything but better information, better service and more efficient care.

There is a problem that, while the major public hospitals (now CHEs) may face competition in the provision of some services, they will be likely to retain a monopoly position with respect to the supply of other services. They will have an incentive to raise the prices of the services over which they hold a monopoly to subsidize the cost of services in which they face competition, thereby undermining smaller competitors. This will be very difficult for the RHAs to discover because of their lack of information with respect to production costs.

One of the biggest problems identified in the old system was growing waiting lists for elective surgery in the public hospitals, and unfair and inefficient management of those lists. The creation of twenty-three stand-alone enterprises to run the public hospitals does not augur well for the rationalization of waiting lists. CHEs are not only meant to

150 Sharp, above, n 105, p 10 notes that, unlike religious organizations, while Southern Cross’ surplus income does not attract tax it has to pay goods and services tax.
151 Sharp, idem.
152 Stone, "When Patients Go to the Market" (1993 Spring) The American Prospect 109, p 115.
153 For example, Sharp, above, n 105, p 7 notes that the Auckland CHEs will face competition in the provision of some surgical services but there is a relative lack of competition in the areas of clinical support, disabilities and public health.
154 In fact it appears now that there is no national data available on the length of waiting lists and times spent on waiting lists.
Compete with private hospitals but with each other. CHEs will have little incentive to co-
ordinate the delivery of services between themselves. They will provide the kind and
quality of care, to the specified individuals within the time period, that they have
contracted with the RHAs to provide, regardless of how allocatively efficient and fair that
arrangement may subsequently prove to be.

2 Private providers

a) Private hospitals

Although there were no specific reforms of the private sector it was intended that the
reforms would be neutral as to whether care was provided by the private or public sector.
The ownership of the entity providing care was not considered as important as whether
it was the most efficient provider. Private hospitals have grown in importance from the
1960s when insurance premiums started to be treated as a tax-deductible item of personal
expenditure.155

Scott notes that the private sector has the capacity in the three main centres to duplicate
nearly everything that could be done in the largest public hospitals. The only exception
is in respect of critical care facilities for multiple injuries and for serious infection with
metabolic failure, presumably because this is not as profitable a service to provide.156
Sharp takes a more conservative approach to the level of competition that CHEs will face
from private hospitals. He notes that the Auckland CHEs will face competition in the
provision of some surgical services, but that there is a relative lack of competition in the
areas of clinical support, disabilities and public health. Undoubtedly, the CHEs in the
three main centres potentially face greater competition from private hospitals than those
operating in more rural areas.

It remains to be seen whether or not private hospitals will be able to secure a larger share
of government funding through competitive contracting. Earlier we discussed both the
advantages and disadvantages CHEs will have in competing with private hospitals. It is
far from clear that competition will develop in the provider market in the manner
envisaged by the architects of the reforms. Unlike the RHAs, there is no prohibition
against private insurance companies owning private hospitals. If the reforms do not
improve upon the efficiency and fairness of the system and waiting lists for public
hospitals continue to grow, more and more individuals will turn to private insurance. The
biggest source of growth for private hospitals may be private insurance.

b) General practitioners

155 Pursuant to a 1967 amendment to the Land and Income Tax Act. Section 59(6) of the Income Tax Act
1986 provides that premiums paid in respect of any policy of personal accident or sickness insurance
are not deductible after 17 December 1987. Section 59 (6) was added by s 4(3) of the Income Tax
Amendment Act (No. 2) 1988. Prior to the reforms, 9.65% of all monies spent on institutional (or
secondary) care was spent in the private sector. Of the NZ$2,974,085,000 spent in total on institutional
care, NZ$286,867,000 was paid to private institutions—Muthumala & McKendry, above, n 9. By 31
March 1992, the 200 licensed private hospitals in New Zealand provided a total of 7149 beds compared
with 18,823 beds in the public sector—Department of Statistics, New Zealand Official 1993 Yearbook
(Wellington: 1993), p 162.

156 Scott, "The Health Service After Reform", New Zealand Medical Association Newsletter, p 4 in (1992)
105: 946 NZMJ.
General practitioners play a key role in controlling access to (and therefore the total cost of) health services as they are the gatekeepers to further care, they prescribe drugs, refer patients to specialists, admit patients to hospitals, and order laboratory tests. Despite their importance in the health system, general practitioners have historically strongly resisted political interference in their relationships with patients. General practitioners receive government subsidies that cover all or part of the price they charge to patients. There was (and is) no restriction on the price that can be charged for general practitioner care or the volume of services provided. Since 1941, the percentage of the price charged by general practitioners paid for by government subsidies has sharply declined. This has resulted in growing user charges for patients. Earlier we argued that user charges restrict the access of those on lower incomes to health care, who are most often in need of care. Increasing user charges for general practitioner care may explain New Zealanders’ poor health status relative to other OECD countries. Because of user charges for general practitioner care there is a perverse incentive for patients to consume hospital care (particularly in the accident and emergency department) over general practitioner care. Delaying seeing a general practitioner may also result in aggravation of the illness or injury and so result in greater overall costs of treatment. Another inefficient incentive is for general practitioners to over-prescribe pharmaceuticals. Scott claims this is because patients are unwilling to make repeat visits to general practitioners because of user charges and because of pharmacy dispensing fees. General practitioners over-prescribe drugs to ensure patients have sufficient drugs and do not need to return to renew their prescription as this entails user charges for patients.

From 1 September 1990, general practitioners were given the option of joining a contract scheme that offered an inflation-adjusted subsidy for all consultations in return for limits on user charges and the provision of patient information for a national database. This scheme met with strong resistance from general practitioners because of the desire to cap the prices that patients could be charged and the scheme was abandoned by the National government upon its election in December 1990. Despite this, one of the most important goals of the National government’s reforms was to integrate primary and secondary care. It seems to be generally accepted that it is through the integration of primary and secondary care and through the reform of the primary care sector that most improvements in efficiency are likely to occur. However, notwithstanding the importance of this area, to date the RHAs have done relatively little to effect integration and to reform the organization of the primary sector. The four Regional Health Authority Establishment Boards in November 1992 identified the advantages and disadvantages of different methods of funding general practitioners. These included the current fee-for-service regime, block or fixed sum payments (capitation), salaries, cost and volume payments and hybrid payment arrangements. Cost and volume contracts were considered the most appropriate method of reimbursement as they would enhance both quality and

158 Scott, idem.
159 See the various articles in (1994) 29: 1 & 2 Health Policy.
efficiency.\textsuperscript{161} Notwithstanding the expressed preference for cost and volume contracts, the RHAs have now announced that they will not attempt to alter the fee-for-service regime at least until December 1995. Moreover, few new initiatives seem to have been taken with respect to reforming general practitioners’ roles as gatekeepers to the consumption of other health services and towards evolving incentives for them to choose the most cost-effective treatment and services on behalf of their patients.\textsuperscript{162}

Conclusion

Through competitive contracting the reformed health care system is intended to operate more efficiently, be more accountable and result in fairer outcomes. However, the reforms are ill-founded, as while competition is generally thought to maximize efficiency in free market economic models this is not the case where the market operates imperfectly because of imperfect knowledge. In the markets for many health care services an information asymmetry exists between patients and providers which means that competitive contracting is unlikely to result in efficiency gains. There are also economies of scale and specialization in the production of many secondary health care services. The usual assumptions of perfect competition do not apply to health service markets. The creation of a number of new government-appointed bureaucracies seems unlikely to result in increased accountability and responsibility for the provision of quality health care services is now diffused between the government, purchasers and providers. Moreover, most of the reforms are geared towards the secondary sector whereas it is in the primary sector that there is the most potential for efficiency gains. The appropriate reform of general practitioner care will lead not only to savings in the delivery of general practitioner care but, because of the special role of general practitioners as gatekeepers, also result in savings in pharmaceuticals, laboratory, and secondary care costs. One of the

\textsuperscript{161} In cost and volume contracts a pre-determined amount is paid (in this case by the RHAs) in return for a specified volume of service, but the contract allows for renegotiation or variation in payment if volume changes. It was though that cost and volume contracts would more fairly apportion risk between purchasers and providers than either capitation or fee-for-service arrangements, and that cost and volume contracts would enhance provider accountability more than a capitation regime as payments to providers would be limited to outputs—Regional Health Authority Establishment Boards, ibid, p 12.

\textsuperscript{162} On a more positive note Malcolm and Barnett above, n 10 note that a number of primary care pilot projects were established during 1991 and that this has lead to an increasing number of independent practice association ("IPAs") being formed (some thirty-five), which they estimate may now include half of all general practitioners. Marshall, "The Reforms in Midstream—a GP Perspective", New Zealand Medical Association Newsletter, p 5 in (1992) 105: 939 NZMJ, notes that the New Zealand General Practitioners' Association encouraged the formation of IPAs to enable general practitioners to negotiate the best contracts possible with the RHAs if they were forced to do so. IPAs are legal entities capable of contracting for health care services, and in which doctors and their practices retain their own identity and characteristics. According to Malcolm "General Practitioner Fund-Holding: Experimental Sideshow or Main Event of the NHS Reforms" (1993) 106: 955 NZMJ, p 183 amongst IPAs there is increased interest in budget holding. Budget holding involves groups of general practitioners being given budgets for the pharmaceuticals they prescribe, to purchase referrals to specialists and outpatient clinics, and to purchase elective surgical procedures. Budget or fund holding has been extended to some 25\% of all practitioners in the United Kingdom. Malcolm notes the problems that have been identified with budget holding include the risk of practitioners trying to filter out the sick from their practices in order to reduce expenditure, practitioners squeezing out other primary care providers such as nurses and social workers, and the fact that the associated level of risk means that relatively large groups of practitioners must band together—and that may not be as feasible in New Zealand.
greatest problems in the secondary sector is growing waiting lists, particularly for elective surgery, and inefficient and inequitable management of those lists. This problem will not be solved by the creation of twenty-three stand-alone CHEs who have little or no incentive to co-ordinate waiting lists on a national basis. The reforms focus heavily on the technical efficiencies of the system and largely ignore allocative efficiency considerations. There is no process whereby important cost-benefit calculations are undertaken by the RHAs and providers. For example, although it may seem logical from the perspective of a CHE under tight budgetary constraints to close down relatively unprofitable small rural hospitals, this decision should factor in the extra opportunity costs of patients and their families of having to travel longer distances to obtain secondary services. Shifting costs to patients should not be the primary focus of health reform. The primary focus should be seeking to ensure everyone has access to needed health care services regardless of ability to pay or risk of ill-health while reducing overall costs and maintaining and enhancing quality where necessary or possible.

Ultimately, it is easy to criticize and much more difficult to offer solutions. At some point a government must make a decision as to the type of health system to be implemented. One cannot debate these complex issues forever. It is true, however, that the reforms occurred in indecent haste and this haste is now reflected in a system which seems unlikely to address pre-existing problems and in fact seems likely to create more. Undoubtedly, there are excellent professionals within the health care system who will struggle to minimize problems and ensure that the public continues to receive adequate health care. However, the failures of the health system are more likely to be felt by those who are most disadvantaged and are unlikely to be identifiable in the short term. As the publicly-funded system deteriorates more and more people will rely on private insurance and private care.

