TREASURY WORKING PAPER

00/20

A Review of Options for Health and Disability Support Purchasing in New Zealand

Nicholas Mays, Kenneth Hand

Abstract

The introduction of an internal market into New Zealand's publicly financed health system based on a purchaser-provider separation was highly controversial. From four Regional Health Authorities, the purchasing side of the internal market was subsequently reconfigured into a single national purchasing agency, the Health Funding Authority, in 1997.

This Working Paper reviews the original rationale for the separation of purchase from provision, discusses the recent experience of the separation in New Zealand and reviews options for the possible evolution of the purchasing function. The options reviewed include vertical integration (ie, the abolition of the purchaser-provider split).

It is argued that there are benefits associated with the separation of purchaser and provider, and that, on balance, it was a good thing, although its application to *all* services was probably inadvisable. However, no one model of purchaser organisation can fulfil all the requirements described by proponents of system change. Health services' purchasers are inescapably in a weak position vis-à-vis their providers. Whichever model of purchasing/planning services is implemented, purchasers will need to develop a new set of relationships with primary care providers, especially general practitioners, since primary care services are important for the functioning of the remainder of the health system. There are currently few incentives on primary care providers to consider the wider implications of their decisions for the rest of the sector and the delivery of primary care is imperfectly coordinated with other services.

This paper is a background paper and does not provide policy advice, nor does it propose any particular course of action. The Treasury has chosen to publish it (or make it available) in order to encourage peer comment with a view to ensuring that it is of good quality. The views expressed in the paper is/are those of the author(s) and do not necessarily reflect the views of the New Zealand Treasury. The Treasury takes no responsibility for any errors or omissions in, or for the correctness of, the information contained in this paper.

Acknowledgements

We are particularly grateful to the following external reviewers for detailed comments on, and criticism of, this Working Paper: Toni Aston, University of Auckland, Gregor Coster, University of Auckland, Mark Booth, Ministry of Health, Carol Searle, Health Funding Authority, Chip Cangialose, Health Funding Authority (now at the Health Services Research Centre of the Victoria University of Wellington and University of Otago) and John Waldon, Te Putahi a-Toi, School of Maori Studies, Massey University.

We are very grateful for discussion and written comments offered by colleagues of the Social Policy Branch at the Treasury, especially Annette Bridgman and Ron Crawford. We are also grateful to Peter Bushnell for his challenging observations on the draft.

As always, if we had had more energy, time and insight to take their suggestions further we would have produced a better analysis. None of our internal or external reviewers can be held responsible for the contents of this Working Paper.

CONTENTS

Explanatory Note on the Purpose and Context of the Review

This analysis of the strengths and weaknesses of different approaches to the planning and procurement of publicly financed health and disability support services was prepared in 1999, before the November General Election which brought a Labour-Alliance coalition Government to power (the references, but not the original analysis, were subsequently updated in 2000).

The incentives facing the agencies which plan or procure services and their relationships with providers are crucial to the ability of the publicly financed health and disability support system to manage within its allocated resources. All publicly financed systems face similar difficulties in managing their financial risks. It is the responsibility of the Treasury to advise the Minister of Finance on such issues.

The aim of the project was to review recent experience with the separation between purchase and provision functions in the sector as it existed at the time and to conduct an impartial assessment of the pros and cons of alternative options for organising the relations between purchase and provision in order to contribute to the Treasury's capacity to advise any incoming government.

Since the report was prepared, the Government has decided to abolish the separation between purchaser and provider in respect of public hospital and related services. The separation between purchaser and provider remains for many other health services (e.g. general practitioner services) and for all disability support services. The Government has also decided to introduce majority elected District Health Boards to be responsible for both planning and delivering public hospital and related health services. Although a generic option based on the integration of purchase and provision of services is discussed in the current analysis, the specifics of the Government's policy were not known at the time of writing and are, therefore, not discussed.

Although the Government has taken a number of decisions which could not have been anticipated when the paper was written, the analysis is still relevant to the sector since it discusses a number of important issues which the new District Health Boards will face in order to manage their budgetary responsibilities. In particular, the paper identifies the significance for risk management of developing strong relationships with the primary care sector.

The paper is published in line with the Treasury's policy of undertaking rigorous, forward-looking analyses of important issues in public policy in order to improve its ability to advise the government of the day and making these publicly available so that the quality of its analysis can be tested through open debate.

The paper was released under the Official Information Act in October 2000.

Summary

This report sets out the rationale for a separation between purchase and provision of publicly funded health and disability support services, discusses the recent experience of the purchaser – provider split in New Zealand and elsewhere and then reviews six potential options for the possible evolution of the purchasing function in the New Zealand publicly funded health and disability support system. The models discussed are:

- a single national public purchasing agency (ie, the current arrangements with possible modifications);
- sub-national, monopoly purchasing agencies;
- primary care-based, sub-national, monopoly purchasing agencies;
- national or sub-national, competing purchasers;
- specialist purchasers;
- vertical integration (ie, abolition of the current purchaser – provider split).

The models cover the three basic types of publicly financed system:

- vertical integration in which purchase and provision occurs through the same organisations;
- quasi-market or internal market in which purchase is separated from provision, purchasers are appointed to act on behalf of groups of patients and competition is largely confined to the supply of health services;
- regulated competition in which 'health plans' (ie, integrated purchaser-provider organisations) compete for patient enrolments and, in turn, decide which health and disability support services they will provide themselves and which they will purchase from provider organisations, thereby bringing about both demand and supply side competition (Reinhardt, 1998).

The review has demonstrated that there are benefits associated with the separation of purchaser and provider within the New Zealand publicly financed system. The principal benefits appear to relate, firstly, to the entry into the system of a wider range of non-government providers, particularly those offering services to deprived populations from Maori and Pacific Island backgrounds. These have allowed a flexible range of culturally appropriate services to be provided and widened patient choice. However, evidence is not available on their relative efficiency versus conventional service providers and there has been little sign of such developments in the hospital sector. Secondly, breaking the automatic link between the decision to provide a service and the precise institutional form of provision of that service allows government, at least in principle, to take strategic decisions on resource allocation which would otherwise be extremely difficult. In practice, issues such as hospital closures or re-locations have remained politically contentious. Finally, the separation has produced greater clarity and better information about what is being provided at tax payers' expense. However, it is virtually

impossible to determine the specific contribution of particular purchasing arrangements to trends in productivity, quality and outcomes in the health system. This is because many of the trends in system performance are long established (eg, shorter lengths of stay) and have little to do directly with institutional arrangements.

Although purchaser – provider contracting was introduced for *all* Personal Health and Disability Support Services, there are theoretical and practical grounds for concluding that the strict separation of the two roles as in the New Zealand version of the quasi-market in health services works better for some services than others. Instead, under the 1993 reforms of the health care system, it was assumed that all services would be improved by purchaser-provider contracting, rather than regarding this as an empirical matter. In general, the purchaser is in a better position to specify and monitor the nature, quality and reasonable cost of the Disability Support Services (eg, residential care in rest homes) than of many acute hospital services. The market for Disability Support Services is also considerably more contestable than that for acute hospital services. The position of public purchasers is currently further weakened in relation to acute hospital services by the fact that the Hospital and Health Services (HHSs), formerly Crown Health Enterprises (CHEs), are generally local monopoly providers of acute hospital services with very strong motivations to put pressure on the purchaser for additional funding. It is less clear what incentives the purchaser faces to take decisions which might be unpopular with influential hospital providers. It is argued that purchasers are further handicapped by the fact that the public hospitals are Crown-owned companies, thereby placing the Crown on both sides of the quasi-market and reducing the willingness of the Crown to allow the purchaser to threaten their viability even if this leads to more efficient health services overall. However, private ownership of hospitals per se is unlikely to make a major difference to the leverage of public purchasers. Purchasers are further handicapped by the inevitable tendency of politicians in publicly financed systems to wish to pursue multiple, complex and frequently incompatible health system goals on behalf of the public.

Whichever model of purchasing, including its abolition, is adopted in New Zealand, purchasers/planning organisations will need to develop a new set of relationships with primary care, particularly general practitioners, since primary care services are important determinants of the functioning of the rest of the health system, but weakly co-ordinated with the delivery of other health services. There are currently few incentives on primary care providers to consider the wider implications of their decisions for the rest of the sector. Where primary care does attract public subsidy, the objectives of the subsidy are not clearly specified, except to facilitate access in the broadest sense.

Current ownership arrangements incur many of the transactions costs of a contestable market, while continuing to provide HHSs with implicit Crown guarantees of their future incomes. One possible way of mitigating this difficulty would be to separate contracts for services from contracts for the use of particular facilities, thereby increasing the degree of contestability.

No single model of purchaser organisation is likely to offer all the attributes described by proponents of system change. This is because the goals of the publicly funded health system tend to be multiple and frequently conflicting. For example, there are concerns both to extend life and to improve its quality. Equally, there are concerns simultaneously to respond to 'need' (eg, severity of illness and suffering) and to treat only those who are likely to benefit the most within available resources. These are not necessarily the same groups of people. There are obvious conflicts between system goals which focus on improving the average health of the population and those which emphasise the importance of improving the health of particular social groups or people with particular conditions. Targeting the latter may not always improve overall health.

The option of moving directly to a system based on competition between purchasers for the capitation fee of individual patients, while conceptually attractive, would require fundamental system-wide change and would be hard to introduce on an experimental basis. Furthermore it would require solutions to be found to thorny issues relating to preventing risk selection and enhancing the effectiveness of individual user choice of health plan. The model is further handicapped by the likelihood that a choice of purchaser would only be feasible for about half the population, based in the larger centres. However, there is nothing, in principle, to prevent one model eventually being introduced in the main centres and a different model elsewhere. For example, in the main centres, in theory, there could be competition *in* the market and elsewhere, competition *for* the market.

By contrast, the case for devolving purchasing responsibility to fully or partially risk-bearing sub-purchasing organisations with fully integrated, capitated budgets for Personal Health (including General Medical Services) and Disability Support Services is strong, particularly if they are based on primary care, in both the health and disability spheres, and can offer more horizontally and vertically integrated services. This option would not allow the individual user to choose his/her purchaser, but would permit a range of different forms of purchasing organisation to take responsibility for all or part of the purchasing currently undertaken by the Health Funding Authority.

Primary care health professionals (not just general practitioners) may be able to exert a stronger influence over providers than previous public purchasing agencies, given their relatively greater clinical knowledge and the fact that their decisions frequently influence their patients' use of other health and social care services. They also have relationships with individual patients, usually over a considerable period of time which give them insights into patients' needs. By giving all or most of the health budget to primary care-based organisations with the ability to make 'savings' by better use of these budgets, they will face novel incentives to manage their enrolled patients' use of hospital and other resources. Although this option would require significant change, particularly to the way in which primary care, especially General Medical Services are subsidised, its implementation would not require system–wide upheaval. This option also builds on a number of current trends since a variety of capitated primary care organisations is already emerging, including Maori organisations. If these organisations competed periodically *for* the market

rather than continuously *in* the market, it should be possible to retain some contestability while reducing the likelihood of risk selection. Fully integrated, capitated budgets would allow the primary care-based purchasing organisation to make more flexible use of *all* the public finance available to a defined population. The organisation could, as a result, reduce the current eligibility for and levels of co-payments for primary care services and increase the amount of services provided free at the point of use. However, in order to do so, there would need to changes to the way in which general practitioners and others are remunerated.

This model inevitably has drawbacks as well as advantages compared with current arrangements. Principal among them is the possibility that an increase in the number of sub-purchasers will increase the transactions costs in the system, that central government policy will be interpreted differently by each sub-purchaser, that the available expertise in purchasing will be spread too thinly and that primary care-based purchasers may make inappropriate purchasing decisions influenced by their self-interest as potential providers.

The intrinsic weakness in the position of any purchaser of health services (due to problems of monopoly and information imbalances), coupled with a recognition of the undoubted transactions costs generated by purchaser - provider contracting, have led to calls for reversion to a more vertically integrated system. Under this approach, the most likely design would be to set up a series of equitably funded, territorial health services' authorities or boards across New Zealand, responsible for planning and delivery of all health and disability support services for a defined population. Boards/authorities might have a blend of elected and appointed members, but the emphasis would be on lay involvement and local representation rather than experience in a commercial, contractual environment.

To justify the disruption to existing arrangements which the re-introduction of this model would bring, it would be important to take advantage of the opportunity offered by the abolition of the internal market to make all publicly funded and subsidised services in an area the responsibility of the local health authority/board, including those of general practitioners, in order to improve the co-ordination of services. On the other hand, it is possible that general practitioners would not welcome this, especially if the health authorities included locally elected board members. In addition, it is unclear what greater incentives territorial health authorities would face to challenge inherited patterns of service delivery in order to improve effectiveness and efficiency of local services than the current monopoly national purchaser (the HFA). The only sanction which government could use in the event of poor purchaser performance, as now, would be to remove board members and replace them with more effective individuals or take direct control of the health authority.

One of the difficulties which a model based on re-integration of purchase and provision would face is the fact that disability support services, many parts of primary care and some mental health services are provided by private or 'third sector' organisations. Thus the local territorial health service will need to retain the capacity to contract and would not, in practice, be able to dismantle all parts of the purchaser-provider system. Some of the costs of the contracting process would remain.

As well as the risk of increasing the costs of managing the health system and spreading purchaser expertise more thinly because of the larger number of purchasing bodies compared with a single national purchaser, wholly or partly elected territorial health authorities are also likely to generate increased conflict with central government unless precautions are taken to define their respective responsibilities and decision making autonomy carefully. Finance would continue to come from central government, while the health authorities would tend, inevitably, to identify with their localities.

