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The New Zealand Health Reforms - Ethical or Unethical?

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Our Government is currently reforming the method by which it spends our health budget. It insists that the goal is privatisation. Indeed, one eminent critic calls itself "The Coalition for Public Health". Yet health is and will remain more than three-quarters publicly funded under the reforms. Health is and is likely to remain a complex and fairly stable mix of public and private provision. Is the Coalition's *raison d'etre* instead to champion public health (here distinguished from illness services)? The evidence is to the contrary. I conclude that among many others, The Coalition for Public Health is surprisingly confused on this central issue.

Some critics suppose that competition and profit maketh the reform. Yet the four Regional Health Authorities (RHAs) are its heart. They will spend rather than make money, and co-operate rather than compete. Furthermore, there is reason to believe RHAs will secure the Government's goal of better value per health dollar. As funding or buying agents for their separate regions, RHAs promise two big advances. Area Health Boards (AHBs) currently fund some health services for their communities, but other funding is fragmented among a bewildering range of understandings with the Department of Health. Under the reforms, each RHA will fund all health and disability support services for the people of its region, and should thereby secure big improvements in service co-ordination and cost. Secondly, AHBs are committed to employing providers from within their own ranks. As pure purchasers, on the other hand, RHAs will be asked to spend our health budget on the most cost-effective services available, whoever the provider might be, whether public or private. Significant benefits should again follow.

The provider side of each AHB is to become one or more Crown Health Enterprises (CHEs) under the reforms. CHEs will offer hospital-based services, plus such services as health protection and public health nursing. They may be required to return a profit, a margin, a dividend, or a successful business (nervous governments generate euphemisms) and many critics worry that this will compromise service quality. Competition among health providers is frequently opposed on similar grounds. Given that many profitable GP businesses provide first-rate health services in a competitive environment, however, it cannot be that tension between quality care and competitive profit-making is either fundamental or insurmountable. Under contract to RHA buyers, CHE services are to become more explicitly specified, quality more systematically monitored, and staff more accountable for delivery, then before. To use Professor Malcolm's handy terms, providers will do well by doing good. It would in any case be no fundamental change of the reform programme if CHEs were required merely to keep within budget. Success even in this would distinguish them from some of their largest AHB predecessors.

Those who say there will be no competition among providers frequently mistake hospital services for the whole of the health service. Even in the hospital domain, one should not forget that CHEs may compete with one another. By encouraging cost-saving concentrations of particularly expensive equipment and expertise in just a few hospitals, this new arrangement should do more than its predecessor to prevent extravagant duplication (of CT scanners, for example). Turning to primary health care, there clearly is enough competition to bring benefits. Organisations like Plunket have already sharpened their act, anticipating loss of their trustworthy Department of Health contract for a system of competitive tendering. With child health a reform priority, Plunket is now well placed to win contracts from organisations which are not yet organised regionally, and which know little about which services they actually provide, by which staff, and at what cost. GPs too will enter contracts with RHAs, and many are reportedly concerned that reform will see them "ultimately providing more services for less funding". (*Otago Daily Times*, 13 November 1992.) Those of us whose primary concern is the cost-effectiveness of our health service hope this GP worry is entirely justified.

There is reason to believe we are in for a better health service. When you hear the contrary claimed, ask yourself: Exactly which reform is being criticised? Is the issue core or peripheral? How does the old system fare under that same criticism?

Sexual Abuse in the Professional Relationship

The Medical Council of New Zealand has released a discussion document on sexual abuse in the professional relationship. Published in its latest newsletter, the document outlines the reasons for the Medical Council's commitment to eradicating all forms of sexual abuse in the doctor-patient relationship, spells out the "principle of zero tolerance with respect to a doctor who engages in sexual activity with a current patient", and defines what is understood by sexual inpropriety, sexual transgression and sexual violation. The range of penalties for various levels of offense is named. Guidelines for rehabilitation of doctors who have been struck off as a penalty for sexual abuse are still being developed.

The Council invites constructive comment on this document and hopes to have a statement for the profession finalised by July 1993.

Amongst other initiatives the Medical Council has also prompted a review of teaching in this area, and is working with medical schools to develop a more comprehensive programme.