Substantial inequalities and inefficiencies result if allocation is left predominantly to private markets. The question remains, however, to what degree should government become involved in the funding, regulation and provision of health care services. Without making any final judgements as to what would be the most efficient and equitable system, it is clear that strengthening purchasing power is important in being able to contain costs and to remedy the information asymmetry between patients (purchasers) and providers. In systems where purchasing power has been pooled through government funding of health care services, concern has been expressed that services are being rationed, in some cases inequitably. We agree, despite the ethical dilemmas, with the attempt to identify core health services as an important step in fairly rationing health care services in the face of a need to contain costs. This process allows the public to consider the rationing decisions previously made by health professionals and administrators and to decide where health spending priorities should lie.

For the reforms to operate as they were initially intended, it is important for individuals to be able to "exit" from a Regional Health Authority to a private plan. The concept of private plans was justifiably criticized at the time the reforms were first mooted as likely to increase administrative costs, undermine long-term planning and undermine the government's monopsony purchasing role—which has been identified as an important factor in curtailing costs. However, without the existence of private plans, there is little
incentive for the newly established RHAs to act more efficiently and to contract with more efficient providers than the old Area Health Boards. We have made some suggestions as to how some of the problems identified in the establishment of private plans could be ameliorated.

Both in the pre-existing system and the new system, the wealthy and insured have had the option of contracting out entirely from the government-funded system, and purchasing health services from the private sector. The loss of these individuals from the publicly financed system is a loss of “voice” which has resulted in a progressively deteriorating government financed system—as evidenced by growing waiting lists, particularly for elective surgery. The RHAs have a perverse incentive to encourage quality-conscious individuals to shift to the private sector (and spend either their own money or rely on private insurance) as this will not result in any loss of government funding for the RHAs and reduces both complaints and waiting lists.

We have suggested that both voice and exit need to be improved in order to enhance the efficiency and accountability of the system. In improving voice we have suggested that private insurance be prohibited for core health services. The public would still have the option however of shifting their share of government funding to private plans. The more quality-conscious individuals would have an incentive to use their political voice to maintain both the number and quality of core health services being received by rich and poor alike. Complementing this proposal, user charges for core health services would be prohibited and government would assume responsibility for the funding of all core health services—whether primary (where currently a significant proportion is being paid for by the private sector) or secondary (and, in particular, elective surgery). This initiative would allow for the real integration of primary and secondary care and also result in a strengthening of the purchasing power of government which would then be better able to constrain total expenditures on health care. Other suggestions for enhancing voice include public election of the RHAs’ directors, compulsory consultation and reporting, encouraging patient advocacy groups, and establishing a right for all individuals in need to the “core health services”.

Health care reform is “the issue from hell” because it involves many complex and competing factors: political, social, legal, economic, and ethical. We do not purport to have solutions for all the problems which existed in the pre-existing health care system and that have been identified in the reformed system. Our suggestions are tentative, but we hope to promote continued discussion of the essential features of a health care system for New Zealand that is efficient, accountable and fair.
Voice and Exit in New Zealand's Health Care Sector—
Commentary
Toni Ashton
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The thrust of this paper's argument is that the reforms are a half-hearted attempt to emulate a competitive market. The general conclusion drawn is that, rather than improving the pre-existing system, the reforms introduced into New Zealand are likely to reduce accountability and efficiency.

I don't think anyone here would disagree with the fact that the new system is not a true market and is unlikely to behave as such. Moreover, I am in general agreement with many of the perceived potential deficiencies of the reforms. However the paper conveniently ignores the fact that the old area health board system had deficiencies of its own and that the reformed system does have some important advantages over the old hierarchical arrangements. Therefore, rather than focus on the potential problems, I think what we need to do now is to consider how the new system can be developed to its greatest potential, given the nature of the quasi-market that has emerged.

The paper covers the restructured system in some detail and I do not propose to discuss all of the components. Rather I'd like to focus on just two issues. First, I feel that I must comment on the recommendations for competing health care plans, as my own views on this are rather different from Michael and Colleen's. Then I'll focus my comments on the topic of this seminar—contracting for services.

The paper suggests that serious consideration should be given to the possibility of establishing private health care plans. It is argued that, because these would act as exit mechanisms for consumers, they would impose competitive pressure on RHAs and so encourage them to respond to consumer preferences and to perform efficiently.

The arguments against health care plans are summarized in the paper in the following quote from one of my own papers. The quote stated that competing plans would:

- increase administrative costs, weaken the bargaining power of RHAs, introduce additional problems concerning access to care, and undermine any long-term service planning.

In my view, Michael and Colleen's paper does not satisfactorily address any of these objections to health care plans. The thrust of their argument is to address any potential problems associated with health care plans through regulation. Their proposals for regulation are wide-ranging and include:

- open enrolment (ie, plans must accept all applicants) as a means of preventing "cream-skimming" of low-risk individuals and not limiting access to care to higher risk people;
—a regulation requiring that all plans must purchase a basic package of core health services (assuming that they can be defined) with an upper level on user-charges;

—a requirement for plans to report and publish the use and cost experience of disenrollees, as a means of preventing patient dumping;

—regulations to limit the number of plans by specifying minimum levels of assets and shareholder funds. This is recommended to offset the potential for too many purchasers to fragment services.

The paper notes that the "proposed regulation would not be without cost". Indeed it would not. Nevertheless, Michael and Colleen conclude that:

> Regulation is necessary to ensure the viability of private plans, and without private plans the reforms will generate more inefficiencies and less accountability than the previous system.

This last point is not developed but seems to be based upon the notion that, in the absences of HCPs, RHAs have little incentive to be efficient. I contend that there is in fact already considerable pressure on RHAs to be efficient. First, RHA funding is capped. Those of you who have ever been subject to a budget constraint will appreciate the encouragement that this gives towards shopping around to find the best value for money. Second, RHAs have a contract with the Minister. If they are judged to fail in their task, or not to fulfill this contract, then managers will presumably lose their jobs.

In my view then I think Colleen and Michael underestimate both the potential of the existing system to encourage efficiency at the purchasing level, and the potential additional costs associated with competing health care plans if there were 50 million people living in NZ. Large populations facilitate the pooling of risk and secure economies of scale in areas such as information gathering, rate-setting and marketing costs.

Experiences in Europe indicate that small purchasers are simply not financially viable. My own recommendation is therefore, let's see how the RHAs get on first. If inefficiencies do emerge (and if we can define a set of core services that is of use to purchasers), then we may need to bring health care plans back off the back burner.

Let me turn now to issues relating to contracting. The paper suggests that it will be difficult for RHAs to integrate and coordinate primary and secondary services through contracting because a significant proportion of primary care services are privately rather than publicly funded. In other words, many of us pay in full for a GP consultation. Two points are relevant here. First, there is not a separate primary care system for unsubsidized patients: subsidized and unsubsidized patients use the same primary services. Therefore any changes to these services will affect subsidized and unsubsidized patients alike. For example, in the case of budget-holding by GPs (ie, where the budget covers pharmaceuticals, lab tests and possibly some secondary services), all patients would be entitled to services covered by the budget, albeit sometimes subject to a part-charge. Second, all patients (except emergencies) must normally access publicly-funded secondary, tertiary and community-based services through a GP, regardless of whether or not they pay in part or in full for GP services.
In my view, the extent to which the new system improves integration of primary and secondary services will depend upon the purchasing strategies of RHAs: the fact that some patients must pay in full for a GP consultation should have little or no impact on this process.

A second point of concern for Michael and Colleen is that the playing field is not level on the supply side. Instead, CHEs have a clear competitive advantage in contracting with RHAs to provide services. I agree with this entirely. There is little doubt that CHEs do have an advantage over private sector providers, especially in cases where RHAs are purchasing packages of services, including any support services required where there are complications. Private providers do not (as yet) generally provide these highly specialized services and so they would have to sub-contract with CHEs (ie, their competitors) in order to win a contract with the RHA. There is no obvious reason why the CHEs might agree to do this. The aim of competitive neutrality between public and private providers therefore remains elusive.

It seems to me however that it is competition within rather than between the public and private sectors that really matters. In the case of primary care, competition occurs primarily among private sector providers, while for secondary services, competition among CHEs is likely to be as important, if not more important than competition between public and private hospitals. So although the playing field is definitely not level, this issue may not be as important as the paper implies.

What I do think is important is that potential new providers may not get a fair deal because they have to compete against established organizations which have a proven track record. New organizations are also likely to have some difficulty in getting access to establishment capital. This is a point that I think does need resolving. Otherwise, incumbent providers will always win contracts, even though they may not be providing satisfactory services.

The paper also argues, following the theory of the firm, that contracting for services between purchaser and provider is inefficient in health care because:

(a) it is difficult to define volume and quality of services;
(b) production involves economies of scale or scope;
(c) there is limited competition for many services

I agree completely that contracting out is generally expected to be inefficient if these characteristics are present. I could ramble on at length on this issue. However I shall limit my comments to just three main points.

(i) Many services—such as most primary and community-based services—do not have these features. Therefore, according to the theory of the firm, the purchaser-provider split is quite appropriate for these services. The challenge now is to identify those services where contestable contracting does have some potential to improve efficiency, and then to design a contracting strategy which exploits this potential in full. As Michael and Colleen correctly point out, the split between purchaser and provider already existed for
primary services under the old system and yet the purchasing strategy that was used then failed to encourage either efficiency or accountability.

(ii) The purchaser-provider split does not mean that all contracts should be negotiated competitively and frequently. There are numerous different ways of contracting for services. The success of the process will depend largely upon the ability of RHAs to match up the right sorts of contracts with the right types of providers. It is a question of horses for courses. In cases where contestability is limited, it is likely to be more appropriate for RHAs and providers to establish long-term, informal and cooperative relationships based upon trust. This effectively bridges the gap between purchaser and provider and should reduce the costs of negotiating and enforcing detailed contracts.

(iii) Finally, while I agree that contracting may be more costly and offer little or no efficiency gains over the old system for services where there is a single, monopoly provider, contracting can still be a powerful tool for meeting objectives other than efficiency such as improving the quality of service and accountability of that provider. While there is little doubt that our ability to measure and monitor quality in health services will always be less than perfect, I don’t think this should be used as a reason for not contracting. In fact I think it would be fair to say that contracting for services has encouraged a very rapid improvement in measuring and monitoring quality. Contracting is also improving accountability through the specification of the method and quality of service provision. The question we need to consider now is, are these improvements worth the additional costs associated with contracting?

My general conclusion is that the success or failure of the health reforms is largely a question of balance. If more services are opened up to contestable contracting and contracts become more detailed, the potential gains in productive efficiency and accountability are likely to increase. But so too will the costs of contracting. Our challenge now is to strike the right balance between the potential gains associated with more competitive purchasing strategies and the extra costs of creating and sustaining a health care market.
THE CONTRACTING PROCESS—BUILDING NEW RELATIONSHIPS IN HEALTH CARE

Carl Rowling
Partner, Buddle Findlay

Introduction

It is now a little over a year since the creation of new legal structures in the health care sector including the much discussed purchaser/provider split pursuant to the Health and Disability Services Act 1993.