The final option is the least disruptive and unpredictable: to take opportunities within the existing purchaser–provider arrangements to make purchasing more economical, flexible and effective. A variety of changes are worth considering, including removing the 'ring fences' which currently reduce the flexibility of the purchaser to re-allocate resources between different parts of Vote: Health, purchasing programmes of care rather than services which relate to historic budgetary divisions, shifting to longer term contracts, rewarding providers for quality improvements as well as cost-reducing measures and avoiding strategic policy settings which commit the system to particular institutional solutions to service delivery. This last change would signal the end of policy goals such as those contained in the current hospital plan which focuses on the stability of the institutions as much as the hospital services which should be made available to different populations.

Other potential improvements include experiments with contracts for services and contracts for facilities for public hospital services in order to focus contractual incentives directly on groups of clinicians delivering services and re-negotiating contracts on a rolling basis so that not all contracts require re-negotiation at the same time each year, thereby allowing greater attention to be given to each contract negotiation. Finally, the currency of accountability between the Ministry of Health and the HFA could be adjusted over time to emphasise health and disability outcomes rather than exclusively the delivery of contracted outputs.

Part One: Theory of Effective Purchasing and Review of Recent Experience

This part of the post-election preparation report on health and disability support services' purchasing sets out the rationale for, and origins of, a separate health services purchasing function, generally, and in New Zealand, in particular. It defines health and disability support services' purchasing and its goals. The experience of purchasing in other health systems is briefly summarised together with what is known about the characteristics and strategies of effective purchasers. The paper continues by describing the recent evolution of the purchaser-provider split in New Zealand and its current strengths and weaknesses.

What is Purchasing?

The delivery of health and disability support services involves several key functions:

- a financing role (through taxes, co-payments, insurance premiums and out-of-pocket payment);
- a funding role (allocating resources either to purchasers, directly to providers or to vertically integrated purchaser and provider organisations via a formula of some kind, or payment schedules or on the basis of past or prospective expenditures);
- a purchasing role, which is distinguished from the funding role by a more strategic and proactive resource allocation role than funding, determining which services will be provided in some detail. This usually involves assessing health needs, selectively and differentially contracting with providers, and monitoring performance;
- a provision role – the delivery of services;
- a consumer role, in terms of accessing and using services; and
- a regulatory role.

The separation of these different functions in health care systems is historically quite common, and continues to be common. Given the salience of public financing of health care in all OECD countries, governments have taken a strong interest, on behalf of the population, in the nature and pattern of health services. In order to ensure that adequate and appropriate health services are provided, governments have relied on a variety of intermediary agents either to fund or actively purchase services, to monitor the consequences and to regulate activities in the health sector. Sometimes, these agents have been part of central government; in other countries, they have been quite distinct, though governed by statute. Wherever public finance has predominated in the health sector, the agents have been ultimately politically accountable, regardless of their identity.

In a number of countries, the funding and provider roles have been separated for many years (eg, private medical insurance in New Zealand and in many other countries; Accident Compensation Corporation (ACC) funding of health and rehabilitation services before the changes of July 1999; risk-bearing, gate-keeping arrangements in managed care organisations in the United States; and sickness fund-provider arrangements in many European countries). While many health care systems had planning arrangements in the past, principally to determine the location and scale of major infrastructure such as hospitals, active purchaser organisations are a far more recent feature of Western health systems. Like the previous planners, the purchaser makes decisions on behalf of community members (or the enrolees in various types of pre-paid health plans) as to their health care requirements. Unlike previous planning systems, purchasers are more likely to take decisions which visibly affect the interests of particular patient groups since purchasers commonly determine, or at least strongly shape, the range and balance of services made available to the population rather than simply decide on the location of infrastructure.

The development of the purchasing function is central to the quasi- or 'mimic' market changes in publicly financed health systems which occurred in countries such as the UK and New Zealand in the 1990s. The aim of quasi-market arrangements is for providers to compete to win contracts to provide services to patients whose interests are represented by publicly funded, monopsony purchasing organisations. In such a system, the effectiveness of the purchasers is crucial in driving quality and efficiency gains on the provider side. In turn, public purchasers depend on being given relatively clear objectives to work towards and the freedom to make the necessary changes to the mix and location of services, which enable these objectives to be met. In other words, the purchaser-provider model is predicated on a more business-like and less politically-driven approach to health system management by governments. Whether this can be sustained in publicly financed systems is another matter.

Separation of Purchase and Provision

The "purchaser-provider separation (or split)" is often used to describe the structural arrangements within quasi- or 'internal' markets, in which the purchasing and provision functions are undertaken by separate entities who focus solely on one or other role. Relationships between the purchaser (buyer) and provider (seller) are established by contracts, which specify the services to be provided in exchange for financial returns. However, the separation of purchase and provision can take various forms and at times the roles may be quite blurred. With internal market arrangements, the 'sharpness' of the separation varies. For example, in New Zealand contracts between purchasers and providers are legally recognised and enforceable within the courts, whereas NHS contracts in the UK carry no such legitimacy, and contracting disputes are ultimately arbitrated by the Secretary of State for Health. Purchase and provision roles may also be separated within vertically integrated health care arrangements, that is, single entities that undertake both purchase and provision roles, with providers either owned and managed by the entity or contracted to them. For example, Health Maintenance Organisations in the US are a well-known example where purchase (or insurance) and provision are

managed by the same entity. In New Zealand, some Area Health Boards (AHBs), which both purchased health services for their local populations and provided hospital and related community health services, internally separated purchase and provision functions shortly before their abolition in 1993, the most notable example being the 'Wellbank' within the Wellington AHB.

Goal of purchasing

The allocation of resources within the health care system occurs at every level – government, funder (if separate from government as in a social insurance fund), purchaser (if present), provider and clinician. Purchasers allocate resources to particular services, groups of providers or individual providers in order to achieve particular efficiency and equity goals. This differs from *funding* which describes the more passive process of allocating resources to providers such as through determining a global budget for a hospital or setting and administering fees for specific services to physicians. Under the latter, the providers largely determine the efficiency and equity goals of the system through a large number of more micro-level decisions. The role of allocating resources to individual patients is not generally considered part of the purchasing role. However, there are exceptions to this. For example, under the former GP fundholding scheme which operated at general practice level in the UK NHS, the budget holding GP was both the purchaser and could also act in a clinical capacity as the referral agent for individual patients. Similarly, the HFA is required from time to time to make decisions on a small number of exceptional cases, usually when their treatment incurs extremely high costs. However, the involvement of purchasing agents in, for example, determining criteria for rationing kidney dialysis services, indicates that the purchasing role can extend as far as involvement in decisions about which *types* of patients should receive which sorts of care. The extent to which this occurs will depend on how concerned the purchaser decides to be about the identity of the recipients of particular forms of care and the rarity and cost of the treatment.

Ultimately, in a largely publicly financed health system, the purchaser is the agent of central (and occasionally, local) government, acting on behalf of the people. Ovretveit (1995) defines the goal of the publicly funded health care purchaser as being:

- 'to make the best use of available resources to improve health and prevent illness by influencing other organisations to contribute to those ends and by contracting for health services'.

This is a wide-ranging definition of purchasing, which goes far beyond simply purchasing services. It probably captures the expectations surrounding purchasing in New Zealand, if not the specific goals set for the HFA. However, it raises issues of the appropriate objectives and targets for which purchasers can legitimately be held accountable since it implies that purchasers can be held responsible for improving the health of the population as well as the health of the patients who receive the services which it purchases. Though this is a laudable goal, it is problematic since so many of the determinants of population health lie outside the health sector.

Others have argued that, by contrast, purchasers should only be held to account for the delivery of *outputs* which are regarded as having a causal link with outcomes (Cumming and Scott, 1998) (see below for more on this issue). The latter argument equates to the current approach in New Zealand's public sector to defining the accountability of purchasing organisations and other strategic policy agencies: such bodies are accountable for monitoring the population's need for a range of services, procuring a defined range of 'outputs' which are hypothesised to be capable of positively influencing the desired outcome of maximising health and independence and then monitoring the performance of the providers. This formulation links the desired end (cost-effective health services to improve health) to what the purchaser will be held accountable for achieving towards that end. To work well, this approach requires an analysis (perhaps by the agency which performance manages the purchaser) to determine the degree to which the purchased outputs are, in fact, influencing outcomes positively.

However, both Ovretveit's and Cumming and Scott's formulations of the goals and related accountability of purchasers in a publicly financed health care system, though broad, are over-simplifications. Experience tells us that public health systems (and, therefore, especially purchasers) are simultaneously expected by the public, patients, politicians and control agencies to maintain high levels of allocative and technical efficiency while safeguarding quality, containing costs, assuring equity of access, responding to individual needs and providing acceptable services to all sub-groups in the population. It is no surprise if, from time to time, these goals conflict and this is reflected in the contracts and accountability regimes of the principal institutions in the sector. Public purchasers have to build up support for, and/or trade off, multiple and sometimes conflicting, goals.

Main functions of purchasers

Using a less ambitious definition of purchasing that focuses on outputs, purchasing can be broken into two principal functions:

- to make priority decisions according to 'need' (usually defined in terms of ability to benefit) which result in allocating particular volumes of resources to particular services, client groups and providers rather than to individual patients;
- to specify, negotiate and monitor contracts with providers that embody these resource allocation decisions.

However, even this less ambitious definition of the functions of health care purchasers, cannot escape complexity and controversy. The definition of 'need' used by purchasers to prioritise services and volumes of services is fraught with difficulty. The principal stumbling blocks are the definition(s) of 'need' selected and the acceptability of the chosen definition to a range of interest groups. The main dispute tends to be between those who see 'need' as fundamentally about ability to benefit from treatment or care and those who regard 'need' as concerned with the severity of the patient's condition.

Why have Purchasing?

During the later 1980s and early 1990s, a wide range of countries experimented with developing a purchasing function separate from that of providing health services, within previously vertically integrated health care systems (UK and New Zealand were particularly noteworthy examples). Countries that already had separate financing bodies and providers attempted to encourage the funding bodies, such as sickness funds in the Netherlands and in Germany, to take on a more active purchasing role. The broad concern motivating reformers in each country was a belief that public hospitals and other provider organisations faced few if any clear incentives to operate efficiently or responsively and that patterns of resource allocation tended to be driven by providers' interests rather than by the needs of patients or the strategies of planning authorities (Savas, Sheiman, Tragakes and Maarse, 1998). Rather than privatising the providers or turning them into for-profit firms, which would have been unpopular in many jurisdictions, reformers concentrated on turning planning bodies into purchasing organisations without any ties to specific providers.

The most commonly expressed reasons for introducing a 'purchaser-provider split' were as follows:

- to improve technical efficiency by allowing purchasers to select the best value provider accessible to their populations, including private and voluntary sector providers, thereby giving purchasers some control over providers;
- to allow those charged with determining the future pattern of health services in relation to the needs of the population to concentrate on this task unhindered by their previous responsibilities for managing health care institutions and, at the same time, to allow the providers to manage their own affairs with the minimum of unnecessary interference;
- to act as a counter-weight to decades of professional dominance of service specification and to challenge traditional patterns of resource allocation and sectional interests (active purchasing rather than passive funding or bureaucratic planning);
- to improve allocative efficiency by permitting purchasers to negotiate a new balance of services with providers;
- to encourage providers to respond more accurately and effectively to the needs of individual patients in order to retain contracts from purchasers;
- to facilitate clearer lines of public accountability for the performance of the purchaser and provider roles in the health system;
- to clarify providers' costs and the amount spent in each service area by comparing the services and costs of each provider;
- to make priority decisions in the system more explicit (Secretaries of State for Health, 1989; Hospital and Related Services Taskforce, 1988; Taskforce on the Funding and Provision of Health Services, 1991; Upton, 1991).

The rationale for developing a separate set of institutions to 'purchase' health services is based on the assumption that providers and their staff will inevitably have a partial view on the appropriate range and balance of services to be provided to a population. This necessitates a separate purchaser that can take a population and system-wide perspective on the needs of the population and how best to meet them, irrespective of the well-being of any individual institution or form of health care.

The rationale for having a separate purchaser function also presumes that there is a continuing need to *change* the nature of the health services offered to patients in a conscious, strategic manner which would not spontaneously occur through the aggregation of the individual decisions of providers and their staff, if they were left to take the allocative decisions. The rationale further indicates that there may be conflicts between the purchaser function and a range of professional and commercial interest groups (eg, the tension between Pharmac and the pharmaceutical industry in NZ) and that the ultimate funder (ie, the government) is willing to face the political consequences.

Pre-conditions for Effective Purchasing

For the separation of purchaser and provider functions in a quasi-market within any health care system to produce the gains in efficiency, quality and responsiveness put forward by its proponents (see above), three broad conditions in the environment have, as far as possible, to be met:

- There has to be some likelihood that competition or the threat of competition (contestability) will occur for most services (ie, the purchaser has to have some choice of providers, either institutions or clinician groups).
- It has to be relatively easy for new providers to enter the 'market' created by the separation of purchase and provision. There have to be few economies of scale and scope, but large returns to specialisation and low entry costs for this to occur. Alternatively, it needs to be relatively easy for new providers to exit the market without a large capital loss. In these circumstances, contestability can exist even if there are large economies of scale and scope. In the case of public hospitals, throughout the world, it appears to be difficult for governments to remove support for 'failing' institutions.
- The purchaser has to be sufficiently free from government or funder interference to be able to take decisions in line with its objectives which may adversely affect particular providers (eg, individual hospitals). This requires politicians, specifically, to avoid interventions on the supply side of the health system simply on the grounds that there are professional and/or public criticisms of the effects of the decisions made by the purchaser. This requires the government to acknowledge, in practice, the rationale for setting up a separate purchaser, which is to distance the government from direct involvement in decisions affecting particular provider interests.

