

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 CHEs 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 CHE 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.