Given the complexity of the health sector and, at least in New Zealand terms, the inexperience of those involved in the process, it is hardly surprising that in many respects implementation has been necessarily tentative and, in a number of areas, incomplete.

The new public purchasers of health and disability services, the Regional Health Authorities (RHAs) found themselves in a position where they were being required to purchase the bulk of the health needs of New Zealanders in the region for which they had responsibility with no clear understanding having been reached as to what represented the core health services that they would be expected to procure from providers on behalf of those for whom they purchased services. Moreover, the key element that RHAs require in order to effectively negotiate contracts with providers, information, was and is largely held by the providers. Also, particularly in the early stages of the reforms (and in fact one of the reasons for the reforms), that information was not in fact readily accessible to the providers themselves. This was in turn due to the lack of accountability in the past which had not created any incentives for providers to capture information in a form that would assist a contracting process.

It was always advanced that one of the means of achieving the efficiency goals of the reforms is the principle of contestability; that is maximum value for the health dollar would be achieved when providers were competing for the same funding. Accordingly, it would be the provider that was able to deliver the most efficient cost effective service (subject of course to always meeting the quality requirements dictated by the relevant RHA) that would be the successful tenderer for that service. The fact of the matter is that in many areas there is presently no contestability and, indeed, unlikely to be contestability. As a result, the monopoly position enjoyed (suffered?) by CHEs with respect to a significant part of their services remains undisturbed by the reforms. This is not to say that CHEs have not sought to achieve efficiencies in these areas as a result of other pressures.

It is also important to consider the implications that flow from the sheer complexity of the health care sector. This is amply demonstrated by the activities of the Core Services Committee that has been reporting to the Minister of Health on what does and does not constitute core health services. Further examples of complexity arise in the context of the definition of services, the measurement of performance and the determination of inputs.
that make up a particular service that is required to be provided by a CHE to the RHA pursuant to its purchase agreement with that RHA. These and many other issues are currently being struggled with by both RHAs and providers through the contracting process.

In light of the above, it is hardly surprising that the Core Services Committee came to the view that there should be an initial roll over of existing services provided by CHEs for the 93/94 financial year; that is, all CHEs were required to provide during that year was exactly the same health and disability services as they had provided to the public during the 1992/93 financial year. Unfortunately for the CHEs these services were required to be provided at a funding level that represented 98% of the funding provided to CHEs for the 1992/93 financial year.

In tandem with this roll over and perhaps as much a result of intense lobbying as uncertainty and any information gap, there was a similar roll over in the primary care area in that all general practitioners continued to receive the general medical subsidy or GMS at past levels. This will continue to represent the default position in the primary care area at least until January 1996.

The health care sector was also given a one year reprieve from the application of the Commerce Act in the context of anti-competitive practices. This was effected by a specific statutory provision in the Health and Disability Services Act with respect to RHAs and by Commerce Commission edict with respect to providers (though in theory there was nothing to prevent one provider bringing an action against another provider in relation to a breach under the Commerce Act).

Notwithstanding that integration of purchasing in the health sector was a key goal of the reforms so as to avoid unnecessary duplication of resources and funding, there was no integration of ACC and DSW funding with the funding by RHAs, though the first and somewhat limited steps are now being taken in this area.

Though the reforms remain clearly inchoate in their implementation, the parties involved have sought to improve the position and give meaning to the reforms, particularly as regards coming to a better understanding of their businesses, over those first 12 months. It is apparent to those involved that the implementation of the reforms, specifically the contracting process, is necessarily organic and will grow in sophistication and effectiveness as both purchasers and providers’ understandings deepen.

However, the unavoidable conclusion that one reaches is that it is simply far too early to make any judgements as to the success of the reforms or otherwise. Certainly issues, difficulties, problems and anomalies can be identified but unless one has a particular political, philosophical or economic barrow to push, they do not in sum represent either an indictment of or justification for the reforms.

Certainly with regard to the CHEs, their ability to achieve efficiencies and otherwise fulfil the goals of the reforms, have been significantly hampered by their very weak financial position. The situation is further exacerbated due to the underfunding forced on CHEs, particularly those in the North due to the inequitable distribution of secondary care funding in New Zealand.
Though it is still too early to make any kind of call on the reforms themselves, there are still many issues arising from the structure of those reforms and their application that warrant continued discussion. This paper addresses a number of these, some of which are framed in the overall context of the Health and Disability Services Act itself whilst others are relatively specific to the contracting process itself. As this paper does not seek to advance any particular view as regards the success of the reforms or otherwise, it is somewhat “scattershot” in nature. I make no apology for this. Indeed, in many respects, it is arguably representative of the implementation of the reforms themselves.

The issues that this paper addresses, in no particular order, are the goals of the reforms, the position of the RHA as purchaser, the issue of contestability, the definition of services, interprovider flows, the treatment by CHEs of private patients, and a brief examination of the position as regards primary care services.

The goals of the reforms

Section 4 of the Health and Disability Services Act 1993 sets out the purpose of the reforms relating to the funding and provision of health and disability services. Whilst this section commences with the laudable aims of securing for New Zealanders the best health and best care or support for those in need of services together with the greatest independence for people with disability, there is the all important qualification (and perhaps, some would say, undermining of these purposes) by the statement that these purposes are to be achieved in the context of what is reasonably achievable within the amount of funding provided.

The two further purposes set out in s 4 are the facilitating of access for personal health services and disability services as well as achieving appropriate standards of health services and disability services. What in fact are “appropriate standards” is in some respects a political balancing act as, certainly in the context of the system as it now exists, those standards are effectively set by government, through their funding agreement with each of the RHAs together with RHA directives and guidelines promulgated by government from time to time. To the extent that government miscalculates what is appropriate, which in turn is driven by the level of funding that government is prepared to make available in terms of the Health vote, there is the possibility of the ultimate sanction at the next elections. In the interim there is substantial lobbying activity of which all of those involved in the health sector would be very much aware.

The totality of the above purposes are intended to be achieved by increasing the efficiency of providers and improving, and in some cases introducing, accountability for both providers and purchasers.

From the perspective of providers, the primary tool for obtaining these efficiency and accountability goals is the contracting process. It is this process, particularly in the context of the RHA/CHE interface, on which this paper focuses.

There has been much argument that in order for the contracting process to be effective there must be contestability, equivalence of negotiating strength and no “tainting” influence of government. With respect to this last point, much has already been written
about the potential undermining of the reform process by government caving into a lobbying activity on a piecemeal basis as and when efficiency decisions are sought to be implemented; that is government will override what would otherwise be sensible contracting decisions made between RHAs and providers solely for the purpose of avoiding political fall-out. Time will tell to what degree this is a real concern. The degree to which there are mechanisms available to government to derail and to override the contracting process is discussed in greater detail in the next section of this paper. Obviously if such government activity becomes commonplace, then the goals of the reforms are clearly at risk.

In relation to contestability, it has already been mentioned that there are many areas where this is simply not possible. As is discussed more fully later in this paper, there are a number of circumstances that would appear to run counter to the principle of equivalence of negotiating strengths. Many commentators have previously identified these difficulties. Notwithstanding, one cannot ignore the benefits that would appear to flow from the contracting process alone; that is the good faith attempts by the contracting parties to set and meet output and performance requirements within the constraints of the funding available.

Indeed, it is somewhat ironic and one can’t help but conclude that it was government’s intention, that the very fact of underfunding of many CHEs has forced those providers to seek to obtain maximum efficiencies in the provision of health and disability services. In the 1994/95 policy guidelines for RHAs (p 24) in discussing the management of change in the purchase arrangement for secondary services, the government directed RHAs that “[t]he prices RHAs and CHEs settle on for services should reflect the costs that an efficient provider would incur”.

In the very next sentence government recognized that such prices, in some cases “would be higher than the prices RHAs are currently paying”. This is certainly the experience of CHEs in the North Island and has necessarily placed significant strain on the contracting process between those CHEs and the relevant RHAs.

**The position of the RHA as purchaser**

With the dissolution of Area Health Boards and the introduction of the purchaser/provider split, a new administrative level was introduced to the New Zealand health scene in the guise of RHAs. By creating four RHAs it was clearly hoped that these purchasers would have something of a regional focus though the magnitude of Southern RHA in particular would, at least at the intuitive level, appear something of a countervailing factor in this regard.

It is to be assumed that the introduction of this further tier would to some degree quarantine purchasing decisions from the direct influence of government, at least on a day to day basis.

Clearly the scheme of the Health and Disability Services Act contemplates RHAs having potential competitors in the form of private health plans, subject to the approval of the Minister. However, competition at the purchaser level did not survive the political process and at this stage, at least, RHAs are the only show in town.
Though the RHAs are able to draw on international experience in carrying out their purchasing activities, they are essentially starting from a zero base in New Zealand. To date, one of their key functions has been to gather information and develop a suitable database so as to allow them to contract in an effective and informed manner. No doubt, different providers have different views on just how effective RHAs have been in reaching such a negotiating position.

If we examine the statutory structure under which RHAs operate, it is apparent that the key driver of RHA activity will be the funding agreement entered into between the RHA and the Crown pursuant to s 21 of the Health and Disability Services Act. Not surprisingly, this agreement is strictly confidential between those parties. No doubt if the details of the funding agreement were made available to providers this would confer a negotiating advantage on those providers; at least in theory.

Pursuant to s 8 of the Health and Disability Services Act the Crown is required to give the RHA written notice of the Crown’s objectives in relation to the health status of the community served by the RHA, the health and disability services to be purchased by the RHA, the terms of access to those services as well as the assessment and review procedures to be used in determining access to those services, and the standard of those services and the special needs of Maori and other particular communities or people for those services.

These objectives dovetail into the objectives of the RHAs themselves set out in s 10 of the Health and Disability Services Act which include meeting the Crown objectives notified to the RHA pursuant to s 8. However, there is the all important exception to the RHA’s objectives in that they are only required to meet those Crown objectives and the other objectives set out in s 10 to the extent that their funding agreement with the Crown permits them to do so.

One cannot help speculating on the possible divergence between the publicly notified s 8 objectives and the confidential funding agreement constraints. A more cynical observer might come to the conclusion that this represents a means for the Crown to present an optimal public image whilst achieving a less publicly palatable agenda through the means of the confidential funding agreement. If that ever was government strategy, it does not appear to have worked.

Section 34 of the Health and Disability Services Act imposes a duty on RHAs to consult with both users and providers of the health and disability services in its region on a regular basis. There can be little doubt that any results of this consultation will not be sufficient to displace any obligations on an RHA pursuant to its funding agreement with the Crown nor any objectives of the Crown notified to the RHA pursuant to s 8. The 1994/95 policy guidelines for RHAs (p 21) specifies that RHAs must undertake an appropriate consultation process with affected providers and users “before making decisions that could significantly affect any of the current providers or the delivery of services to a population”.