Unfortunately, in the case of most services and most geographic areas in NZ, these conditions only hold patchily, or for certain services. Information asymmetries between purchaser and provider and barriers to market entry are far less prominent in social care of older people than in the case of many public hospital services. Public hospitals, further, tend to enjoy natural monopolies in many parts of the country and for many services, especially emergency and urgent care and some forms of chronic services (eg, kidney dialysis) for which patients cannot travel long distances. On the other hand, it is possible to envisage greater contestability for the provision of services such as elective surgery where patients can be booked well ahead of treatment. There are few major centres of population in New Zealand able to sustain a number of acute hospitals, the remaining population is thinly scattered and the total population is small. In addition, the general difficulty of measuring the comparative cost and quality of health care is as daunting in NZ as elsewhere. Regulations restrict who can and cannot offer particular services to protect public safety, but also have the effect of further restricting the role of the purchaser. As a result, bilateral monopoly relations are commonplace in the public hospital sector.

This analysis suggests that health care purchasing, in general, and in New Zealand, in particular, is far less likely to be a major driver of improvements in the cost and quality of services than it may be in other service sectors. Competition *in* the health care market appears unlikely to occur for many services. As a result, interest has grown in developing periodic competition *for* the market, in the form of franchising arrangements or tendering devolved purchasing arrangements to other organisations. For example, proposals from consortia involving GP groups and private insurers to take budgetary responsibility for purchasing and/or providing comprehensive health services for a defined population on behalf of the Health Funding Authority under the rubric of 'integrated care' may be seen as one form of franchising.

Whatever the limits to the strict economic rationale for the purchase-provider split in relation to many health services in a country the size of New Zealand, it must be remembered that there are related, but not strictly economic, reasons for a government to implement a separation of purchase from provision. The principal motive for government relates to the possibility that the split makes it easier for government to take controversial decisions which it believes are in the public interest. Thus it may be easier to reduce services at a particular hospital if the government does not also own and manage the hospital and employ the staff (see below for more on this).

This analysis indicates that, in practice, the question is whether imperfect purchasing is better than the previous approach in which health services were relatively passively funded through bodies which incorporated both provision and planning responsibilities.

Characteristics of Effective Purchasers

Despite the difficulties of the task of determining what and how powerful professionals will produce health services, the experience in the UK and the US highlights a number of features of purchaser behaviour which appear to be associated with greater success in pursuing the multiple and sometimes conflicting goals of health systems (Light, 1998; Mays and Dixon, 1996).

Relationships based on trust in order to influence providers

It is difficult to assess the quality of many health services, especially from the vantage point of the purchaser. It can even be difficult to assess whether a service has been (fully) delivered or not in accordance with the agreement reached between purchaser and provider. Thus the scope for writing contracts which have the capacity to describe all eventualities and to describe all service options is limited. The cost of so doing would also be high. In these circumstances, one option is to integrate purchase and provision in a single organisation. Alternatively, the purchaser can work to develop contractual relationships with providers based on trust backed up by systems for auditing the services provided. This is made easier when there is a reasonable degree of continuity of personnel on both sides of the relationship and the negotiation of contracts that are longer than the typical annual contracts seen in the New Zealand health sector at present.

Despite the risks of opportunistic and dishonest behaviour, more rather than less trust can often be a rational strategy provided that those who are trusting can also take strong action against those who take advantage of them. In this context, professionally imposed sanctions on fellow professionals can be a powerful sanction against poor performance. Similarly, professionals are strongly motivated to live up to peer expectations in order to maintain their status within the profession. This sort of motivation can be used by purchasers to encourage desirable behaviour.

Willingness to change provider in extremis in order to improve efficiency

Despite the day-to-day emphasis on building and maintaining relationships of trust, the effective purchaser has to demonstrate the willingness, faced with persistent under-performance or deviation from the objectives contained in contracts, to change providers. In order to do so, the purchaser has to have some choice of providers and/or a willingness to enable new providers to enter the market, thereby enabling some degree of contestability to be maintained.

Without contestability, one of the main justifications for maintaining a separation between purchase and provision within a publicly funded system is lost, since the separation incurs costs (a separate purchasing function can continue to be justified on grounds of public accountability, as a counter-weight to the narrower perspective of specific professional groups and as a means for establishing spending priorities systematically). Yet moving services between, say, one specialist centre and another is always fraught with controversy unless the shift is on a very small scale. As a result, purchasers need to be large enough to recruit high calibre staff with the expertise to take on specialist providers. As hospitals and other provider organisations merge, purchasers may need to become commensurately larger in order to have

purchasing power vis-à-vis local monopoly providers. At the very least, a larger purchaser is likely to have direct access to performance information on a range of providers, thereby enabling some form of 'benchmarking' of individual providers.

Access to Good Information on Cost and Quality of Services

The effective purchaser has access to a wide range of information on the effectiveness and cost-effectiveness of health services derived from research so that well informed choices can be made about the potential menu of services which providers offer. The main use of such research evidence is to enable the purchaser to engage in constructive discussion with clinicians and managers over the specification of services *within* a particular service area. This can lead to the development of clinical protocols for use in contracting. The purchaser must have the capacity to interpret and, if necessary, adjust the findings of the research to take account of local circumstances (eg, population characteristics, costs of inputs, etc).

The effective purchaser also needs access to reliable, up-to-date information on the quality, cost and efficiency of the services provided by different providers. In part this will depend on the requirement for monitoring information included in contracts. On the other hand, it will need investment in information systems to collect comparable data across all providers. Obtaining good information on provider performance is costly, which is why larger rather than smaller purchasing entities are likely to be preferred. This may, in turn, conflict with the desire to ensure that purchasers operate in a manner which is sensitive to local variations in needs and community priorities (see below).

Understanding of Population Needs

The greatest sensitivity to variations in population needs between different areas or in different sub-groups in the population is likely to result from devolved, local forms of purchasing organisation whereas larger purchasers are probably required for other aspects of purchasing such as securing good information on provider performance and spreading contracting costs over a wider population base. In addition, in the New Zealand context, it is important to consider the capacity of the purchaser to understand the needs of Maori and to put in place appropriate services. There are thus trade-offs to be made between the different dimensions of purchaser performance.

Ability to make Priority Decisions in a Manner Commanding Public and Professional Confidence

With declining trust in government agencies a feature of many Western countries, it is important for an effective purchaser to have not only an intellectually defensible strategy for taking hard priority decisions within a finite budget for health care, but also a means for involving the public, patients and professionals in the decision making process in ways which they find appropriate. Evidence suggests that the public does not wish to become involved in the detail of such decisions, but rather wishes to be involved in determining the principles and values to be employed to take such decisions (Lomas, 1997). At the same time, few members of the public will have any understanding or sympathy for the role of the purchaser compared with the

providers. GPs are important to involve since they have extensive contact with patients and influence their views about the system and local services.

The core of the difficulty facing purchasers lies in the multiple, often conflicting, goals both explicit and implicit in the publicly funded health care system. The effective purchaser has to have the ability to explain the nature of the trade-offs which it is making, as well as admitting in advance the likelihood that no one section of the population will be entirely satisfied with its decisions. The co-option of influential clinicians may assist with this task.

An alternative approach, which would result in a very different form of health system, would be to allow individual members of the population to choose the purchaser which they believed would best meet their personal mix of health care goals. In theory, this would place clear incentives of the purchasers to be responsive to the wishes of individual patients rather than attempting to interpret the health care purchasing implications of national government policy. This option is discussed in the second part of this paper. It is interesting to note that the emphasis in market reforms in mainly publicly financed health systems was not so much on individual user choice of purchaser, but on developing new professional agents to act on behalf of groups of patients (eg, general practice budget holders).

Developing a Purchasing Plan

This involves the capacity to decide approximately how much of which services and interventions to purchase, for whom and at what likely cost.

Ability to Specify, Negotiate and Monitor Contracts

Experience and research on total purchasing pilots in the UK suggest that the process of building a relationship with providers is at least as, if not more, important for effective purchasing of health services than the contracting process itself (Mays, Goodwin, Killoran and Malbon, 1998). The preparation of detailed contract documentation may be necessary for financial accountability, but appears to contribute little, in practice, to the goal of improving health services. On the other hand, the purchaser has to be able to specify the service required with some precision. The costs of contract specification have to be relatively low and the purchaser has to be able to obtain the necessary information to know that the service has been delivered as specified (ie, it must be possible to establish and monitor cost and quality even if the precise form of contract is less important).

Ability to Monitor Outcomes, Efficiency and Equity of Access to Services

This characteristic of an effective purchaser relates directly to the sub-sections above on understanding population needs, and accessing good data on the cost and quality of services.

Ability to Minimise Transaction Costs

Here again, there may be a trade offs between transaction costs and the number of purchasers and the number and detail of contracts. It is likely that system-wide costs will rise if purchasing responsibilities are delegated to more, smaller organisations.

Ability to Manage Financial and Clinical Risk

Put simply, this is the ability of the purchaser organisation to predict the demand for services, to work with providers to manage demand, to ensure that providers take appropriate responsibility for the risks they face and to make contingency arrangements for over- or under-spending.

An integrated budget

In order to discourage cost shifting by providers and purchasers, it important that purchasers have a budget, which, as far as possible, covers the entire spectrum of health services. This also encourages purchasers to consider new forms of service delivery that transcend conventional institutional barriers; for example, by contracting for the care of specific patient groups rather than separately for acute hospital, community and general medical services. This does not mean that the budget is managed without internal differentiation (managers will still need to be responsible for particular sub-budgets), but that the purchaser has equal control over all parts of the health services' budget, including the ability to define sub-budgets which relate to the patterns of services most likely to deliver the purchaser's goals.

Reconciling the characteristics of effective purchasers

It is reasonable to ask whether it is possible for a purchasing organisation to exhibit all of the 11 features discussed in this sub-section, whether there are potential conflicts between any of the features and abilities and whether all the characteristics are equally important for successful purchasing. For example, a purchaser might be very well placed to assess the needs of its local population by virtue of its small size or its close identification with a particular ethnic group (eg, Maori or Pacific Island peoples), but struggle to manage clinical and financial risk, or lack expertise in particular clinical areas. A purchaser might be superbly equipped with information about the cost and quality of services, but have little or no choice of providers and, therefore, be unable to use the information to choose the best provider, thus reducing the value of that information.

The 11 characteristics can be grouped into four broader categories which help in understanding the relative importance of each characteristic discussed above:

- The relationship between the purchaser and its environment (affecting its ability and willingness to make the market for services contestable);

- The identity of the purchaser (affecting its ability to make priority decisions with legitimacy, building public confidence and to counter professional objections to its course of action, including decisions to move services between providers) – this also influences the incentives which operate on the purchaser (eg, comparing the incentives acting on a private, for-profit purchaser versus a public authority);
- The technical capacity of the purchaser (in gathering information, in understanding services, in managing risk, in contracting, etc.), including basic features such as its size and scope of budget;
- The costs generated by the purchaser both itself and for providers.

It is extremely difficult to prioritise the four groups or the 11 individual characteristics. However, on balance, the identity of the purchaser, including the incentives operating on the purchaser and the degree of autonomy permitted to the purchaser, together with its relationship with its environment, appear to be more significant than the technical aspects of the purchaser or the costs it generates for the health system. The latter seem to be necessary, but not sufficient characteristics for effective purchasing. The former set of characteristics influences the ability of the purchaser to take decisions and follow them through.

International Experience with Health Care Purchasing

While the expectations of what the purchaser-provider separation could achieve in terms of efficiency and quality gains in publicly funded health care systems (eg, UK and NZ) and in employer-based systems (eg, the USA) have been high, the reality has been less encouraging, because, usually, not all the above pre–conditions have been met and not all purchasers have been able to emulate the behaviour of the most effective purchasers.

A summary of the experience to date with purchasing in the UK NHS is that:

- Purchasers have found it difficult to engage in meaningful dialogue with providers, especially with clinicians, and to obtain adequate information to assist with active purchasing. Health authority purchasers found this a particular difficulty, whereas GP fund holders found it easier to develop relationships with clinicians.
- The initiative continues to lie with the providers to define what will be provided since most of the clinical expertise resides with the providers. Even assuming that health authorities could have afforded to retain the services of clinical experts in every specialty, it is unlikely that practising clinicians would have volunteered to take on the roles. Again, GP fund holders found it easier to challenge their specialist colleagues, and had some incentives to do so, in that they were able to retain any ‘savings’ which they generated from more efficient budgetary management and service purchasing. These ‘savings’ could be used in ways which indirectly increased the attractiveness or value of their practices. In addition, they were clinicians themselves, which may have helped. Health authorities had few, if any, obvious incentives to take on professional interests since, as

public authorities, they could not retain 'savings' and re-invest them in their businesses.

- Few changes brought about by purchasers have been more than marginal – the drivers of health system change appear to be demographic, technological and professional as before – for example, it has proved extremely difficult to extract resources from acute hospitals for investment elsewhere. The main improvements brought about by GP fund holders were shorter waiting times, more information on the progress of their patients and some alterations in the place of care. (Goodwin, 1998)

- Purchasing is intellectually demanding and it is frequently difficult clearly to identify the 'added value' provided by the purchasing process. Purchasers have struggled to recruit the best people. The bias in the training of NHS managers was towards operations not purchasing strategy. It was also easier to justify higher salaries for managers running large hospitals rather than health authorities, the role of which was less well understood by the public or politicians.

- Purchasers have mainly failed to become identified with the public interest rather than with bureaucratic restriction and supposed 'cost-cutting'. The role of the purchaser is generally not understood by the public. Purchasers are easy targets for 'bureaucrat bashing' in the mass media.

- Central agencies and national politicians have been unable to avoid involvement in the provider side of the health system, since the NHS remains tax-funded, which has weakened the position of purchasers. There has been a reluctance to allow public hospitals to 'fail' because of the high esteem in which they are held locally. This has inhibited the private sector from trying to enter the market.

- Purchasers, the public and politicians are all uncomfortable with taking the hard priority decisions that are at the heart of efficient purchasing when faced with a budget constraint. If a budget constraint operates, then these decisions are made, whether by purchasers, providers, or both in collaboration. However, a purchaser-provider separation encourages the providers to behave self-interestedly by exposing the rationing decisions imposed by the purchasers. It is plausible that the public takes greater confidence from a provider-driven system in which clinicians make the decisions and that such decisions are less visible to the public when taken by professionals in the course of their day-to-day clinical work (Le Grand, Mays and Mulligan, 1998; Light, 1998; Rosen and Mays, 1998).

