Voice and Exit in New Zealand's Health Care Sector—Commentary

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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.