In theory, to the extent that an RHA could be shown not to have given due consideration to the results of any public consultation pursuant to s 34 that were not in conflict with the RHA’s funding agreement or any s 8 objectives, an action in administrative law would
lie against those RHAs (see also *Air New Zealand Limited v Wellington International Airport Ltd*, HC Wellington, CP 403/91, McGechan J, 1992). However, recent experience in the public consultations that were carried out in the context of corporatization of electric power boards amply demonstrate the difficulty of successfully challenging any RHA decision on this basis. Notwithstanding the fact that their may be very strong and possibly well reasoned submissions made to an RHA in public consultation, so long as that RHA has not predetermined the matter and can clearly show that it considered the results of the public consultation, there is no imperative for the RHA to implement any results of that public consultation, no matter how widely held the views advanced. In that context and in light of the serious financial constraints placed on RHAs, it seems likely that the consultation process is more likely to be a forum for the gathering of information and the airing of views, rather than one for effecting any meaningful change to RHA policy.

In considering the position of RHAs as regards the Crown, mention should also be made of s 25 of the Health and Disability Services Act. This section allows the Minister of Health at any time by written notice to an RHA to give such directions as the Minister considers necessary or expedient in relation to any matter relating to the RHA. The RHA must comply with that direction. There is an obligation on the Minister to first consult with the RHA before giving that direction and the direction must be gazetted and laid before Parliament as soon as practicable. Accordingly, at least in theory again, there is no mechanism under the Health and Disability Services Act for an invisible hand of government in health policy on an ad hoc basis. To date the government has used the s 25 mechanism to issue a statement of eligibility for the purpose of clarifying who are eligible to receive the services funded by RHAs. The writer is not aware of any other examples of the use of this power.

Reference was made above to the current monopoly purchaser role enjoyed by RHAs. In the context of the contracting process, a concern that flows from such a monopoly position is the ability for a contracting RHA to take what would otherwise be commercially indefensible positions due to an inequality of bargaining power. Whilst it is more than likely that RHAs will take such positions due to the “greenfields” nature of the contracting position (ie, taking the high ground) it is critical to note that there are a number of foils to RHAs assuming such positions.

The first, and perhaps the most important, is that in many cases RHAs have no practical alternative to the CHEs with respect to the services for which they are contracting. This is likely to continue to be the case in a significant number of health service areas, particularly acute services as many of the CHEs and indeed their precursor area health boards have already rationalized the provision of such services among themselves. Tied in with this first point is the imperative for RHAs not to undermine the viability of key providers. There is little point in RHAs taking such an aggressive position that they place undue strain on a provider such that the key goals of the reforms may be undermined. After all, the intermediate goals of efficiency and accountability are only the means to the end of promoting the health of New Zealanders. Also, RHAs have the obligation to secure core services and this again shifts the balance of negotiating power back towards the integrated provider.
No discussion of the position of RHAs as a purchaser of health services would be complete without some comment on s 51 of the Health and Disability Services Act. This section allows RHAs effectively to force providers to contract on RHA specified terms if an alternative agreement cannot be secured between the RHA and that provider. This is effected by the RHA issuing a notice of those terms and conditions which may be given either individually or by public notice. The s 51 mechanism was used for the roll over for both CREs and general practitioners for the 1993/94 contract year. Indeed those specified terms and conditions for general practitioners will remain in place until January 1996.

There can be no doubt that the s 51 notice confers immense contracting power on RHAs as any provider is deemed to have accepted those terms and conditions simply by receiving funding for its services from the RHA. Practically all providers have no choice in this regard. Certainly the use of what might be considered draconian terms and conditions by RHAs using s 51 creates significant incentives to negotiate a contract with the RHA. One suspects that s 51 notices will be little used once the contracting parties develop the necessary systems required to "safely" enter into the contracting process. Certainly, the potential use of s 51 terms and conditions is an incentive for CHEs to wholeheartedly enter into the contracting process.

**Contestability**

The economic theory underlying the health reforms is that providers will obtain maximum efficiency in the provision of health and disability services when the services for which those providers are tendering for funding from the purchaser are contestable. Existing providers are accordingly confronted with the potential loss of funding for a particular service if those providers are inefficient and therefore too costly.

As has already been discussed, the reality is that many areas are non-contestable, particularly due to the specializations already adopted by many CHEs. There are also many low margin (and indeed in some cases, negative margin) services where there is no economic incentive for alternative providers to compete.

Taken together, these factors call into question the government's stated objective of making the provision of helping disability services contestable. To what extent this is the case remains unclear.

Viewed from another perspective, contestability carries with it the potential to undermine the financial viability and therefore the efficiency of CHEs. For instance, in order for CHEs to plan effectively for the future, there needs to be a reasonable degree of certainty as regards their future funding levels. In particular, when a CHE is considering whether or not to make capital expenditure for the purpose of securing future efficiencies, that CHE needs to have a reasonable degree of confidence that it will continue to be in a position to provide the services to which that capital expenditure relates.

Due to the funding levels experienced by most CHEs at present, this is something of an abstract consideration. However, it is likely to become of greater relevance in the near term as the reforms are bedded down. A recent example of the potential for contestability to precipitate expenditure that cannot be recovered is the loss by the Canterbury CHE of cardiothoracic services in the tender carried out by the Southern RHA. In that case the
Canterbury CHE concerned has taken on an expensive specialist, one imagines with a view to promoting its tender prospects. With the decision of the Southern RHA to withdraw its tender for additional cardiothoracic services and award the tender for existing services to the relevant Otago CHE, that Canterbury CHE has been left with what could be quite substantial and potentially unrecoverable costs.

This position may indeed be worsened for CHEs by the apparent practice of at least one RHA to reserve the right to withdraw particular services from a contract with CHEs when that service becomes contestable. Such a contractual term gives rise to further uncertainty for the CHEs concerned in their planning and from a long run perspective may well have an overall negative economic impact.

One also has to question the ability of alternative providers to enter the market where CHEs are currently being underfunded for many of the services they provide.

**Definition of services**

A fundamental aspect of all contracts between RHAs and providers is the definition of the services required of a particular provider. With the roll over of existing services for the 1993/94 financial year, the services to be provided by CHEs remained extremely vague. However, over the course of that year there have been ongoing efforts by both RHAs and providers to define those services. At the heart of this process is the continuing development of the definition of core services by the Core Services Committee which in turn largely drives the purchasing obligations of the RHA.

Whatever definition is arrived at, there is a strong incentive for CHEs to identify those areas outside of the service definitions on the basis that the CHEs are free to charge for such services and thus receive income over and above the funding they receive from the RHA. This again points out the balancing act that the government must carry out in negotiating its funding agreement with RHAs in that if CHEs are given too much latitude in their ability to charge for non-funded services, it would not be too long before this manifests itself as intense government lobbying.

As the service definitions will be locked in contractually, there will also be a continuing incentive for CHEs to develop new procedures and treatments not caught by service definitions that can also be the subject of user charges so as to increase CHE income.

One of the more significant competitive threats for CHEs is the loss of those services which provide the best returns on investment and the highest margins relative to costs. The current lack of capital resources available to CHEs in concert with rapid technological change in the health sector tends to confer an advantage on other providers that have the necessary capital available to them and who can set up new and more efficient operations utilizing the latest technology and thus secure such services. This has a particularly negative impact for CHEs in that the profits realized from those services are used to cross subsidize the low margin or, more likely, negative margin services required to be provided by CHEs pursuant to their purchase agreement with the RHA. At this point it becomes that much more difficult for a CHE to fulfil the objectives for CHEs set out in s 11 of the Health and Disability Services Act, particularly that of operating as a successful and efficient business.
Interprovider flows

Pursuant to their purchase agreements with the RHAs, CHEs are required to service a particular population. In some specialist areas this may be the entire population of New Zealand, but in many cases it will only be the population immediately surrounding a CHE’s physical location. This gives rise to a number of important contractual issues relating to the treatment of patients from outside the CHE’s area of responsibility; what are referred to as interprovider flows.

From the outset there was a recognition that a system had to be put in place to avoid anomalies and inequities resulting from users obtaining health services from a CHE other than that CHE which had received RHA funding for the population of which the particular user was a member. Difficulties have arisen with respect to the negotiation of suitable levels of compensation that a CHE should be able to secure whether from an RHA or another CHE, so as to address the concern of interprovider flows.

In some areas the contracting process with respect to interprovider flows has been no different from the contracting process in general. A CHE that has been providing health and disability services for users domiciled in other regions, can simply enter into negotiations with those other RHAs for the purpose of meeting those interregional interprovider flows. Where a CHE provides a national service and has done so for some time, there is a measurable risk with respect to setting the level of funding that those other RHAs should provide for that service. Where the services are more sporadic in nature and arise more as a result of a user simply visiting another region, then the issue becomes more complex.

This has been addressed at the inter-regional level by the recent guide to inter-regional flows promulgated jointly by the four RHAs. This guide provides for a fee for service payable by the relevant RHA (or budget-holding CHE) to the CRE provider, which fee is determined by reference to approximately 460 diagnostic-related groups or DRGs. These DRGs are used to classify general and obstetric hospital and psychiatric unit inpatient and daypatient episodes. This scheme has operated since 11 March 1994 and was given effect as a s 51 notice. In many cases CHEs and RHAs have contracted out of this regime.

CHE treatment of private patients

Similar to the position as regards identifying services that fall outside of the purchase agreement with the RHA, there is an incentive for CHEs to provide private patient services. This is a further opportunity for CHEs to augment their income over and above funding received from the RHA. In the 1994/95 Policy Guidelines for RHAs (p 25) the Crown set out a number of policies to be adopted by RHAs in the context of private patient treatment by CHEs. In particular RHAs were directed to ensure that their purchase agreements prevented CHEs from using RHA funding for health users other than those covered by that purchase agreement, required CHEs to provide an undertaking that RHA funded services would not be reduced or delayed as a result of any other contracts that a CHE may enter into and, finally, required CHEs to inform patients and their families about just what publicly funded services are available and the timing and terms of access to those services before that patient could be offered the option of private treatment.
On 25 May 1994, as a further development of the Policy Guidelines, the Ministry of Health released draft protocols for the treatment of private patients in public hospitals. Though these protocols have not yet been finalized it would seem likely that they will not change appreciably from those set out in the draft.

The draft protocols provide that private patient treatment by CHEs is only permissible where surplus capacity exists. The key issue that flows from this requirement is just what constitutes surplus capacity. It does not mean that there is no waiting list for the particular procedure or treatment under consideration. The Crown has expressly rejected that approach on the basis that the government must prioritize expenditure on health and to allow utilization to be totally demand driven would result in health costs to the government in excess of available funding. The government’s preferred option is to make available “surplus capacity” for CHE treatment of private patients as it would allow CHEs to earn much needed additional income, should result in an overall lower cost being paid by the RHA for the relevant service as part of the fixed cost for that service would be built into the fees paid by private patients and, finally, should enhance the quality and safety of the relevant service as a result of staff having more cases to work on.