The experience in the UK NHS can be explained, in large part, by the fact that the quasi-market model was put in place on the assumption that relatively straightforward supply-side competition would be the norm. In fact, purchasers have generally faced managing bilateral monopoly relationships in which there has been a considerable divergence of interest between purchasers and providers, especially for hospital services.

Where purchasers have been able to tender competitively for services (eg, state mental health services in USA), they have made substantial, but mostly one–off gains, for example by being able to reconfigure provision in ways which were not possible under the former vertically integrated systems (Bachmann, 1996). However, soon after, they have found themselves re-establishing former bilateral monopoly relations once the contracts have been awarded (albeit with new providers) since there are high costs associated with re-tendering and disruption to patient care. In addition, over time, alternative providers cease to operate, leaving the purchaser without a choice of provider in future. In the long term, the purchaser has had little scope for driving efficiency gains and little opportunity to engender contestability. A large part of the gains of these tendering exercises has been strictly non-economic in that they weakened producer interests and allowed certain strategic decisions to be taken which had proved impossible under the previous arrangements. Nonetheless, this is an important benefit of purchaser-provider separation from a government decision making perspective.

In the USA, where purchasing has probably been the most advanced (though usually for enrolees in a competitive environment rather than for a geographic population in a monopoly purchase environment), experience has shown that successful purchasing requires large, well informed and tough organisations with strong motivation to take on vested producer interests (Light, 1998). These organisations are costly to run. Even in these circumstances, the benefits of active purchasing take a number of years to appear.

Rationale for New Zealand's Purchaser-Provider Separation

Before the purchaser-provider split

With the passing of the Area Health Boards Act in 1983, the administration of publicly funded hospital and community health services was gradually transferred from hospital boards to 14 geographically based Area Health Boards (AHBs). Each was allocated a budget based on the relative needs of its populations using the newly introduced Population-Based Funding Formula. AHBs were integrated purchaser-providers that allocated budgets to services and to individual service users for hospital and community health services. The Department of Health continued to fund primary health care directly through primary health care subsidies. Administration of disability support services was split between the Departments of Social Welfare and Health. AHBs did not compete with each other or with the private sector to attract public patients, and they received their funding regardless of the level of their performance. Aside from simple forms of financial accountability, AHBs were generally not upwardly accountable to their funder (the government) for the services they provided, but to their elected boards. In the late 1980s, general management was introduced into AHBs, and the Department of Health began to develop more explicit expectations of what the AHBs were to do in return for their funding.

In 1987 the Fourth Labour Government established the Hospital and Related Services Taskforce (the Gibbs Taskforce). While recommending that the government remain the dominant source of finance for the sector, both the

Taskforce, and its successor the Taskforce on Funding and Provision of Health Services, recommended separating out the purchase and provider functions of the Area Health Boards (AHBs), and establishing regional purchasers that would buy publicly-funded health services on behalf of their populations (Hospital and Related Services Taskforce, 1988; Taskforce on the Funding and Provision of Health Services, 1991).

The Taskforces perceived several key problems with the structure and terms of reference of the then AHBs, together with the incentives that they faced, as follows:

- a conflict of interest between the planning or 'purchase' and provision roles of the AHBs. Their hospital service provision role dominated the planning of other services;
- weak incentives for AHBs to use the most cost-effective providers and seek out cost-saving technology and service delivery options. There was little or no incentive for the AHB to choose alternative (more efficient) providers when they would directly face the costs associated with closing down their own facilities and reducing their own staffing levels. As a result, they tended to continue inherited patterns of hospital and related services' funding;
- slack in the system, as shown by the variations between the AHBs in unit costs and other measures of financial efficiency;
- a tendency to fund over-spends and service developments by running down capital investment (eg, deferring essential maintenance);
- an unresolved conflict between the requirement for upward accountability for their resources and for the implementation of government health services policy, as opposed to their locally elected board members' concept of accountability downwards to the local community. As well as political friction, this conflict was also associated (rightly or wrongly) with poor cost control on the part of AHBs; and
- lack of fully integrated purchasing budgets (eg, not able to influence GMS or DSS and a separation between ACC and other health funding).

The Taskforces and subsequent government policy documents identified a number of benefits potentially flowing from the purchaser-provider separation and the resultant opportunity for provider competition for the business of purchasers, as follows:

- Government could set clear non-conflicting objectives for purchasers and providers (AHBs' mixed, conflicting objectives would be removed). Performance could be monitored more readily against objectives. Decisions on resource allocation would no longer be made by provider organisations with a vested interest in the status quo. The influence of large hospitals on resource allocation should be reduced and, with it, an increased likelihood of shifts of resources in response to consumer demand and considerations of cost-effectiveness. Purchasers would focus on the effectiveness and efficiency of different types of services and methods of

health care provision, while providers would focus on the quality and cost of services. The two would be linked by contracts which would specify efficiency improvements which could then be monitored;

- Market or quasi-market arrangements would permit and encourage greater competition in the provision of health care services, and thereby improve overall efficiency. The poorer performing hospitals would be compelled to improve their efficiency levels, thereby releasing resources;
- The creation of a set of prices would allow the performance of hospitals to be compared, while competition between providers for contracts would encourage the elimination of waste and improve the allocation of resources within provider organisations;
- Successful provider organisations would be rewarded for their performance and poor ones penalised, instead of both automatically securing their budgets;
- Competition between providers would promote greater responsiveness and choice for service users;
- The reforms would allow providers greater autonomy to manage their own affairs flexibly without bureaucratic interference and would distance Ministers from operational decisions;
- Allowing purchasers a choice of providers including the private sector would reduce the likelihood of over-investment in particular facilities. It was argued that the previous separation between public and private finance and provision might have led to duplication of investment and inefficiency.

The case for moving towards a more market-oriented structure mirrored the nature of wider economic reforms, which had taken place in New Zealand after 1984.

Recent Purchase Arrangements in New Zealand

1993 quasi-market changes

Following the statement of government policy in the ‘Green and White Paper' (Upton, 1991) purchasing and provision was separated in 1993 with the establishment of four RHAs comprising Ministerial appointees as purchasers to replace the partially elected AHBs. Population-focused public health services were purchased separately by a national Public Health Commission (PHC). Twenty-three Crown Health Enterprises (CHEs) were set up to provide hospital and community health services. These were separate state-owned entities operating as shareholding enterprises under the Companies Act 1993 with statutory objectives to exhibit a sense of social responsibility while also operating as successful and efficient businesses able to make profits. Their boards of directors were Ministerial appointees. The RHAs were accountable to the Minister of Health and the CHEs to a separate Minister of Crown Health Enterprises, thereby extending the purchaser-provider distinction into central government at ministerial level.

The four RHAs established a joint subsidiary, Pharmac, responsible for purchasing GP pharmaceuticals. Pharmac's role was to determine which drugs within each therapeutic category attracted government subsidies and which did not on grounds which include their relative cost-effectiveness.

Although the original thinking had been to allow patients to choose whether they wished to obtain their health care competitively either through the RHAs or through non-governmental purchasers (unlike the internal market in the UK NHS), this aspect of the reforms was suspended for a mixture of practical and political reasons. RHAs remained regional monopoly purchasers, having started life on the assumption that they would eventually either be taken over by competing, independent health plans or compete with such plans. When the plan for demand side competition was suspended, the justification for the separate PHC was weakened since population-based RHAs were regarded as being capable of purchasing public health services in a way that competing health plans would not have been. It had been argued, on theoretical grounds, that since patient choice of competing health plans might lead to considerable patient movement between plans, this would discourage plans from investing in screening and health promotion services for their enrolees. Eventually, the PHC was abolished.

RHAs were allocated budgets according to a needs-weighted capitation formula in the same way as the former AHBs. They were to purchase all primary and secondary care as well as community health services and public health services, which had previously been administered separately. They were also nominally responsible for GMS subsidies. Later, disability support services were gradually shifted into Vote: Health and included in the health services purchasing process. Despite an original intention to include services for accident victims paid for by ACC in the purchasing responsibilities of the RHAs, this plan was eventually dropped in 1995. Instead, the RHAs purchased acute accident care, but elective surgery, rehabilitation and primary care associated with accidents remained with ACC.

A range of Ministerial advisory bodies was established, including The National Advisory Committee on Core Health and Disability Services which was set up in 1992 to define the package of health services to be financed from the public purse to which all New Zealanders should have access. A 'core' set of publicly funded services was essential to the original concept of developing competing health plans since there could not be fair competition unless each plan agreed to provide the same basic package of services to its enrolees. Not only did the task of defining a 'core' and agreed terms of access prove impossible, it rapidly lost its political purpose as it became apparent that the Government did not wish to pursue the option of developing competition on the demand side of the quasi-market. Instead, the Committee under its new name of the National Advisory Committee on Health and Disability (known as the National Health Committee) has concentrated on developing guidelines and protocols to shape clinical practice in the direction of beneficial treatments. It also provides the Minister of Health with independent analysis and advice on major health issues.

As part of an approach to demand management across the primary and secondary care divide, subsidies towards the charges faced by patients for GP visits were targeted more sharply on those with low incomes, user charges for pharmaceuticals were increased and new charges for laboratory tests and outpatient and inpatient secondary health care services were introduced alongside the quasi-market (Shipley 1991). The hospital user charges were intensely unpopular. Inpatient hospital charges were removed after 13 months and hospital outpatient charges in 1997, leaving the re-targeted charges for GP visits, but not for hospital attendances such as visits to the A&E department. The increases in pharmaceutical charges and new laboratory charges were accompanied by the gradual phasing out of demand-driven budgets for pharmaceuticals and DSS.

Adjustments after 1996

The Coalition Health Agreement of 1996 retained the basic architecture of the 1993 system by maintaining the separation of purchaser and provider which enables the potential for some form of competition between providers. The company model of provider governance was also retained. However, the Agreement marked significant change and a shift away from the earlier emphasis on supply side competition as the motor for health care improvement towards giving a greater emphasis to collaboration between providers and across the purchaser-provider split. The Agreement also signalled that the original idea of having competing health plans financed by individual patient 'vouchers' was very unlikely to be developed. The separation of purchase and provision at Ministerial level was removed and the Minister of Health and Minister of Finance made jointly responsible for the Crown's ownership interest in the public providers rather than the Minister for Crown Health Enterprises. The 23 CHEs were given the less commercial-sounding name of Hospital and Health Services (HHSs) and formally turned from for profit to not-for-profit status. This last change of status was largely symbolic since any 'profits' from the CHEs would have been ploughed back into the health system under the arrangements which existed between 1993 and 1996. A new capital charging regime was instituted in order to encourage the HHSs to consider the opportunity cost of their capital in the same way as their revenue. There was also to be a shift towards longer-term contractual relationships between purchasers and providers based on comparative performance data rather than on a competitive price and volume basis. This change was largely a recognition of how the system was operating in practice, rather than a substantial alteration of payment incentives. In September 1998, a single, national purchasing authority, the Health Funding Authority (HFA) took over purchasing responsibilities from a Transitional Health Authority which had been managing the shift from four RHAs to a single national agency. Finally, in 1998/99, the prices paid by the purchaser to HHSs were uprated in order more fully to reflect underlying costs and to eliminate HHSs' deficits (the so called 'deficit switch'). The HSSs had argued since the inception of the quasi-market that the public purchasers had placed unreasonable demands on them in terms of volume and quality criteria compared with the level of resources which they had been prepared to make available. As a result, they had mostly run deficits.

Objectives of the HFA

- To monitor the need for public health, personal health and disability support services of the people of New Zealand;
- To purchase the best mix of public health, personal health and disability services to maximise the population's health and independence within available resources through purchase agreements and other arrangements;
- To monitor the performance of providers against those purchase agreements or arrangements.

Roles and functions in the post-1996 system have remained broadly the same, but the Ministry of Health has encouraged the HFA to use more diverse approaches to contracting, including longer-term contracts. In line with a shift towards 'benchmark' competition, a national pricing schedule has been developed by the HFA. HHSs and the HFA are now required to disclose information relevant to the contracting process to one another. Previously, a wide range of information on price, cost and quality standards was deemed commercially sensitive by the CHEs on the assumption that they were competing companies.

Following the earlier attempt to define a 'core' of publicly funded health services, the HFA has begun work on its own method for setting priorities across its entire portfolio based on maximising 'health gain' within available resources. In parallel, the Ministry of Health and the HFA have used the annual Funding Agreement between the Minister of Health and the HFA to increase the level of explicitness in documents setting out the services covered by Vote: Health. This represents a continuation of the earlier aim of establishing 'core services' in the public sector and of giving the public greater certainty as to what it can expect from the sector. Private health insurers have encouraged this trend believing that it is in their long term interests for patients to be able to identify more precisely what the public sector will and will not provide for them.

The ACC has increasingly moved away from a relatively passive role towards a more active purchasing role in relation to its health services, especially in the case of elective surgery. For example, in 1998/99 ACC signed a contract with the naval hospital at Devonport for elective surgery rather than with any of the HSSs in Auckland. This was made possible by the fact that the hospital had spare capacity which it offered at a competitive price, and was prepared to implement the detailed treatment protocols developed by ACC. The major changes to employer and employee accident insurance introduced in July 1999, in which companies must now choose a private insurer rather than ACC to manage their risk of work-related accidents, is already leading to changes in the purchase of accident-related health services. For the present, the HFA will continue to purchase hospital emergency services relating to accidents, wherever they occur. However, the new private insurers will reimburse providers for the primary medical, elective surgical and rehabilitative services required by workplace accident victims. Increasingly, private insurers are likely to shift from funders to active purchasers of these services, particularly electives and rehabilitation.

