

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.