The extent to which CHEs are able to take advantage of this flexibility and thus obtain additional income is reliant on the permissible number of people and period of waiting for those users of relevant service in the public sector. No doubt this would become an area of intense negotiation in the contracting process as CHEs attempt to increase the level of private patient use.

To date, at least two CHEs have utilized surplus capacity to provide services to private patients.

**Primary care**

The bulk of income received by the primary care health sector comes directly from users of those services. Notwithstanding, there are a number of incentives for RHAs to play a strong role in the contracting process with primary care providers. Though the amount of government funding, largely provided through GMS, to the primary care sector is quite low compared to funding levels to the secondary care sector, the participation by primary care providers in contracts may well be key to obtaining the desired benefits of the reforms due to the fact that primary care providers direct many users of health care services through the health system. Accordingly, the greater the degree to which primary care providers have accountability for their decisions as to the utilization of health care services, the less likely it is that users will be directed into possibly unnecessary or more expensive procedures and treatments where more suitable or less expensive procedures or treatments are available. At least that is the economic theory. In response, primary care providers and particularly general practitioners have strongly resisted the contracting process and have argued that the use of economic incentives, particularly budget-holding, are ethically questionable.

As stated earlier, GPs, largely through intense lobbying of government, managed to roll back the current GMS funding as a default option until January 1996. In the meantime some primary care provider groups have entered into limited alternative contracts with
RHA. As far as I am aware, these have been largely budget-holding contracts in the area of pharmaceuticals.

Those general practitioners continuing to operate under the s 51 default option remain in an essentially unchanged position other than the obligation to provide information to the RHA. This information flow is designed to place RHAs in a position where they will be able to contract on a more effective basis with general practitioners come January 1996. As the basis of future contracts with general practitioners is likely to be based on capitation, that is the number of patients for which a general practitioner or a group of general practitioners is responsible, in combination with budget-holding, general practitioners are being required to put in place enrolment systems and provide such enrolment information to the RHA.

This in turn has led to some disagreements over the application of the Privacy Act and specifically the Health Information Privacy Code promulgated pursuant to the Privacy Act to this disclosure of information to the RHAs.

Whilst the Code makes it clear that the assigning of a National Health Index number ("NHI") to an individual as a unique identifier allows for the relatively free movement of health information between the provider, RHA and the Ministry of Health, NHIs are not yet universally used. Accordingly some general practitioners are resisting the disclosure of health information that is not provided on the basis of NHIs to the relevant RHA. This resistance is premised on s 22C of the Health Act which provides that health information may only be disclosed to an RHA where such disclosure is essential for the exercising or performing of the RHA’s powers, duties or functions under the Health and Disability Services Act.

This limited interpretation of the law by general practitioners has not met with RHA acceptance. However, it is interesting to note that the 1994/95 policy guidelines for RHAs specifically state that the use of NHIs represents the only system with unique identification which grants access under the Health Privacy Code to RHAs, GPs and the Ministry of Health. RHAs are also directed in the policy guidelines to include a strategy in their purchase plans for handling privacy issues and are required to discuss their proposals not only with the Privacy Commissioner but also with consumer and provider groups.

**Conclusions**

This paper is entitled “The Contracting Process—Building New Relationships in Health Care”. That title was carefully chosen. The entering into of contracts represents the entering into of relationships between the contracting parties. That relationship often goes well beyond the specific terms of the contract and indeed there is a need in the more complex contractual arrangements for the relationship to be able to operate effectively outside of the four corners of the contract. It is probably not an overstatement to suggest that the key issue in terms of the success of a complex contract such as the purchase agreement between an RHA and a CHE is not so much that there is a clear contractual framework between the parties but that there is a positive working relationship that to some extent is reflected in the contract itself.

Given the complexity and the importance of the health contracting process, it is crucial
that the parties involved have an attitude focused on making the contract work rather than one focused on finding loopholes or an opportunity to "put one over" the other side.

There can be no doubt that the funding constraints both on the purchaser and provider sides place significant pressure on the contract relationship. However it is key to the success of the contracting process, that neither party perceives that it is in a dominant bargaining position and consequently free to exploit that position so as to obtain an unfair and possibly oppressive result.

On the assumption that the reforms are here to stay, in the final analysis the best health care for New Zealanders will be realized when both RHAs and CHEs negotiate in an environment of trust. The legislative environment in which both purchaser and provider operate should ensure that both purchaser and provider are working towards the promotion of the health interests of the people they represent and to which they provide services respectively.
The Contracting Process—Building New Relationships in Health Care—Commentary

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Introduction

Like Carl, I think that it is too early to reasonably assess the performance of the new health entities against the objectives set out in the Green and White Paper ("Your Health and the Public Health" released with Budget July 1991) and s 4 of the Health and Disability Services Act 1993. So far, despite the new structures, health services have been largely delivered on the basis of past arrangements which have been rolled over. I think, too, the term “contracting” in health may suggest competition among providers and an independence between the Regional Health Authorities and Crown Health Enterprises which is not real. I have thought about the issues raised by contracting necessarily from a more theoretical perspective than Carl who has had a greater involvement in the actual contracting process.

There are three issues which seemed to me important:
— putting contracting for health services in context;
— the opportunities for greater efficiency and transparency within the contracting process;
— the place of the health consumer and the need for more effective consultation.

Context of contracting

Contracting for health and disability services takes place within a framework that provides for direct government action. The government has direct responsibility for regulating and acting to preserve public health. This power includes maintaining border control, powers to stop the spread of infectious disease and powers to regulate specific services where those services are custodial or used by people who may be particularly vulnerable—the Old Peoples’ Homes Regulations are an example of this.

The government also steers the contracting process by the statement of Crown objectives notified to Regional Health Authorities (RHAs) and the Public Health Commission (PHC). These purchasers are under a duty to function in a way that will meet the Crown objectives.

Third, the Minister of Health can give express directions to an RHA or the PHC. These three types of powers set limits on contracting for the purchase of services.

Efficiency and transparency

I have mentioned that connotations of the word “contracting” may be misleading. There is no necessary link between the state contracting with another and competition for the
state's business. The other feature of the new health environment is that the Regional Health Authorities cannot choose not to contract and in the case of many services they have few providers from which to choose. Equally the Crown Health Enterprises (CHEs) are historically reliant upon public funding (now purchase) of services. These features mean that the major participants in the contracting process are "locked" into it. This has two effects.

First, it influences the kind of agreement that is likely to be negotiated. The RHAs and CHEs have to recognize that they will have an on-going relationship. The contracts are not for one-off purchases of something as straightforward as a load of firewood. They are not one-off. They are for services which are multi-dimensional and where the needs of those in the region for health services are forecast rather than known. This means the contracts will tend to be of what Harden calls a "secondary type" (Harden, The Contracting State (1992)). Harden says that this type of contract is likely to arise whenever the detail of obligations is difficult to define and the prospect of changes in circumstances altering the value or the cost of obligations agreed to is less acceptable to the contracting parties. That is, where parties are hesitant to allocate risk finally at the time the contract is made. It is hard to think of a case where these considerations are more true than in contracting for health services.

"Secondary type" contracts are more likely to include mechanisms for agreement on purchased services than specify the actual services to be purchased in great detail. Obviously the agreements will be some mix of specific obligations and rules about how specific obligations will be defined. This second rule aspect can be thought of as setting the ground rules for negotiation.

The second effect of the RHAs and the CHEs being locked into the contracting process is linked to the first. As Carl has noted, the possibility of competition among providers for many secondary services is limited. (It may of course become a more real possibility as components of broadly defined services are identified.)

Where there is limited scope for contestability of services the contracting process is essentially a process for managing decisions about health and disability services rather than it being allocation of resources through a competitive market. But contracting as a global management process is valuable in itself. The separation of the funder from the provider has sharply focused the role of the RHAs and CHEs. Contracting pits the interests of those parties. The public interest can be seen as being served by the process of negotiating. This is in distinction to the public interest being furthered by a unitary funding and providing organization.

But if the public interest is intended to be served by the process of contracting that process needs to be more transparent. Otherwise how are we to know what the process is achieving and whether what is achieved is in the public good? In the United Kingdom the National Health Management Executive has recommended that "contracts for health services, with both public and private providers be publicly available once they are signed" (Harden, p 45). Transparency requires that purchase agreements between RHAs and providers also be publicly available. Standard descriptions and definitions of services should be used as far as possible so that comparisons can be made between providers. In the past even
comparison between current and previous years’ outputs of the same Area Health Board were difficult as different dividing lines were drawn between services from year to year. These difficulties are part of the general problem of the RHAs having sufficient information about services and service costs to effectively bargain with providers.

A last comment on what we can expect from the contracting process is that we cannot expect it nor should it replace government regulation of the quality and baseline minimum standards of services. This will still be necessary. This is especially so as RHAs are expected to purchase services within tight budgets—creating a risk that quality may be traded off against volume of services. The Ministry of Health retains a role in setting minimum service standards. An example of its work in this area is the recent Health Consumer Safety Project. It might be suggested that the chain of contracts mandated by the reforms would enable the Crown as funder to stipulate quality standards. But these standards should not, in my view, be reviewable from year to year. Instead they ought to be the baseline requirements that are enforceable not simply as a term of agreement between two parties but enforceable by the State on behalf of the general public as part of the State’s overall responsibility for ensuring safety.

**Place of the health consumer**

The place of quality specifications— in contract or in legislation and regulation leads to my last issue—the place of the health consumer. It seems that the health consumer has no legal right to particular services that have been purchased within his or her region. The Health and Disability Commissioner Act 1994 will not guarantee levels of service. The Act’s focus is on procedural rights and the process of service delivery. This approach reflects the origins of the Act consequent on the Cartwright Report which was concerned with the way patients had been treated rather than what services they were entitled to. The Act is not a vehicle for collective protest against the mix of services or particular services purchased.

Under the previous health system services were not guaranteed. But the Social Security Act 1964 did provide for a wide range of benefits that paid for services. Services for which those benefits paid were supported by the government. To date, the pattern of services historically provided has been preserved by roll over arrangements. But it is intended that this will change so that the services purchased are those judged to best meet the needs of people, in New Zealand as a whole and in the four regions, for health and disability services.

The National Advisory Committee on Core Health and Disability Services is responsible for advising the Minister on the relative priority of services and which services should be publicly funded. Its progress has been slow.

The lack of an emerging consensus on relative priorities has left a vacuum as RHAs move away from historical patterns of service. Reaction to changes in services at a regional level has predictably been protective of local interests. Direct political lobbying is seen by the public as the most effective way to challenge these initiatives. It is hard to deny this when opposition MPs are eager for information that can be used to criticize the reforms and television has enabled Paul Holmes to become something of an ombudsman on health issues.
Finding “voice” at a political level on health issues has been easy. But absent from much of the political debate and public discussion is a realization that purchasing some health services involves deciding not to purchase others. Conversely deciding to discontinue buying some health services frees up money for new, better, or more comprehensive service elsewhere. Rationing of services and relative priorities has not been highlighted. This is in distinction to the experience in Oregon upon whose “experiment” the idea of core health and disability services has been based. In Oregon, the debate about health rationing that led to legislative reform there arose after a child died because Medicaid officials refused to fund a bone marrow transplant (Fox & Leicher “Rationing Care in Oregon The New Accountability”, Health Affairs 1 Summer 1991 7, 15).