New Zealand's Experience of the Purchaser-Provider Separation

Very little evaluation work has been undertaken or published on the experiences in New Zealand since 1993, other than at a very general level (Cumming and Salmond 1998; Ashton, 1999). The reforms are also difficult to evaluate because of the increased public funding allocated to the sector between 1993 and 1999, and because of the changes in policy and structure which have occurred over the five years the reforms have been in place. Nevertheless, it is possible to make some general observations about the purchaser-provider split and contracting processes (eg, Cumming, 1998):

General points

- Purchaser-provider contracting was initially hampered by the lack of information on the pattern of services previously delivered, their quality and their costs. This was particularly the case for mental health services.
- The ring-fencing of budgets (eg, that for Disability Support Services [DSS]), the continued separation of accident-related health care services' funding from the rest of the health services, the continuing involvement of Ministers in setting priorities, and the requirements placed on Crown Health Enterprises (CHEs) and later Hospital and Health Services (HSSs) to signal in advance their intentions to exit the provision of particular services, have reduced the flexibility that the reforms were in part intended to increase.
- There was relatively little competition between CHEs, and between CHEs and the private sector for acute services, despite the expectation that the quasi-market system would generate supply-side competition thereby improving efficiency. In many cases, public hospitals are monopolies or face very limited competition. There is little sign that the purchaser-provider split has increased the level of competition (Ashton and Press, 1997). Where competition has occurred it has been at the margin and only for specific services. This may have reduced the potential efficiency gains of the market system. There has been more competition for rest homes and other services in which the cost of market entry is relatively low and it is easier for purchasers to assess service quality. In any event, purchasers have been compelled to contract out rather than make decisions on a service by service basis as to whether to "make or buy" as a private firm would do.
- Very little work has been tendered to private acute hospitals. The Crown and the RHAs have both been perceived to be biased in favour of the public sector and to have worked together in the early stages of the quasi-market to prevent private hospitals entering the market. In part, this conservatism may have been due to difficulties in drawing up detailed contract specifications for individual services that had traditionally been bundled together with other services.
- The separation of purchasing and provision functions has proved difficult, with trade-offs required between contract specificity and allowing providers flexibility to allocate resources as health care needs and demand change.

On occasions, relations between RHAs and CHEs were confrontational, reflecting the difficulty of managing relations between monopoly providers and monopsony purchasers. At the same time, while CHEs were legally companies like any other, their shareholders were unusual in being two 'shareholding' ministers of the Crown (the Minister of Health and the Minister of Finance). As a result, two central government agencies (CCMAU and Treasury) and their Ministers were directly involved in relatively detailed aspects of the finance and operation of the CHEs, while ultimately having limited control over them as legal companies. This pattern has continued in the case of the HSSs. This situation might be likened to the relationships between a parent company and its subsidiaries in the private sector in which the subsidiaries are stand-alone entities, but reliant on the parent for finance.

- Additional transaction costs were undoubtedly incurred in negotiating and monitoring contracts between purchasers and providers, especially for services such as surgery which had traditionally been part of hospital global budgets and less so for rest homes and the like (Ashton, 1998). These costs have been increased by the legal status of contracts which has led to detailed service specifications and protracted negotiations. On the other hand, with only four RHAs, followed by a single national purchaser, the number of contracts has been contained. It is not clear whether the extra transaction costs have been justified in terms of efficiency gains.

The experience of purchasing

- There have been problems with contracting arrangements: delays in concluding contracts (eg, because of disputes about realistic prices and volumes), poor communication and high costs in negotiating one-year contracts.

- Monopsony purchasers faced with monopoly providers have, on occasion, demanded more output for the same or less money, regardless of providers' costs, as a way of attempting to drive efficiency improvements. Providers have argued that this has led them to sign unrealistic contracts that have resulted in deficits. However, provider costs have risen over time, weakening this argument on the part of providers. It has taken several years to determine reasonable prices in such a context (see the 'deficit switch', above). In practice, neither purchasers nor providers faced any clear incentive to avoid over-spending/deficits, since they were reasonably confident that the Crown would step in and assist.

- Purchasers have found it difficult to make comparisons between prices for different providers and to draw boundaries around contracts.

- It is argued that too much attention may have been paid to the legal form of contracts rather than to their purpose which is to build relations which enable the purchaser to have confidence that appropriate, timely and cost-effective services are being provided within budget. However, the emphasis on legal contracting can be traced back to the original aim in the Green and White Paper (Upton, 1991) to set up a system of competing health plans with eventual privatisation of hospitals.

- However, the novel development of contracting arrangements with general practitioners has proceeded more smoothly than expected. There has been some movement away from fee-for-service payments towards capitation and modest budget-holding experiments which have reported impressive 'savings' in GP-initiated expenditure on pharmaceuticals and laboratory tests (Malcolm, 1997). Such arrangements appear to have led to significant savings against projected budgets and have also created greater possibilities for integrating primary and secondary care, thereby possibly improving the cost-effectiveness of service delivery. This is a major achievement of the development of the purchasing function, but it must be recognised that the budget holding groups were, by definition, self-selected. In addition, their level of funding has proved controversial. Sceptics have argued that the 'savings' reported are no more than a reflection of the generosity of the RHA funding.

- The purchaser-provider separation has had the effect of permitting new suppliers to promote their services and to receive government contracts in a way that did not occur under the AHBs, perhaps because they were more strongly influenced by the interests of the public hospitals. Most notably, there has been an increased focus in purchasing on services delivered by Maori for Maori. For example, according to the Ministry of Health, the number of Maori health care providers increased from around 21 in 1993 to 240 by 1998. This is likely to have improved access, at least to primary care services, in a small way. However, firm evidence is lacking.

- New provider organisational forms have also emerged. In particular, the organisational form of general practice has also changed. The very numerous solo or small group GPs practices prior to the reforms have now grouped or affiliated themselves to fewer, larger primary care organisations, predominantly "Independent Practitioner Associations" (IPAs) most of which are limited liability companies. This organisational change is primarily attributed to the need of GPs, but also RHAs, to find more effective structures to negotiate contracts. IPAs have taken budgets for pharmaceuticals and laboratory investigations, but have tended not to manage their GPs' GMS payments directly. The GPs have continued to claim fee-for-service subsidies in most cases. IPAs have increased in size, while the total number of IPAs has decreased, since the reforms began, prompting speculation that IPAs are increasingly strengthening their relative bargaining position and may achieve provider monopoly in some areas.

- Purchasers have been persuaded by Ministers and the Ministry of Health to introduce the elective surgery 'booking system' designed to give patients greater certainty in the timing of their admission and to improve equity of access to electives across the country. This was largely a central government initiative which built on the concern of providers to change the way in which surgical waiting lists were managed.

- Improvements in waiting times have been reported as a result of particular contracts and competitive tendering processes in secondary care, mental health and for Disability Support Services.

- Significant savings have been made in relation to the pharmaceuticals budget, due to an aggressive purchasing stance taken by Pharmac, the national pharmaceuticals' purchaser. It is not known whether savings in the drug budget have led to increased use of hospital and other services. Pharmac also reports that the proportion of pharmaceuticals prescribed by GPs in line with its 'best evidence' recommendations has increased.

The experience in relation to provision of care

- Competition between private and public providers has been difficult to promote, particularly for public hospital services and it has not always resulted in lower prices. The need for many services to be provided near to where people live has limited opportunities for competition, although there has also been virtually no public-private competition even for elective surgery. Competition has been more noticeable in the rest home market.

- Efficiency gains - particularly in CHEs - appear to have been limited; and the rate of improvement in simple measures of performance such as throughput appeared to slow down compared to the AHB period, though throughput has continued to rise and length of stay to fall.

- Keeping expenditure within budget has proved a problem for CHEs and HHSs. The CCMAU noted that an extra $200 million a year was paid to CHEs between 1993/94 and 1995/96, but CHEs reported that their costs had increased by $267 million in the same period, resulting in rising deficits (Crown Company Monitoring Advisory Unit, 1996). Although CHEs/HSSs tended to argue that unrealistically low purchaser prices were to blame for their deficits, there were other factors involved such as an inability in some cases to manage the volume of clinical work in the hospital and rising costs (eg, clinical salaries rose immediately after 1993). In addition, the advent of price/volume contracts based on Diagnosis-Related Groups (DRGs) encouraged providers to record patient activity more assiduously than before, leading to notionally increased volumes for which they then expected to be paid. The so-called 'deficit switch' implemented in 1997/98 effectively increased purchasing power in the sector sufficient to eliminate most deficits by 1998/99.

- The expenditure cap made it difficult for CHEs to increase their revenues by expanding service delivery since this led to income reductions for other CHEs, all of which were government owned.

- A number of provider groups argued that the new contracting process imposed significant costs in terms of contract negotiation and monitoring requirements. This was said to have been exacerbated by the fact that each of the RHAs had its own requirements, the poor state of information when the contracting environment was initiated, the legalistic approach to contracting (including the tendency to specify all obligations in detail), the adversarial relations between many purchasers and providers and the financial environment in which there was normally a gap between what RHAs wished to purchase with their budgets and the costs of the services which were on offer (Ashton, 1998).

- On the positive side, providers have reported greater clarity and focus and increased accountability as a result of the contracting process. In principle, this should have enabled managers and clinicians to plan the pattern of clinical activity within budgets.
- It is widely held that the requirements of contracting have improved the quantity and quality of information on the costs of providing services and that this has been beneficial regardless of how the health care system is organised in future. Although routine information on primary care is still weak, IPAs have developed good information systems covering the activities of their member GPs.
- Waiting lists and waiting times increased between 1993 and 1996, but fell after that due to the addition of an earmarked sum for waiting list surgery to the health budget (the so called Waiting Times Fund).
- Beyond information on waiting times and lists, there is very little information about the effects of the reforms on service users. For example, the impact of the reforms on quality of care is largely unknown, although some CHEs reported steadily rising rates of overall satisfaction with treatment and reduced readmission rates (Ashton, 1998). There is little information on the quality and cost of specific services, and so far, relatively little use has been made of 'benchmarking' of provider performance on a range of clinically relevant indicators. 'Benchmarking' activity has been confined to analyses of costs between hospitals by the HFA with a view to setting fair and 'efficient' prices by Diagnosis-Related Group (DRG).

By the end of 1996, most commentators had concluded that the New Zealand reforms were yet to produce the efficiency gains, such as savings from the hospital sector, to justify the costs associated with the reforms. The analysis of 'the problem' of the lack of incentives to efficiency in the public hospitals and the potential for 'savings' which was carried out by Arthur Andersen for the Hospital and Related Services Taskforce (1988), had argued that public hospitals were inefficient because they were not operating in a competitive market. Without international benchmarking, this had been impossible to tell. The expected benefits of the quasi-market from this analysis included major 'savings' in the running costs of the acute hospitals. However, the expectation of 'savings' which could be removed from the health budget failed to take into account the fact that if hospitals become more efficient, this alters referral and treatment thresholds downward, thereby leading to more admissions. As a result, 'savings' would be swallowed up in additional services. This has been the case. The analysis also failed to take account of the likely effect of provider competition on the wages of clinical staff, particularly those in short supply. Rising demand for hospital admission, which is poorly understood, has also been a feature of the period and has influenced the effects of the changes.

Explaining the difficulties facing New Zealand purchasers

Purchasing health services is inherently difficult in publicly financed health systems since purchasers are continually faced with the multiple and frequently conflicting explicit and implicit expectations of politicians, central government officials, managers, clinicians, patients and the public for the

health system. In addition, purchasers are legitimately required to contribute to better population health, despite the knowledge that their contribution to this end can only be partial and that many of the most powerful determinants of population health lie outside the health sector and, particularly, outside the scope of personal health services (Cumming and Scott, 1998). For this reason, it is important that purchasers are only held accountable for outcomes that it is reasonable to expect that they can influence. As a result, the current accountability arrangements focus on outputs (eg, the volume and quality of services secured) and an additional sub-set of outputs which are known to be associated with better outcomes.

Some of the specific difficulties faced by New Zealand purchasers between 1993 and 1998 were as follows:

- Lack of a single, integrated health care budget. Despite bringing together under Vote: Health the budgets for Personal Health Services and DSS, this was no more than an administrative integration. General Medical Services are still largely separate from other Personal Health Services since spending is demand-led and DSS is still 'ring fenced' (ie, its share of health spending is fixed on historic grounds) and mainly separately managed. The Waiting Times Fund was another earmarked sum of money determined with central government rather than purchasers' priorities in mind, whatever its impact on waiting times. Similarly, central government 'tagged' additional resources for mental health services before it allocated them to purchasers. Accident-related health care is still separately funded and purchased, now by a range of private and public insurers. As a result, purchasers have been constrained to some degree in making certain innovative substitution decisions. In addition, accident insurers face different incentives compared with the HFA and may make different priority decisions, since the former internalise the trade-off between treatment/rehabilitation costs and the costs of cash benefits to those who have suffered workplace accidents. The HFA does not bear the societal costs of continued ill-health as a charge on its budget. On the other hand, if its priorities are set on the basis of a society-wide cost-utility analysis, it should take account of the wider costs of ill-health, not just those measured by benefit transfer payments.
- Lack of time to develop skills, relationships and experience between reorganisations. Purchasing takes time and is not helped by organisational instability that discourages providers from taking purchasers' objectives seriously. Restructuring has also led to loss of experienced staff.
- Annual funding of purchasers has resulted in contracts with providers for the same period, which providers have argued, limits their ability to bring about significant service changes. However, in practice, a 'funding path' is set for Vote: Health over a three year period, thereby allowing a greater degree of budgetary certainty than is frequently acknowledged.
- Lack of choice and competition between providers, especially for public hospital services, because of population size and dispersion outside the main centres.

