

## **Contracting to Purchase Health and Disability Services— Commentary**

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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 than 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 insurances 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 Economics 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 than 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% increase 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 multiplication 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.