In New Zealand there is not yet public recognition and acceptance that we cannot have all the services we would like. The Core Services Committee has to ask not just “what do you want or need” but “what would you give up in order to ensure a fairer system for all?” (Wyndham-Smith in Otago Bioethics Report Vol 3 No 1 Feb. 1994). If these questions are not asked and answered soon the Core Services Committee and the RHAs risk having their public consultations overwhelmed by clamouring at a political level.

Effective consultation is needed to lift the debate about changes in services above the voices of vested interests. It is also surely one of the ways in which the RHAs make a real contribution to the shape of the funding and purchase agreements. It has been noted that the Crown’s objectives notified to the RHA would override any inconsistent proposals that emerge from consultation. However, consultation by RHAs could be used to inform the authorities’ negotiation of the funding agreement with the Crown. The Crown’s objectives to date have been relatively general. In my view, there is considerable room for consultation by RHAs to influence both the funding and purchase agreements. Otherwise RHAs are simply the bargaining agents of the government.

In terms of the Health and Disability Services Act 1993 the RHAs enter funding agreements with the Crown. In negotiating these agreements they ought to be aware of the bargaining position of providers and also what kinds of services the people in their regions would like. English commentators have suggested that the practice of contracting submerges the policy considerations relevant to purchasing decisions (Freedland, “Government by Contract and Public Law”, Public Law 1994 Spring 86, 98–99). Consultation is critical in making these considerations more visible and ensuring that the policy of RHAs incorporates the “voice” of the wider community.

In summary I am making two points:

——the avenue for collective public influence of the choice of services purchased is through consultation or lobbying RHAs, the Core Services Committee or the government. (The Health and Disability Commissioner will deal with complaints about services that have been provided, not complaints that services have not been);

——the debate so far has not focused on the need to choose some services over others. RHAs and the Core Services Committee need to make this explicit in their consultation or the opportunity for public development of relative priorities will be lost.
Summary

The contracting process envisaged by the Health and Disability Services Act 1993 takes place within limits the government determines—such as registration requirements, minimum service standards and its powers to act directly to preserve public health.

The legislation also presumes the inclusion of publicly developed policy about what health and disability services should be bought. Advice from the Core Services Committee should inform the Crown’s objectives. Consultation by RHAs should inform its negotiation of the funding and purchase agreements. Contracting is currently taking place without clear directions (especially at a national level) about how to use limited budgets to purchase services which will promote the personal health of people. This may leave too much to the contracting process. The process creates opportunities for more efficient use of resources but needs to be more informed by advice and consultation and more transparent so that the public can assess contractual outcomes.
Dr Ray Naden
General Manager of Health Services, North Health

I knew it would be unwise to even attempt to talk in detail about the legal framework of contracting philosophies and, having heard the two previous speakers, I’m now very happy that I made that decision. But what I thought I could offer to this audience is a perspective from a person in an RHA, particularly as someone who has come from a total involvement in health all my life. So very much from the point of view of health service delivery, and what we need to achieve.

I think this afternoon there has already been, as has been the case in health reforms in New Zealand in general, a very heavy emphasis on efficiency. This has dominated the health reforms in New Zealand, far more than it has in other countries, to the exclusion in New Zealand of concerns that we need to have about effectiveness and appropriateness of services. I need hardly state that to do more efficiently things that do not need to be done or which are inappropriate is no gain for people who need the service. So in the time that I have I want to concentrate more on what we are seeking to achieve and strategies that we might adopt to achieve this, rather than dealing with some of the how issues and the methods of contracting.

A key feature of the health reforms is that disability services were brought together with health services. There are areas of important integration here, something that other countries in the world are trying to do. However, there is still a very great tendency to forget disability support services and there is also a tendency to forget that health services are more than elective surgical services. Elective surgical services probably make up less than five percent of the total services that we are involved in purchasing and yet very often we find ourselves discussing models of purchasing that apply quite successfully to elective surgery but which apply poorly to other services. For example, disability services account for a third of the purchasing expenditure for which we are responsible. The comment was made earlier that there had been no integration. However already 54 million dollars has been integrated into the health sector in our region and there have been some very substantial changes, which I could discuss later. The contracting changes which have occurred in the long term care of older people have probably been some of the most startling which have occurred since the health reforms began.

I will start with a brief outline of the new arrangements in New Zealand. Most of you will be familiar with this arrangement; the only point I want to make is that all payment for services is through contracts for services between RHAs and all the providers of services, and RHAs are set up in a way that they can in theory be a neutral purchaser. The important thing to perceive however is that above the RHA is an open ended and quite unsustainable demand—demand from government and demand from the public for the provision of
services. And at the other end we are faced with a lack of capacity and to some extent a lack of willingness to continue to meet that demand. Crown Health Enterprises have come from area health boards and public hospitals who by the nature of their setup were forced in the past to meet an impossible demand. In the way they have been set up now, they are increasingly saying that, in order to be commercially viable and sustainable organizations, they cannot any longer accept this responsibility for meeting completely unsustainable demand. This leaves an RHA in a very difficult position, between the rock of open-ended requirements from the government and the public and the hard place of providers who quite understandably say "your money will only buy so much".

The four RHAs are quite different geographically. We in the Northern Region have a population of 1.1 million residents; effectively we have 1.1 million members of our insurance scheme. We also have significant population growth, very significant Maori and Pacific Island populations growing quite rapidly.

Our mission statement which reflects the health and disability services legislation is to achieve maximum possible health for the people of our region through purchasing health and disability services. It is not to purchase just health and disability services. Nor is it to purchase against a prescription given to us by government because, although in theory there would be a defined set of core services, that has not eventuated and is highly unlikely to. So our task is to maximize health and that can be done in a wide range of ways including the purchase of services. There are a number of things that we need to take into consideration. One of the most significant and one that we are finding challenging is to develop a meaningful partnership with Maori which acknowledges the Treaty of Waitangi as more than just words. We are putting considerable effort into developing a true sense of partnership, particularly with iwi in co-purchasing arrangements and in supporting Maori to become providers and to develop autonomy.

Another major focus in the early stages has been an increasing emphasis on control of demand driven costs in primary care. It is important to appreciate that hospital based services have effectively been capped in terms of expenditure for some four years now and the burgeoning health expenditure worldwide has been controlled in the hospital sector. Until the health reforms began a year ago there had been something like a 13% reduction in purchasing power in the hospital sector in the previous four or five years. Expenditure in the demand driven sector, however, in primary care, pharmaceuticals, maternity and laboratory services has risen at approximately 10% per year for some years now.

We are also looking to develop community based care rather than hospital based care. New Zealand is still one of the most hospitalized countries in the world; there are a few who have as many hospital beds per head of population as we do. And then of course there are priority groups that have often missed out in the past. Mental health has been a Cinderella for many years and is finally getting recognition. Child health—New Zealand's child health statistics are quite appalling by international standards. Twenty years ago New Zealand had one of the best records of child health in the world and now we have one of the worst of the developed countries, and young people tend to miss out quite consistently. We also need to ensure targeting of many services to Maori and Pacific Island people who have high need and often poor access at present.
A point that I want to make is that we tend to forget that a service is what is received by the consumer. We often talk about surgical services or laboratory services or whatever and we are frequently talking about provider entities—provider units, provider groups, responsibility centres, etc. It is a very provider-orientated concept. We need to be continually conscious that a service ought to be defined in consumer terms; this is not a common situation in the public health sector.

North Health by its set-up is more in the nature of a health insurer than it is a health purchaser. In the United States, health purchasers have a range of formats, and depending on whether they are an active purchaser or whether they tend to lay off their purchasing in terms of contracting with others, they use anywhere between 8% and 18% of the purchasing budget on the administration of that function. North Health has 0.8% of the purchasing budget to run its operations and it is quite unrealistic to expect North Health to develop an active, hands-on purchasing role as clearly has been envisaged by some of the people who set up the health reform process. Active hands-on purchasing requires significantly more people and investment than New Zealand is putting into RHAs. This unrealistic expectation and excessive concern to minimize management costs creates a serious risk of failure in the current situation. North Health is much more in a position of arranging for others, on a contracting out basis, to provide, organize and arrange services.

We are more in the nature of a health insurer. Therefore we are very concerned about issues of coverage for our membership—making sure that all of the people who are our members are covered. We are concerned about the adequacy of that coverage and, an issue that is particularly important in New Zealand, the issue of equity. Because it is a socialized system that we are talking about—the Social Welfare System—equity and particularly equity of access to services is critically important. There are few models throughout the world that deal with the issue of equity. There are many that deal with the issue of efficiency but few that deal with the issue of equity.

Quality has a number of dimensions and it is important that all of these are considered together because none of them can be considered in isolation. Again, if efficiency is considered in isolation from all of the others, we may get more for less, but more services which are less appropriate. So for a purchaser, our concerns are particularly around who receives the service, what is received in terms of the description and the quality of the services, what price is payable, and who is responsible for providing it. For the RHA it is more a question of who takes the responsibility for providing a service even if they arrange it or sub-contract it or do it through other people. These are the issues that we as a purchaser, or as a regional health authority, are particularly concerned about. And these are the issues that we have found the greatest difficulty in developing in terms of our contracting. A provider will also want to know about other issues—what cost is involved, what revenue they can expect, and what resources are needed. But as a purchaser we are not necessarily concerned about these things. And where we become concerned about them, then we are running the risk of distracting ourselves from our primary purpose which is meeting the needs of the consumer. It has been quite difficult in many situations to avoid getting involved in some of these things and there is a clear pressure from government and from some of our staff that we should know about cost and production matters. We should know what an appropriate cost structure should be, but as I say, with
the limited infra-structure that we have, there is a strong reason not to get too involved in these matters.

A major issue for us is co-ordination of care. Increasingly these days consumers are concerned about their total treatment rather than about a single episode of care. Gone are the days when most people who required services required an ingrown toenail dealt with or a splinter removed or something simple, discreet and time limited. Most people these days are requiring complex, integrated services, often on an on-going basis, and it is very important that a total service is provided. All of the components may be present but unless they are assembled, co-ordinated and integrated together, the outcome for the consumer is not good. Consequently, a major focus of our contracting is on the provider who will provide co-ordinated care. And we are looking particularly for the arrangement where all the components are provided and there is a co-ordinating function within the provider. In our contracts with secondary and tertiary providers for such things as an end-stage renal failure program, an oncology service, a fertility service, we are looking not just for episodes of dialysis or episodes of chemotherapy, we are looking for total integrated packages of care for an individual. If we purchase only episodes of care, the client is highly likely to find that there are major gaps in their total care. Equally, in primary care, it is vitally important that the current fragmentation of primary care services, where there isn’t an effective co-ordinator of care, is addressed. This is no more startlingly illustrated than in children’s services at the moment. Children’s services in New Zealand are incredibly fragmented. There are numerous agencies providing all sorts of services—immunisation services, well-baby checks, growth and development checks, or whatever, but there is no mechanism at all for co-ordinating the care of children. And consequently, this leads to recent comments in the media that we can’t get proper services for young people. In fact, there are probably sufficient agencies involved, which are providing sufficient services, but the overlaps and the gaps between them make for inadequacies in meeting the needs of young people.

