

## **CONTRACTING TO PURCHASE HEALTH AND DISABILITY SERVICES: AN RHA PERSPECTIVE**

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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 the services being provided to those 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

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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 inappropriate 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.