- Lack of clear incentives for hospitals and other providers to become more efficient since the total level of spending was fixed. One provider's increased budget was perceived as a potential loss for another. Providers also, correctly, perceived that government was reluctant to see them fail and so had little reason to be overly concerned about their deficits. Since 1996, hospitals have been allowed to keep any efficiency gains which they have been able to make, thereby improving incentives to efficiency. The capital charge regime has had a similar effect.
- Ministers' and the Crown's continuing commitment to an ownership interest in the CHEs/HHSs led to the protection and subsidy of specific providers, sometimes in circumstances when purchasers might have acted to close them down. For example, the HFA is currently constrained by its Funding Agreement with the Minister of Health not to do anything by its purchasing which would alter the public hospital system. Implicit Crown guarantees also reduce the incentives for hospitals to alter their activities to improve efficiency.
- Ministers' and central government's continuing ad hoc involvement in the detail of purchasing; for example, by specifying individual services which should be made available regardless of the goals and priorities of the purchasers. The Funding Agreement between the Minister of Health and the RHAs included a great deal of detail, much of which the RHAs ignored. However, requirements for additional services tended to be accompanied by extra resources and were usually responded to, though sometimes only as a result of central pressure.
- Lack of good, reliable price and quality information which has hampered the contracting process, particularly the tendering of services.
- Excessive attention to the legal form of contracts coupled with early adversarial relations between purchasers and providers has increased transaction costs without necessarily improving services. It appears that contract negotiations can take place without involving clinicians in a meaningful way, thereby reducing the likelihood that the purchasers' priorities will be implemented in practice.

Conclusions on Theory and Experience of Purchasing

This review of the justification for a separate purchasing function in health care, together with a review of some of the international and domestic experience shows that health care purchasing is a difficult task in any system. Purchasing normally takes time to show results since the current providers tend to have far more information on the current pattern of provision, 'best practice' and the feasibility of change, than the purchasers. Public purchasers have to attempt to satisfy multiple, conflicting objectives and are unlikely to be able to escape entirely from political imperatives as long as health services remain publicly financed. Furthermore, given the nature of health care markets, the ideal pre-conditions for purchasing rarely obtain consistently. For example, the predominant situation in the public hospital sector, if not for residential care, is one of bilateral monopoly in which a single purchaser faces a single provider. Contracting in health care is a relatively blunt instrument for bringing about change and improvement and incurs its own costs. Purchasers

need to be well informed and have considerable expertise, which is costly too. They also need to develop relatively long-term relations with providers to bring about measurable service gains without losing sight of their ultimate *raison d'etre*.

In addition, it is impossible to design purchasing organisations which combine all the features generally regarded as desirable by policy makers since some of these are mutually incompatible (eg, sensitivity to local needs and a high level of expertise in particular service areas; or public participation and consistent expectations of providers). Some of the characteristics of purchaser organisations, such as their responsiveness to the views of local community leaders, are hard, if not impossible, to assess, let alone 'measure' in relative terms. As a result, it is unlikely that there is a single, 'best' configuration of purchasing for the New Zealand health system. Instead, trade-offs will need to be made between different goals (eg, between reducing contracting costs and holding providers closely to account for their actions) when deciding how to evolve the current organisation of health services' purchasing.

Despite all the above limitations and caveats about the separation of purchasing from providing functions, the separation has generated far more information on the nature of the health services paid for from public funds. For example, it is now possible to construct and use 'benchmark' national prices for hospital services with some confidence that these will encourage efficiency while being feasible for the hospitals. Adaptations have been made to the contracting process to reduce the transactions costs associated with purchaser-provider separation such as long term contracts and national pricing to reduce bargaining costs over price. In addition, steps have been taken since 1996 to reduce the transaction costs of bilateral monopoly associated with information imbalance by insisting on full disclosure of information between providers and purchasers and an end to notions of 'commercial confidentiality'.

The separation of purchasing from providing and the changes to public accountability which go with this, have also made the resource allocation decisions in the health sector far more transparent and explicit than they were in the former vertically integrated system. This is a particularly important justification for maintaining a separation between purchase and provision in a publicly funded system. In a private market, the decisions of individual users determine the 'success' of the health care organisation. With public funding, these signals are far more indirect and government has to put in place arrangements that allow citizens to have confidence that reasonable decisions are being taken about their health care.

As a result of the development of purchasing and the related work to debate priorities and 'core services' (National Advisory Committee on Core Health and Disability Support Services, 1994), together with the more recent elective surgical 'booking system', the public may be more aware of the choices and decisions made in the health sector. This situation has both positive and negative consequences. People may be more worried about the direction of the sector, while, at the same time, transparency is consonant with the wider goals of public sector and government reform. There is evidence from international opinion surveys (Commonwealth Fund, 1998) that New

Zealanders have significant concerns about the health system. Public disquiet appears to be considerably higher than in the UK, which has a health system very similar to New Zealand's. However, users report high levels of satisfaction with services, as in the UK. A possible explanation for the disquiet may lie in specific features of the 1993 reform process, particularly its rapid implementation in the face of considerable professional opposition, the short-lived introduction of hospital co-payments and the original aim of the government to shift from monopoly purchasers to health plans competing for individual patient enrolments. Disquiet may have been maintained, despite the compromises which followed 1993, by the experience of paying considerably more out-of-pocket for primary health services than had been the case previously and far more than people in most OECD countries. It is also possible that disquiet with the publicly financed health system was part of a more general rise in anxiety about changes to the welfare state produced by an increase in private contributions in other fields, notably higher education.

A further justification for purchasing, in some form, lies in the fact that provider organisations will always take a partial view of the needs of the health sector and the population. As a result, it is valuable to have a purchaser perspective in the system, which is less influenced in its decision making by the self-interest of particular institutions and professional sectional interests as by a concern to meet the needs of the population in the most equitable and cost-effective way possible.

Finally, some sort of separation between purchase and provision permits a range of different forms of competition and contestability to develop, at least in theory. For example, although straightforward forms of supply-side competition for the business of purchasers has proved difficult to organise in many health systems, including in New Zealand, there is still scope for competition *for* rather than *in* the market in the shape of periodic competitions for the right to purchase or provide services to particular populations. This is already largely a reality in most fields within the DSS. In addition, the separation continues to allow the purchaser *in extremis* to alter the pattern of purchasing away from unsatisfactory providers, as long as an acceptable alternative exists or could conceivably be established. This, in turn, means that comparisons of performance and other benchmarking exercises are more than token exercises.

The purchaser-provider split is likely to work better for some services than others (eg, those where information asymmetries and market entry and exit are less of a problem). Perhaps greater freedom should have been given to the purchasers to determine in which circumstances to contract and in which to integrate vertically, rather than forcing them to develop a purchaser-provider contract in all circumstances. In a private market, firms can always choose whether to 'make or buy' goods and services. However, it is likely that the compulsory separation of health care purchase from delivery in the publicly financed market in New Zealand reflected the fact that the purchasers continued to be monopolies. It was judged, therefore, that they could not be permitted to make these decisions spontaneously themselves since they would lack incentives to make efficient choices.

Despite these undoubted advantages of the separation of purchase from provision, there are limitations to the current arrangements. Providers and the HFA are strictly separated in the New Zealand arrangements, but the government is represented on both sides of the contracting process as it

applies to the HHSs and most of the relationships involve bilateral monopolies. This tends to lead to contracting problems, high transaction costs and, in turn, to Ministerial and official intervention in what would in other markets be matters to be resolved between the two parties. However, the Crown Company status of the HHSs increases the complexity of Ministerial intervention since the Boards of HHSs have considerable operational autonomy while they recognise that the Crown is unlikely to wish to see them fail financially. Similarly, the publicly funded health system currently relies on a single national purchaser, the HFA, which appears to face relatively weak incentives to hold influential providers to account for the cost-effectiveness of their services and to take action, accordingly, if it judges that services can be improved. The HFA and its staff will not be rewarded any more or less depending on the quality and cost-effectiveness of the publicly financed health services. Indeed, there might well be strong public resistance to any such move. It can be argued that the current system represents potentially 'the worst of both worlds': a system without the incentives and financial disciplines of the market, but lacking the straightforward controls of a single hierarchy.

For these reasons, it might be argued that the Crown should cease to own any providers, thereby attempting to remove the implicit Crown guarantee of funding and increasing the influence of the purchaser, since the Crown would not then be responsible for any losses incurred by providers should the purchaser alter the pattern of health services purchased in order to pursue greater efficiency. Unfortunately, this remedy cannot directly tackle the monopoly status of many hospitals, for example. Such a change would replace a public by a private monopoly. Destabilising providers runs the risk of undermining continuity of access to health services. The Crown would be equally reluctant to de-stabilise providers through its purchasing decisions because of concerns that gaps in service might occur. Hospitals and their senior clinicians would also continue to enjoy high levels of public support, as they do in other countries such as Canada and the Netherlands where government does not own the hospitals, when their interests were threatened by purchasers' decisions. It is also doubtful whether the implicit Crown guarantee of funding can be entirely removed in relation to non-hospital non-Crown providers, particularly where there are major health problems to be addressed.

As a result of these limitations, a judgement has to be made as to whether the imperfect merits of a purchaser-provider separation in publicly financed health care outweigh the limitations of the previous vertically integrated, hierarchical model. If a separation between purchase and provision is retained, there are a number of options for strengthening purchasing; for example, abolishing the purchaser-provider split for those services which do not match the criteria for purchaser-provider contracting; or encouraging a range of alternative forms of purchaser-provider relationship such as devolving the purchasing role to primary care based organisations; developing purchaser competition (so called 'regulated competition'); or acting to make the provider side of the market more competitive (eg, via facilities-services splits in HHSs or compulsory tendering of acute services for private provision of all DSS). The range of options for the purchase of health care, and the extent of separation between purchase and provision within those models, is explored in the second part of

this paper. The second part also considers the case for returning the health system to some form of completely vertically integrated service which existed, in part, before 1993 under the AHBs.

Part Two: Review of Purchasing Options

The Options

Dimensions on which options can vary

The potential range of ways in which purchasing of publicly funded health services can be organised is determined by varying combinations of the following features of purchasing arrangements:

- Whether purchasing is organised around geographic areas/populations or not (eg, national, regional or local purchasers versus patient enrolment with purchasers);
- How purchasers are paid (eg, needs weighted capitation based on aggregate information about population characteristics or individually risk-rated premia related to patients enrolled);
- Whether there are monopoly purchasers or some degree of competition between purchasers (either driven by patient choice or periodic competition for the market through government franchising);
- The identity and legal status of the purchaser (whether a public, semi-public, private, or voluntary organisation and whether for-profit or not);
- The range of services purchased and the scope of the budget (eg, specialist purchasers responsible for purchasing particular services versus generalist purchasers and whether the budget extends beyond health services to include disability support, education, housing, etc.);
- Whether the purchaser exclusively purchases or has some provider capacity of its own as in GP budget holding (ie, the extent of vertical integration and the nature of the relationships between purchasers and providers which includes forms of regulated competition in which patients choose their managed or integrated health care organisation which offers comprehensive care);
- How the purchasers are held to account for their actions (ie, whether accountability is exclusively to central government as funder or shared with patients and/or the local population; eg, whether the board of management of the purchasing organisation is appointed, elected or a hybrid);
- Whether the purchasers can raise additional revenue from their enrolees beyond the tax dollars allocated to them.

All options require government to set out clearly the strategic aims, shorter term objectives and service priorities which it expects purchasers to embody in their purchasing decisions and means for assessing the extent to which purchasers have been successful. All options require some degree of regulation. For example, particularly in a tax-funded health system, it would be inappropriate for purchasers to be permitted to indulge in 'cream skimming' or the under-service of needy patients in order to protect a surplus

or profits. If purchasing is decentralised, and, especially if it is devolved to non-state entities, government may need to specify with reasonable clarity at least the minimum range of services which citizens should expect to receive via each purchaser. In general, purchasers with more integrated budgets (ie, budgets which cover a wider range of services) are to be preferred to those with more specialised or narrower purchasing responsibilities. However, the wider the potential range of services to be purchased by a purchaser, the more difficult it is for government to specify users' expectations of access to care in advance. This problem of performance assessment is exacerbated if the focus is less on the delivery of specific services to a particular standard and more on the purchasers' ability to secure specific outcomes.

The main options to be assessed

The following comprise the principal options for organising the purchasing side of the publicly funded health system. The six possible options for separating purchase from provision can exist in combination as well as alone. For example, a national purchaser could choose to delegate part of its purchasing role to more local purchasing organisations while retaining purchasing responsibility for, say, highly specialised services provided on a national basis. In addition, it is conceivable that different options could be instituted in different parts of New Zealand. For example, it might be possible to envisage user choice of purchaser (eg, via competing health plans) in the larger cities, but monopoly purchasing arrangements might be inevitable in rural areas. Whether such dual arrangements would be acceptable politically is another matter. The final option discussed is the abandonment of the current purchaser-provider separation coupled with a full or partial return to a more vertically integrated publicly funded health care system. Again, this broad option could be combined with others. For example, it might be decided that the purchaser-provider separation would be maintained for those services within Vote: Health where contracting appears to be cost-effective (eg, residential care) and abandoned for those where it might be judged to be more problematic (eg, non-elective acute hospital services). At present, the system in respect of Vote: Health mandates a strict form of purchaser-provider separation, but this may not be sensible in relation to all services. The July 1999 changes to the purchasing of health services related to accident compensation claims has distinguished between those services for which a strict separation of purchase and provision will be maintained (elective surgery and rehabilitation which will be purchased by private insurers) and those which will be funded largely in response to demand (emergency and urgent treatment of injuries). It will be interesting to see how successfully this approach works.

1. Single national public purchasing agency

Under this option, a single, public body would undertake all the health care purchasing in the public sector. This is the current arrangement with the HFA, its regional offices and subsidiary (Pharmac) responsible for purchasing all the services covered by Vote: Health.

2. Sub-national, monopoly public purchasing agencies

The main sub-types are determined by the number and population size of purchasing organisations (eg, regional, area, or more local) and whether board members are appointed, elected or derived from a mix of the two methods. The operation of sub-national, public purchasers will also depend on the degree of autonomy (eg, to deviate from national policies) which they are granted.