I might just touch briefly on an issue of funding. In the past the hospital services have largely been funded on a bulk funding basis, in that a large, single amount of money was paid to the hospital. The client receives services but there is no relationship between the amount of money coming in and the services being received. There is no alignment between those two. The dollars may be able to be tracked within the organization to where they are used but they are not allocated to any of the services. So that when we set out to find out the price of services, it has been extremely difficult. It is impossible, for example, for CHEs to tell us even the global amount that they spend on services like orthopaedics, let alone the amount that is allocated to individual services. That is understandable. There has never been a need to do that in the public sector.

We could move to a fee for service system, and there has been a lot of pressure to do that, where every service provided to a client has a dollar value attached to it. The administrative cost of that in New Zealand would be enormous. That is largely the way the American system has worked in the past, and much of Australia is still heavily dominated by this. I think the American system is the best example of one which is rapidly moving away from the micro allocation of dollars and services because the administrative cost is too great. We should be careful not to move to that type of system no matter how seductive may be
the appeal. Instead, we should be looking for a compromise somewhere in between, such as looking at groups of clients with services being provided to these groups of clients and a specific dollar amount attached to that package of services. That group of clients might be, for example, people with end-stage renal failure requiring dialysis, some three hundred people in our region. And we are saying that we want comprehensive services, including dialysis, kidney transplantation, assessment, eventually palliative care, treatment of bone complications, etc, all to be provided to that definable group. The dollar price that we would be prepared to pay for this package of services is the issue that would be negotiated. The advantage of this approach is that it gives the provider considerable flexibility in adapting the service to particular individuals. Where the service is paid for on a fee for service basis, there is a tendency for the provider to provide the service that is paid for even though that service may not be the most appropriate. There are also clear examples where arrangements have been set up on a fee for service basis and led to rapid escalation. A current example of this is Victoria in Australia which has currently moved to a DRG-based payment system, and is seeing a very significant increase in some of the procedural things that have been paid for. A major concern, however, has been the increase in the number of children who are being admitted to hospital. The best treatment for children provides care out of hospital. However, if providers are paid to admit children to hospital, they will do so. That is the sort of perverse incentive that this sort of fee for service will create.

To come to the goals for purchasing arrangement, I think it is important that we focus on our primary goal which is to improve health. Therefore we are looking for the most appropriate services for the population in terms of equity, then at providing the most appropriate services for individuals. Any arrangements that we set up must be able to be evaluated against these criteria. Are we getting the most appropriate services for individuals and for groups as a whole? There are also other goals that we must achieve—for example, managing financial risk. This is a major responsibility. We have a fixed allocation of funds made available to us and we have no ability at all under the legislation to raise extra funds. Of course we are looking for the best value for money.

I will discuss a couple of examples of some of our purchasing strategies. In the first place we take a specified population group, which might be the geographic population. It might for example be all of the people who reside in our region as with our regional services. We specify a range of services but we don’t specify them in great detail. The problem with specifying in great detail is that it creates the possibility or probability that the provider who has that contract can say, “well this person requires the following; you didn’t specify it in the contract and therefore, if you want it, you are going to have to pay extra outside the contract”. You can appreciate that for a regional health authority concerned with coverage and with a cap on its funding, that sort of contingency is something that we cannot handle. So in general terms we specify population groups and specify services, but with a fair amount of flexibility within the specification of services for the provider to meet the needs of individuals. In another form of contract, the people served may be specified individuals. In the future this may be how we purchase some of the specialized services, where people will be identified as those who will reach certain criteria. For example, for treatment like leukemia chemotherapy, renal failure treatment, coronary artery surgery, etc, there will be certain criteria set and when individuals meet those
criteria, they will receive specified services. Case management is going to become increasingly important, and will be specifically purchased. For a group of specified individuals, the contract will actually be for the co-ordination of care. There may be no direct provision of care by the group who take responsibility for case management. We will increasingly see this phenomenon in the disability support area. Here the co-ordination of care for people with disabilities is a very important function and the provider who takes the responsibility for care co-ordination may not themselves directly provide any of the care. Geriatricians are increasingly taking this sort of responsibility for the placement of people in long-term hospital care. In our region, the geriatricians have largely taken themselves out of the business of providing long-term care, but they take a major role in the assessment and care planning, the arrangement of care and in the monitoring of it.

Although there are some general principles of purchasing which I have outlined—about appropriateness of care for individuals, equity, co-ordination of care, proper integration—there is also some considerable diversity of requirements within individual services. For example, the priorities for surgical services are the services which will meet the acute needs of all the people in the population and there will be as much as possible of elective surgical services provided in addition. If people are asked what the priorities are, they are definitely in that order. People expect their acute surgical needs to be met first and elective surgical services to be provided secondarily. If we separate out these two and we contract for acute services for surgery separately, the cost of these is very considerable because the acute demand is quite variable, particularly in the smaller centres. It is obviously necessary to have adequate capacity to meet the peaks of those demands. The only efficient way to do that is to combine acute services with what we call complementary elective services, so that surgical services are provided on the basis that we meet acute demand first and as much elective services as possible within the available resources left over. We accept that on a day to day basis the amount of elective surgery that is done will vary. Over a longer period, this will be remarkably predictable but over shorter periods of days to weeks it can be quite variable. However, we also contract for elective surgical services outside those block contracts because elective surgical services come into the category where market forces can apply. They are able to be specified reasonably well, the quality can be monitored and there are alternative providers. If the markets are available, we will use markets as we have done recently in purchasing some additional elective surgery.

In disability support services, the priorities are quite different. There are people who have a disability who do not see themselves as having a sickness or illnesses. Cure is not the objective—maintenance of independence, empowerment, optimisation of quality of life are the major objectives. And in this sense, involvement of the individual and adaptability of services to that individual are critical. For these services we will move more and more towards care co-ordination contracts, for an agent type of service in that disability support area. In disability support it is more likely to be that type of contract where we contract for care co-ordination with the actual provision of the services being the subject of a separate contract or a sub-contract.

In primary care there are two major issues. Most of the expenditure is in the pharmaceutical area; about 50% of the expenditure is on pharmaceuticals ($180 million), and about
15% on laboratory services ($50 million). These two have been growing by at least 10% per year and by international standards are both quite high. In the past there has been no mechanism at all to restrain or control that growth and this is simply now an unacceptable drain on a limited total funding resource. The way that we will need to deal with this is to move towards GP budget holding. The doctors or primary care healthworkers who order these drugs or tests are the ones who have the control over utilization; it is necessary on the one hand to make them accountable for the utilization and on the other hand to give them incentives to manage that utilization better. In addition it will be possible to use market forces in both of these areas. These areas also meet the criteria—there are alternative providers, the services are able to be specified and the quality is able to be monitored (in this case, by the consumer). Market forces can be used and there could be some interesting dynamics. We expect to see alternative providers of some primary care services develop, for example, well child care. On the other hand, we want to use the GPs to do what they do best which is to manage the utilization of primary diagnostic and treatment services. We are moving to the GPs having budget holding responsibility for these services; on the other hand they are unlikely to contract for the actual purchase of those services in a sub-contracting way, because of the substantial administrative duplication of costs of these arrangements. We expect the RHA to continue to have direct contracts for these services with suppliers, with GPs having budget-holding responsibility for utilization.

Clinical support services is the area that has probably captured people’s imagination most in terms of contracting out. In the areas of hospital services, such as food services, technical services such as engineering, painting, electrical contracting, the contracting out of these services is easy to understand and will proceed. On the other hand, clinical support services also includes physiotherapy, occupational therapy, dietetics, and even nursing can be seen as a support service in some contexts. The degree to which providers decide to contract out clinical support services is going to be an area of considerable development. It is not one that we as a purchaser are going to have a great deal of direct involvement with. Our position is that we want to contract for the total package of services for the consumer and we do not wish to contract for clinical support services separately; we wish to see those incorporated into the package of services.

To conclude, some points were made earlier by other speakers, I think very validly, outlining some of the ideals of health systems and particularly how the New Zealand system in many ways does not meet the ideals of a reformed health system. I think that most countries in the world are struggling with this issue and New Zealand is closer than many to the ideal model. But there are some very significant areas in which we do not follow the ideal model and they relate particularly to the issue of competitive purchasers. Personally, I would be more than happy for there to be health care plans as alternative purchasers to RHAs. But in this country at the moment it is not thought to be sustainable. There are understandable transition issues that need to be taken into account and they are largely related to what the public can cope with and how quickly. So we have a situation which may not be the theoretical ideal, but which is certainly a major advance from what we had in the past. The challenge for all of us is to make the best of that and to move towards a more ideal system in the future. We should also be looking for flexible and adaptable solutions to meet the various objectives. It is a very significant mistake to look
for single idealistic solutions that may be applicable to one area, like elective surgery or pharmaceutical services, and try and apply those same solutions to areas such as mental health services or disability support services. "Horses for courses" is what we have to look for.

One of the key issues that we need to be conscious of is "where does the choice lie?" Consumer choice is going to increase significantly in some areas. In the selection of primary care provider, clients already have essentially freedom of choice and they will have even greater choice in the future because what they are getting from a primary care provider will become rather clearer. In maternity there is also a large element of choice and that will be advanced in the future rather than decreased. So those are areas where the client will have more choice—not to choose a health care plan which covers all core services but to choose some parts of the plan where they have the ability to make a good choice and there is choice available.

The second area is agent choice. I have talked already about the disability support service area and the clinical support service area where either a broker or primary care practitioner will be in the role of purchasing on behalf of clients. Then we will continue to have a number of situations where we will have preferred providers. This will particularly apply in regional services, tertiary services such as cardiac surgical services, and oncology services; small volume, very specific services where it makes no sense at all in a region of one million people to have more than one provider of those services. As I have mentioned, we will use market forces where market forces are appropriate and market forces are clearly appropriate in a number of areas and clearly quite inappropriate in others. I think that in assessing the health reforms we should be careful to judge the success of the health environment not on the success or failure of providers but on the success or failure of the system for consumers. Like all social services, we should assess how well a service works by how well the services meet the needs of the people who are least able to look after themselves.
Thank you for the opportunity to respond to the Regional Health Authorities’ view of purchasing. As a social scientist, my interest in contracting in the health services grew from my fascination with the political assumption that was made in the Green and White Paper (Upton, Your Health and The Public Health: A Statement of Government Policy, Wellington, 1991). Separating purchase and provider roles and requiring legal contracts between them was considered universally better that the previous bureaucratic area health board arrangements where, with some exceptions, purchasing and provision roles had been integrated. That efficiencies would flow from arm’s length contracting seemed to be an article of faith. However the evidence, particularly within the interdisciplinary socio-legal framework, raises many doubts, some of which have been highlighted by the Regional Health Authorities’ views expressed today.