3. Sub-national, monopoly independent purchasing agencies

This option would include periodic franchising of the purchasing function either for geographic, ethnic or other populations, to non-governmental bodies (eg, commercial companies, iwi-based organisations, etc.). The 1998 Marlborough Trust proposal for an integrated care pilot is of this type. Under this option competition exists periodically *for* rather than continuously *in* the market.

4. Primary care-based, sub-national, monopoly purchasing agencies

The main sub-types under this heading consist of GP-based organisations (eg, based on Independent Practitioner Associations) or more broadly based primary care organisations (PCOs) in which a team of primary care professionals has responsibility for a budget including primary and potentially some proportion or all of secondary care for the population registered with the PCO. Both sub-types are likely to be largely local monopolies, but there is scope for periodic tendering or re-accreditation of such organisations, particularly if they were not owned by GPs. Under this group of options, patients would continue to have a choice of primary care provider/team or GP (although they would be required to register with one), thereby, indirectly, choosing their purchaser. However, in order to be large enough to manage risk, organisations would tend towards being local monopolies or near-monopolies.

5. National or sub-national, competing purchasers

In brief, this option represents individual patient choice between competing health plans as envisaged in the original 'Green and White Paper' of 1991 (Upton, 1991). This represents a radical departure from the current system since it relies on individuals to make their own choices between purchasing agents rather than relying on the government to engineer an effective pattern of purchasing agents. Under this arrangement, the whole of Vote: Health would be allocated to a number of comprehensive health plans, based on the risk profile of their enrolees. Each plan would be free to decide how it secured comprehensive publicly funded health care for its enrolees through a range of sub-contracts with provider groups, hospitals and so on. Given the size and dispersion of the New Zealand population, it is possible that such a system could only be developed in the largest urban centres. An important design issue under this option concerns whether or not people would be offered the choice to remain with the public purchaser, the HFA.

6. Specialist purchasers

Under this option, specific service areas might be purchased on behalf of the HFA or the Ministry of Health by a specialist-purchasing organisation. This organisation could operate throughout the country or in specific locations. These so-called 'carve-outs' tend to be discussed in relation either to highly specialised, tertiary services or services such as mental health or services for people with learning difficulties. However, 'carve-outs' could be based on the extent to which the individual service can easily be contracted for, with the national purchaser retaining responsibility for other services such as public hospitals where market entry and choice of provider are more problematic. Another variant of this option would be for the HFA to retain responsibility for purchasing 'high cost-low volume' services in the context of, say, a shift of the remainder of the purchasing function to GP-led organisations or some form of area purchasing authority.

7. Vertical integration

This set of options involves either the abandonment of the distinction between purchase and provision (eg, the Ministry of Health running the public provider organisations directly) or internalising the distinctive roles within a single entity responsible for both functions (eg, establishing district health services across the country with responsibility for both planning and delivering health services). In either event, there are certain areas within Vote: Health where it is most unlikely that the purchaser-provider split could be removed since the vast majority of the providers are in the private sector and separate from government (eg, rest homes).

The Status Quo – A Single National Purchaser at Arm's Length from Central Government

In 1999/2000 the planned level of funding for Vote: Health is $6.5 billion. The great majority of Vote: Health is allocated to the Health Funding Authority (HFA), which, in turn, purchases health services from a range of providers in the public, private and voluntary sectors. A far smaller percentage of health spending in the public sector is via workplace accident insurers and ACC in their roles of making available health services to people after accidents (less than 10%). The HFA's subsidiary, Pharmac, is responsible, exclusively, for the purchase of GP prescribed pharmaceuticals. Viewed in this way, there are, in reality, three national health care purchasers – ACC/accident insurers, Pharmac and the HFA. Each has responsibility for a different range of services and products and has a distinct approach to its remit. For example, ACC funds a range of complementary therapies that are not funded by the HFA. Thus patients with identical needs will be treated differently depending on the whether the needs arose following an accident or not. Intriguing as such issues are, they are beyond the scope of this paper.

Rationale

The first element in the rationale for having a national purchasing agency for Vote: Health separate from the Ministry of Health appears to be that it will enable the Ministry to focus on strategic, sector-wide policy and regulation, while the HFA concentrates on purchasing the mix of services required to meet strategic goals. This part of the rationale is thus one of specialisation and clarity of function. This arrangement is mimicked on the provider side of the publicly funded sector by the role of CCMAU which is responsible for representing the Crown's ownership interest in the HHSs separate from the Ministry of Health and Treasury. Such an arrangement aims to maintain the separation between purchase and provision and strategy and operations at the centre as well as locally. The existence of a purchaser distinct from the Ministry of Health is also intended to distance the centre and, especially, politicians from priority setting and direct involvement in purchasing decisions. Finally, the replacement of four Regional Health Authorities by a single national purchaser at the end of 1996, was designed to overcome the lack of consistency and collaboration between the RHAs, as well as to reduce cost by collapsing four territorial organisations into one.

Assessment of current arrangements

Purchaser accountability and inter-agency relationships

Although it is apparent that the relations between the Ministry and the HFA have settled down after an initial teething period, and that role demarcation is now clearer, it is intrinsically difficult to separate the making of policy for strategic purposes and the making of policy to support purchasing. Some Ministry policy work is beyond the scope of the HFA (eg, altering public health regulations and developing inter-sectoral initiatives) and, therefore, quite distinct, but much of the work of the two organisations, particularly in the field of health services policy, overlaps. In addition, the advent of the HFA has had the effect of removing experienced Ministry staff from the 'frontline' of policy into a more advisory role. There is thus experience and knowledge in the Ministry that cannot be directly drawn on to support purchasing. On the other hand, Ministry staff become involved in the affairs of the providers when Ministers are put under political pressure to deal with difficulties caused for providers by the objectives of the purchaser. For example, the Minister and Ministry may be drawn into debates about the future of small, rural hospitals to the extent of issuing policies which curtail the freedom of manoeuvre of the HFA.

The existence of the Ministry and an independent purchaser in the shape of the HFA has placed a premium on the quality of communication between the two organisations since the Ministry continues to require detailed information about the sector in order to support political accountability processes. When there are perceived to be specific problems arising in the publicly funded health system, Ministers tend to turn to the Ministry in the first instance for briefing and advice, though not invariably. Ministers continue to use advice from both agencies, without being greatly concerned about the distinction between the roles of each.

Although the separation of the purchasing function from the Ministry and the Minister was intended to reduce the level of political involvement in day-to-day decision making in the publicly funded health sector, there is little indication that this has occurred. This is because the lines of accountability of the HFA and the publicly owned providers (the HSSs) still end with the Minister of Health. There is no New Zealand equivalent, for example, of the NHS in England, whose Chief Executive and Board are responsible for the strategic and operational management of both the purchase and provision sides of the publicly funded health system. Much of the political and Parliamentary discussion of health issues still relates to the internal, managerial affairs of the HSSs from which the changes in the system since 1993 were designed to remove Ministers as far as possible. However, opposition politicians continue to wish to make political capital out of laying providers' problems at the door of the Minister, while Ministers continue to wish to gain political credit from presiding over developments in HSSs (HSDP in Auckland and the plans for a new hospital to serve the Wellington region are the latest and most prominent examples). The latter can be justified since Ministers are required to make the decision whether or not to approve a large, new investment in the health system.

The existence of two separate national bodies with a major input into determining the direction of the sector also spreads scarce skills and experience thinly. For example, both HFA and the Ministry have the capacity to commission, undertake and use research, particularly in the shape of programme/policy evaluation. With the very limited resources likely to be available both to manage and undertake this research, questions have to be raised about the wisdom of such duplication. In a similar vein, both the Ministry and HFA are separately involved in developing service strategies for particular service areas. The most notable recent example was in relation to dental health.

Further, there is the issue of the cost of having a number of inevitably overlapping, central control, strategy and advisory agencies. Work needs to be done to review the costs of the Ministry and HFA in their own terms and to compare them with other similar organisations in the publicly funded health sector in other countries before definitive conclusions can be reached about the appropriateness of the current costs of the central agencies. The justification for additional independent policy advice from bodies such as the National Health Committee, the Mental Health Commission and Maori Health Commission should also be scrutinised. There may also be scope for the central agencies to share more functions and support services in common (eg, for IT, supplies, payroll, R&D, etc.). The NHS in Scotland (population 5 million) has long relied on a Common Services Agency to provide such services to central and local organisations involved in purchase and provision in order to reduce systemic overheads. The same Agency also administers payments to GPs and other family practitioners as the separate Health Benefits Ltd does in New Zealand.

Another difficulty with the current arrangement concerns the monopoly status of the HFA. Whereas with four RHAs, the government at least had some comparative information on direction and performance with which to

encourage improvement, now there are no such pressures and the government is wholly reliant on a single body. It is not clear what incentives the HFA faces to tackle difficult issues involving conflict with providers or professional interests. This makes the task of monitoring and incentivising the HFA very difficult. Much rests on the system for setting the objectives and monitoring the performance of the HFA.

The final tension in the current structure predates the advent of a single purchaser and relates to the strict separation at central government level between the Crown's 'ownership' and 'purchase' interests in the health sector. CCMAU, representing the government as 'shareholder' has traditionally encouraged the CHEs/HHSs to press for adequate revenue, frequently at the same time as the RHAs/HFA were being encouraged by the Ministry of Health to purchase the same or higher levels of service with smaller allocations on the assumption that efficiency gains could be made. With monopolies on both sides, this sort of situation often led to contracting stalemates.

Counter-balancing concerns about the costs, complexity and potential for overlap, confusion and conflict between national agencies (Ministry, HFA, CCMAU, Pharmac, ACC and private accident insurers, National Health Committee, Mental Health Commission, etc) under the current arrangements, it must be recognised that the last major structural reorganisation of purchasing in the sector occurred comparatively recently. The HFA has only existed in its current form since early 1998. Internal re-structuring and recruitment of staff continued well into the second half of 1998. Anecdotal evidence hints that a considerable number of experienced staff were lost in the transition from four RHAs to a single national purchaser. Experience tends to show that structural reorganisation, while superficially attractive and giving the impression of purposive change, rarely achieves its desired outcomes. Furthermore, there is a strong sense in the health system of change fatigue in that most clinicians and managers appear to prefer to work towards improving the status quo rather than facing further wholesale reorganisation. For these reasons, it may not be wise to make further major changes to the national organisations in the system. For example, there is a case for absorbing the HFA's purchasing role into the Ministry of Health, or even to slim down the Ministry of Health and absorb most of its functions into the HFA. However, this would divert the energies of all the purchasing staff away from their main role for at least 18 months, judging by the disruption caused by the abolition of the four RHAs, as well as generating costs of its own and risking losing more experienced staff. It would be more sensible to focus attention on new ways for the HFA to devolve parts of its responsibility for purchasing to a range of different intermediaries on an experimental basis than to devise new national bodies.

The purchasing process

Assuming that the current agency structures and allocation of functions remain in place, there are still aspects of the current purchasing arrangements that could be improved without major re-structuring. Table 1 summarises some of the positive and negative features of the current arrangements for national level purchasing.

Table 1: Assessment of the current arrangements for HFA purchasing

Features which appear to be beneficial to effective purchasing	Features which appear to handicap the purchasing process
HFA's exclusive mission to purchase services with no responsibility for provider organisations. In theory, this allows Ministry of Health to focus on strategy and inter-sectoral health policy work, though signs of overlap and duplication of work between Ministry and HFA.	Minister of Health remains responsible for financial 'health' of HHSs and for purchaser – contradiction between government as owner of institutions and purchaser of services with monopolies on both sides. Potential to improve allocative efficiency in hospital budgets is prevented by government commitment to 'stability' in hospital sector. Other incompatible government goals include protecting electives irrespective of trends in unplanned use of hospitals. Ministers ultimately determine the degree of autonomy of the HFA
Fully integrated budget covering all of Vote: Health (at least in theory) including GMS and DSS as well as preventive and curative services. Wider scope of budget than in many systems. Should allow for rational priority setting across the whole of health and social care.	Financial accountability still not fully integrated (accident-related services purchased to pursue different goals) and ring-fence around DSS spending level remains. Not possible to substitute between GMS and other areas because of structure of GMS subsidy. Small number of integrated care pilots. None fully integrated in budgetary terms. Still ample scope for inadvertent cost shifting between budget heads within Vote: Health, from GMS to out-of-pocket payments and now between private accident insurers and Vote: Health. Need for careful monitoring. Separation of Pharmac from wider purchasing prevents consideration of substitution of drug therapy for hospital care as does DSS ring fence. Bundles of services mostly still purchased according to historic budget heads (eg, DSS, GMS, GP pharmaceuticals). Little programme of care purchasing outside a small number of integrated care pilots. Few disincentives for GPs not to refer patients to hospital.
Single national purchaser overcomes supposed rivalry and inconsistency of former RHAs. This reduces transaction costs of monitoring performance for MoH. Potential to set nationally consistent quality standards and access thresholds in key service areas (and allow for local variation in other areas) and to mount national initiatives (eg, mammography, elective surgery booking system).	Unresolved tension between national consistency and local responsiveness to variations in need and priorities in the role of the HFA. Also HFA priority setting method under development is likely to require major modifications to the surgical booking system criteria since the two approaches use different criteria of 'need' and different methods for arriving at priorities.

Features which appear to be beneficial to effective purchasing	Features which appear to handicap the purchasing process
Still able to contract selectively and move business between providers though scope limited outside main centres of population and by policy settings. HFA is required by Ministry of Health to progress a range of integrated care (IC) initiatives in order to improve co-ordination of local services for particular conditions, client groups, etc. These have potential to develop into devolved purchasing organisations on contract to HFA.	Reluctance of HFA, to date, to devolve any of its risk management function to other purchasing organisations prevents experiments with sub-purchasers which may face clearer incentives than HFA to purchase cost-effective services. Preference for 'bulk funding' of more integrated provider organisations. IC pilots to date have focused on care co-ordination rather than devolved budget management. Unclear what incentives act on HFA to surrender part of its purchasing role to sub-purchasers Hospital Services Plan constrains purchasing of public hospital services.
Contracting process has generated more and better information on what has been provided, how much and at what cost, including some 'benchmark' prices.	No outcomes-based purchasing. Contracts tend to reward providers for identifying sick people and devoting inputs to them. Tend to be based on past patterns of care. Contracts may encourage a culture of 'contract compliance', including having to balance income and expenditure within each contract rather than across all contracts. Long term care contracts do not include incentives to rehabilitate and discharge clients home. DRG-based contracts encourage separate identification of items of service and recording of more complex interventions (DRG creep).
Little or no money is held for contingencies in an effort to encourage provider cost control. Gradual shift towards longer term contracts and national 'benchmark' prices in acute sector may reduce transaction costs and encourage more constructive relations with providers.	By committing all resources at once, HFA over stretches contracting staff and loses scope for marginal cost purchasing in-year. Providers support this approach because it gives them financial certainty.