Charles Wolfe, in his book analysing non-market and market organizations (Markets or Governments: Choosing Between Imperfect Alternatives, Cambridge, Massachusetts, 1988), makes the astute observation that political rewards go to politicians and officials who articulate, publicize, formulate and legislate proposed solutions without assuming responsibility for implementation. This provides incentives for politicians to focus on the short term, so that there is a marked disjuncture between their short-term horizons and the longer time required to analyse, experiment with and understand a particular problem or shortcoming so as to work out a practical remedy. As a result, future costs and benefits are heavily discounted while current and short-term benefits and costs are magnified. Public choice theory suggests it is in the self-interest of Ministers to say that operational problems in the sector are not their responsibility. Chief Executive Officers of Regional Health Authorities (RHAs) cannot be as expedient. The Legal Research Foundation has provided a valuable forum for public reflection and discussion on these matters.

The new players in the health service face a difficult task. They are partners, but at arm’s length and dancing to different music. In his paper Dr Tony Cull remarked that the purchasing authorities, the RHAs and the Public Health Commission (PHC) are required to “do good” and the Crown Health Enterprises (CHEs) to “do well”. These agendas are difficult for the RHAs to reconcile:

1. They are required to roll over services during the financial year 1993/94, but nonetheless be able to demonstrate short-term beneficial changes.

2. They are exhorted to provide a seamless web of services, while encouraging innovation.

3. They must use market mechanisms and begin competitive tendering even when
faced with monopoly providers and little competition in the provision of many services, and opportunities for economies of scale only in our largest cities.

4 They must implement a system pivotally based on having core services defined. These have not, will not and cannot be defined.

5 The new system is based on arm’s length contracts but, as has been pointed out, it is debatable whether these contracts are in fact freely entered into. There is already evidence of Government interference.

Dr Naden pointed out that the Government requires the RHAs to maintain existing area health board services, incorporate disability services and primary care including voluntary health services while at the same time expecting them to make efficiency gains within a capped budget.

The RHAs are not the only purchasers. The Accident Rehabilitation and Compensation Insurance Corporation has strengthened its purchasing function, despite the original intention in the Green and White Paper which called for its purchasing function to be contracted to the RHAs. The prospect of significant competing purchasers in the health services can be expected to lead to increased costs.

The RHAs’ task is made more difficult because the CHEs must attempt to be commercially viable and many are therefore wanting to discard some services like public health provision which they see as generating less income.

Moreover the RHAs have a political credibility problem. In the public mind the CHEs are associated somewhat erroneously with public hospitals, but they are at least embedded in the public consciousness. The RHAs have no natural political constituency and therefore are politically vulnerable to being rearranged or disestablished if they are not seen to be performing efficiently in the short to medium term.

I was interested to hear Dr Naden talk of his RHA as being closer to a health insurer concerned “about issues of coverage for our membership”, on the grounds that the Northern Regional Health Authority has less than 1% of the purchasing budget to run its operations and thus is unable to develop a hands-on purchasing role. He describes a contracting chain where others organize and arrange services. But in such a conception who is responsible for monitoring the quality of the service? Monitoring the quality of easily specified acute operations such as cataracts and heart operations is a relatively straightforward job, but in areas like disability services for those with head injuries, services for the mentally disabled and community-based primary care services, desired outcomes are more difficult and expensive to specify and therefore to monitor. As Dr Naden has pointed out, elective surgical services probably make up less than five per cent of the total services purchased by the RHAs.

Conceiving of the Regional Health Authorities as insurers rather than purchasers has significant implications beyond a name change. Purchasing authorities, bound to specific regional populations, are responsible to the Government for the health of that population. Insurance companies, which can of course more readily be privatized, compete for members on the margin. They are also exposed to “adverse selection” and will tend to rely
on “cream skimming” to protect themselves from being exposed to undue financial risk from insuring those who are at high risk from ill health—notably the poor. Unlike Regional Health Authorities, who must operate within a capped budget, insurance companies can alter premiums and service coverage relatively arbitrarily and thereby (depending on whether there really is competition) raise extra funds. Such an option may well be an attractive one for the Government attracted to notions of competition, and whose officials have studied the various Dutch and American insurance schemes closely.

The RHA representatives believe the present system is a major advance on the area health boards. But how can we tell if the new configuration of purchasers and providers is more efficient than the former area health boards in their two key tasks: providing efficient and accessible health services and improving the overall health of the population? Does the contracting process facilitate the development of a partnership with Maori? Are community groups’ views seriously taken into account?

The RHAs as separate purchasers were set up on the basis of the alleged efficiency gains from the purchaser/provider split, for which the evidence is in fact largely theoretical. Contracting would only be expected to lead to efficiencies under conditions where the service purchased is easily specified, monitored and there are competing providers available (Howden-Chapman, “Doing the Splits: Contracting Issues in the New Zealand Health Service” (1993) 24 Health Policy 273–286). Despite the rhetoric, there is no evidence internationally that a population’s health status is improved or consumer choice enhanced through a separate purchasing agency. As has been pointed out, the advent of contracts has in fact decreased patient choice in some ways, as the new system precluded pre-existing entitlements.

The evidence that increased competitive contracting in health services will lead to greater efficiencies is weak (Howden-Chapman & Ashton, “Shopping for Health: Purchasing Health Services through Contracts” (1994) 29 Health Policy 61–83). As Toni Ashton’s review pointed out, it is only in the predominantly private U.S. health system that there is any evidence for efficiency gains from competition and then only under particularly restricted conditions. There is clear evidence in areas such as mental health, where outcomes are difficult to specify, that competition has led to more fragmented, poorer quality services and that providers have been forced to drop their advocacy role (Smith & Lipsky Nonprofits for Hire: The Welfare State in the Age of Contracting, Cambridge, Massachusetts, 1993). An American review of contracting for mental health care found that competitive bidding systems often degenerate into administratively complicated negotiations between the State and private monopolies, resulting in greater costs and lower quality (Davidson, Schlesinger, Dorwart & Schnell, “State Purchase of Mental Health Care: Models and Motivations for Maintaining Accountability” (1991) 14 International Journal of Law and Psychiatry 387–403).

When the outcome criteria are broadened to include quality, community participation and equity the impact of competitive contracting is even more equivocal. For example, competition among New Zealand maternity providers has led not only to a rapid increase in expenditure on maternity benefits but several highly publicized incidents where lack of co-operation between GPs and midwives has led to avoidably damaged babies.
A comparative approach to institutional arrangements recognizes that it is unhelpful to
think of universally good systems and bad systems. Both government funded non-market
services and markets can have clear advantages. The key question is not whether four legs
are better than two, but to paraphrase Oliver Williamson, "What kind of contractual
relations should be institutionalized in what circumstances?" (Williamson "The Econom­
ics of Governance: Framework and Implications" (1984) 140 Journal of Institutional and
Theoretical Economics 195–223).

One way of comparing different institutional arrangements is to look at the transaction
costs of operating in different ways. This is particularly useful in an area like the New
Zealand health services where there has been almost no history of markets and market
regulation. Implementing the reforms has clearly been more expensive that was originally
foreseen, but in some ways the transition costs, while significant, are of less interest than
the ongoing transaction costs of the new system. Transaction costs are the costs which
must be borne by one or both parties beyond the direct costs of production of the service
or product itself. To minimize transaction costs agencies have incentives to act
opportunistically and try to shift costs onto another agency or back onto the patient’s
family. When purchasers and providers are highly dependent on mutual trust there is a
good case for integration.

I am concerned that the decision taken in the health reforms to require purchasing of
almost all services from providers through legally binding contracts subject to the
Commerce Act, takes little account of transaction costs. Within a fixed budget, this
decision has led to significant opportunity costs that must be extracted from the health
service. The bright side for present company is that it is a bonanza for lawyers. There is
indeed “gold in them there hills”. Writing, monitoring and enforcing legal contracts is an
expensive legal business.

I was interested in the comment of Dr Cull, as CEO of the Waikato CHE, that in his
organization there are 50 people whose jobs are solely to respond to their main purchaser,
the Midland Regional Health Authority. Since the reforms there has been a 50% in
crease in the combined numbers of people employed in the Ministry, RHAs, PHC and
CHEMU, compared to the Department of Health. And that increase ignores the multipli­
cation of 14 AHBs into 23 CHEs.

Mention was made of the central position of the consumer, but the contracting process
does not directly concern the consumer or the public. The Regional Health Authorities are
beholden to their unelected boards who are responsible to the Minister of Health. The
CHEs are responsible to their unelected boards who must answer to the Minister of Crown
Health Enterprises. From the patient’s or public’s point of view, accountability is unclear.
It is difficult to hold a Minister accountable, given the nature of the electoral system. A
patient who is on a long waiting list for a coronary by-pass operation, or has been denied
treatment such as dialysis and wishes to appeal the decision, is faced with appeals to an
array of people—the CHE managers, the RHA, eventually the Health Commissioner, and
lastly but probably most effectively the Minister of Health. When the clinician is in the
front-line of rationing, but increasingly makes it clear that the CHEs are restrained by the
RHAs who in turn are constrained by Government funding levels, there is plenty of space
for public confusion and dissatisfaction.
Those like myself concerned both with the equity and efficiency of different institutional arrangements call into question the appropriateness of relying solely on arm’s length contracting for all purchasing for health and health services. In a human services market like the health sector, where there are services which are difficult to specify and monitor, an organization based in large part on relationships of trust with integrated providers is likely in my view to be more efficient. In other words, rather than positioning themselves as remote insurers, the Regional Health Authorities could be more efficient if they were able under the legislation to contract out only easily specified services where a competitive market is feasible, but were enabled to develop within their organization operational services in areas where the inputs, such as staffing levels, are easier to specify than outputs.

The RHAs have entered new territory in social policy in New Zealand and there are potential conflicts of interest that have yet to be faced. For example, there are regulations in Californian law requiring physicians to disclose any financial interests in diagnostic facilities to which they refer. Similarly a Commission of Good Governance in the United Kingdom was required to address the issues of contract fraud that had arisen in the United Kingdom health reforms. A regulatory framework to consider these issues has not yet developed in New Zealand.

In conclusion, both speakers have highlighted the difficulties faced by the RHAs. They are required to move to competitive tendering whereas in many of the services they need to foster a more efficient approach through ensuring co-ordinated care and developing closer relationships with providers. The regulatory environment is underdeveloped and lines of political accountability are unclear. The undesirable secrecy now surrounding “commercially sensitive” contracts in the health sector means trends are difficult to evaluate, but while progress may have been made in refining contracts with providers, we have yet to see any overall evidence of increased efficiencies in the health service nor marked progress in the even more difficult task of improving health outcomes.