Table 1 indicates that there is considerable potential for continuing to work on refining the contracting process to make it more flexible, less fragmented and more collaborative. There is change underway to better manage the embedded bilateral monopoly problem. Changes since the Coalition Health Agreement of 1996 have led to a national approach to setting HHSs' prices based on benchmarks designed to narrow the discrepancies between HHSs over time and to provide 'fair' price levels designed to avoid HHS deficits. Separate price negotiations with each of the 23 HHSs have been replaced by a national pricing policy and an attempt to set 'fair' service volumes between HHSs in order to ensure equitable access to services in relation to need across the country. Although negotiations between the HFA and the Crown Health Association (CHA), representing the HHSs, with the aid of a national approach to prices, has reduced some of the costs of dealing with 23 separate

organisations, the bi-lateral relationship has not been straightforward. The HHSs via CHA rejected the HFA's approach to setting volumes and prices in 1998/99. Steps are already in hand to move away from annual contracting towards longer-term agreements with guarantees to providers that they will receive a high proportion of current funding with the remainder contestable. HHSs could be given permission and encouragement to sub-contract where this appeared to bring advantages.

The HFA is gradually organising its own operations to reflect programmes of care for particular client groups rather than historic budgetary distinctions with a view to making better use of the totality of its resources through an explicit priority setting methodology focused on maximising health improvement at the aggregate level. For example, while it is relevant to the HFA's mission to have staff who understand the potential and appropriate role for DSS, it makes no sense for DSS to be purchased separately from other services to older people. Indeed, at least one of the former RHAs organised its purchasing around 'services for older people' rather than the conventional divisions of budgetary responsibility. There is also scope for the HFA to hold back part of its budget for in-year contracting in response to capacity bottle-necks, availability of unused capacity, changes in patterns of demand and so on, and even to use this money to reward providers who improve patient outcomes rather than those who simply consume inputs. The Authority is now trying to organise its purchasing in order to free some resources which it can use flexibly during the year.

The HFA accountability arrangements are driven off a strategic business plan that the Authority should develop with the sector and the Crown Statement of Objectives which the Minister of Health expects the HFA to contribute directly to achieving through its purchasing. The Ministry of Health and HFA subsequently negotiate a detailed Funding Agreement. The Funding Agreement is the principal accountability document against which the Ministry of Health assesses the performance of the HFA. The Agreement incorporates a Service Coverage Document agreed with the Ministry of Health that sets out the range and type of services to be purchased from public funds. The HFA is held accountable for purchasing these outputs and contracts tend to be structured into similar bundles of outputs, often defined historically. Thus providers are typically paid to deliver outputs rather than for the 'added value' or health status improvement associated with their efforts. For example, public hospitals are largely paid on the basis of the severity and complexity of their case mix measured by Diagnosis-Related Groups (DRGs) rather than with reference to the effectiveness or cost-effectiveness of their treatments. It is usually easier to classify patients so that they appear sicker, thereby attracting higher DRG reimbursement, than to treat them any more effectively or at lower cost in order to make a surplus! Case-mix based funding also rewards providers, which lower patient lengths of stay and allow more frequent admissions. One way of encouraging more of a focus in contracting on outcomes would be to reimburse providers, at least in part, for delivering service 'protocols' (ie, patterns of care regarded as best practice based on research on cost-effectiveness), not outputs (Sheldon and Borowitz, 1993), or for the 'value added' which they have been able to achieve given the severity of illness of their patients on presentation. In any event, the categorisation of

patients by DRG within each hospital could be audited for fairness and consistency. Where patients have chronic or continuing care needs, few, if any, providers currently face any specific incentives to improve the level of symptoms or functioning of their clients.

Sub-National Monopoly Public Purchasing Agencies

Rationale

Currently, there are no public purchasers below national level. The rationale for having a number of geographic purchasing agencies in the public sector rests on the fact that different parts of the country have different health needs and inherit a different pattern of provision. In addition, it is argued that the people in different parts of the country should be able to play some part in influencing the nature of the health care in their areas. The response is to set up agencies or public authorities responsible for purchasing services for people living in different geographic areas. Whether these organisations should be elected or appointed bodies (see below the section on abolishing the purchaser-provider split, below), their precise functions, their degree of decision-making autonomy and their size are then usually the subject of considerable debate, frequently followed by a series of reorganisations. Most publicly funded health systems are organised on a hierarchical, geographic basis even when their funding is largely derived from the national level. However, this does not necessarily mean that the sub-national purchasers operate independently. They usually work to a set of national health system goals. They may also be regulated nationally, for example, by being required to purchase public hospital services according to a national, 'efficient' pricing schedule designed to minimise bi-lateral monopoly problems between purchasers and large hospitals and to reduce the transactions costs of the system.

Previous experience of sub-national purchasing agencies in New Zealand

Between 1983 and 1993, New Zealand's hospital and community health services were increasingly planned and delivered by 14 geographically based, part locally elected AHBs, which gradually replaced the former hospital boards and their districts. The AHBs were abolished as a result of the practical difficulties that they raised for central government (eg, conflict between the AHBs and the government), together with a theoretical critique of their incentives and accountability structures. Although some of the problems and criticisms related to the fact that the AHBs were both purchasers and providers, others are still relevant to today's system with its purchaser-provider distinction. Firstly, there were difficulties in determining the objectives against which the AHBs were to be held to account and in assessing whether these had been met, although over time more detailed performance targets were set for AHBs. Secondly, the objectives of the AHBs sometimes conflicted with one another. There was no single, simple measure of performance such as shareholder value in a private company. Thirdly, the Crown's ownership interest in the institutions of the publicly funded health sector sat uneasily with its strategic interest in health services. Fourthly, there

were conflicts between local and national accountability. Locally elected AHB members, in particular, faced divided loyalties to government for the proper use of public money and to the local community for the improvement of local services. The fact that AHBs were partly locally elected, but had no responsibility for raising even part of their revenue risked muddled lines of accountability and weak AHB incentives to contain their expenditure within budget. Finally, it was unclear what incentives existed for good AHB performance and what sanctions, in the event of AHB failure, were available to the Health Minister beyond removing board members or cutting budgets. The latter would simply penalise patients and was unlikely to be useable (see below for more on AHBs and vertical integration).

Although the RHAs that replaced the AHBs were set up exclusively to be purchasers and without locally elected members, thereby mitigating two of the sources of conflicts of interest, many of the same difficulties remained. RHAs developed their own interpretations of government policy and moved at different speeds towards policy goals. Central government found it difficult to distinguish between legitimate variation based on regional circumstances and differences derived from RHA competence and commitment to implementing government strategic priorities. Accountability and incentive regimes remained problem areas. Just like the AHBs, the RHAs faced no threat of take-over from more efficient purchasers.

The replacement of the RHAs by the HFA has left the same set of problems in place, apart from the difficulty of distinguishing legitimate differences in focus from variations in competence.

Assessment of the case for sub-national purchasing agencies

Conflict between local and central accountability does not necessarily invalidate policies to devolve responsibility to a more local level. Twin, competing lines of accountability are possible and exist elsewhere (Klein and New, 1998). For example, the UK NHS has had territorial health authorities since 1974 within a national service. The difficulty of sustaining increased local *democratic* involvement in a centrally funded system, however, lies in the potential it brings for *increased* conflict between the national and locally elected representatives (see below). Conflict may occur even with local appointees, but is likely to be more acute with elected representatives at local level and more difficult to resolve since appointees are upwardly accountable, ultimately. Such conflict may be worthwhile if locally elected boards improve democracy in the wider sense of accountability, pluralistic debate, transparency, responsiveness to citizens and protection against arbitrary decisions (Klein and New, 1998). However, direct electoral control is unlikely to do so, principally because of the likely low level of voter knowledge concerning the function of local health authorities and low level of interest in health system-specific elections. As a result, those putting themselves forward for election in the health system tend to come from health-related interest groups. Frequently, they are service providers. There are also concerns that minority views may be lost as elected representatives attempt to respond to popular opinion.

Strong local accountability requires a central government which is willing to live with the consequences of local variation in decision making affecting the availability of different services across the country. It also requires an effort to distinguish what the local purchaser is and is not required to account for to central government.

Nevertheless, there remain legitimate concerns about unelected boards whether at regional, area or local levels. Part of the solution to dissatisfaction with the current system of appointees and reservations about locally elected bodies, may lie in efforts to develop new ways of bridging the gap between the citizen and political representatives. Such approaches are generally termed '*shared decision-making*'. They include innovations such as citizens' juries, health panels, issues forums, deliberative polls, future search conferences and 'round tables' (Stewart, 1996) and can operate in the context of a variety of different forms of health system organisation (see below for more on these techniques). However, none of these techniques is perfect. For example, while voting potentially allows everyone to take part, their participation is episodic and can only set a broad direction for a set of representatives. By contrast, citizens' juries offer in-depth participation in the decision-making process, but only for a small number of people chosen at random and over a small number of decisions. Finally, no system will remove the potential for political conflict. As long as there is national funding for health care, upward accountability to the political centre will remain a priority which has to be managed ahead of local accountability to electors (see below for more on this in the section on vertical integration and the role of local representation).

Primary Care-Based Devolved Purchasers

Current primary care budget-holding in New Zealand

Currently, the vast majority of public health and social care resources are deployed at national level by the HFA. However, almost all Independent Practitioner Associations (IPAs) (independent GP groups, mostly organised as private limited companies) now hold at least some form of indicative budget for their members' pharmaceutical and laboratory test expenditure, irrespective of whether their members are also capitated for their General Medical Services (GMS) expenditure. About 20% of GPs are reimbursed for providing GMS via capitation contracts. There are indications that such budget holding may have potential both to slow the rate of increase in spending in these demand-led service areas as well as to lead to new ways of improving the quality of primary care by allowing the IPA to use *'savings'* to develop new services (Malcolm, 1998a). However, before budget holding by groups in primary care can be generalised, there needs to be an agreed fair way of setting such budgets that can be applied to all primary care organisations.

In addition to developments centred on IPAs, a range of other organisations providing primary care has developed since 1993. There are so called 'loose networks' of GPs and practices (Malcolm, Wright and Barnett, 1999). These are the so-called '*third sector*' primary care organisations (PCOs) (Crampton, 1999) which include organisations providing primary care 'by and for Maori'.

Maori primary care organisations vary widely in size, services delivered, level of funding, staffing and managerial sophistication (Crengle, 1999). However, they are distinguished from the IPAs, which are GP owned and controlled in the main, by being community owned and controlled. All groups tend to operate on a not-for-profit basis. Third sector groups are a response by consumer and iwi groups to a desire to overcome the financial barriers and availability problems which characterise 'main stream' primary care for low income populations and to tackle the poor health status of Maori. Maori primary care organisations tend to provide a wide variety of services including those of nurse practitioners, GPs, midwives, community mental health workers, health promoters, etc. They tend to be block funded or on the basis of rough and ready capitation amounts and to use their resources to offer as much free care as possible. Some of the primary care organisations have become involved in Integrated Care Pilots. The ultimate vision of this sub-group of providers is to develop into integrated purchasing organisations capable of taking responsibility for an entire Maori population either in an area or by enrolment.

Rationale for devolving purchasing responsibility and budgets to primary care

The rationale for giving greater budgetary and purchasing responsibility to GPs and/or other primary care professionals is generally couched in the following terms:

1. It either fully or partially reduces budgetary fragmentation by integrating primary care and other funding in order to reduce incentives to cost shift between sectors. For example, there is no disincentive under current arrangements for GPs to refer patients to hospital outpatients or to take any interest in the cost of their patients' hospital care.

2. It sensitises professionals such as prescribers and referral agents (eg, community nurses and GPs) to the opportunity costs of their behaviour and encourages them to seek better ways of using resources, including providing more services themselves or reducing unnecessary use of resources, since they are able to retain any 'surpluses'.

3. If clinician-led, it brings a direct clinical (provider) perspective to bear on health care purchasing, allied to local knowledge of patients' needs and providers' capacities. This is fundamentally different from purchasing undertaken by staff in public authorities.

4. It can reduce the traditional dominance in the health system of specialist providers, particularly the acute hospitals, and stimulate the development of more cost-effective alternatives to hospital services.

5. Like other forms of devolved purchasing, it allows decisions on the type of services to be provided to be taken nearer to the patient level. This may lead to services that are more closely attuned to the needs of particular sub-groups in the community such as Maori.

By contrast to systems such as the UK NHS, New Zealand has made relatively little use of devolving extensive budgets for purchasing to integrated 'purchaser-providers' like GP practices or groups of practices or other new

primary care organisations. For example, none of the IPA budget holding schemes currently covers any hospital services. Yet, there is circumstantial evidence from Malcolm's study of South-Med IPA in Auckland that the low use of primary care services and pharmaceuticals observed in deprived areas is associated with a higher use of more costly hospital services (Malcolm, 1997). Similarly, work in Christchurch South suggests that well organised primary care may reduce the requirement for hospital admission especially among older people. Malcolm's work also suggests that, contrary to international evidence, improved access to primary health care may lead to some increase in utilisation of hospital or secondary health care services. There is some evidence internationally that where a population has good access to primary care services and there are weak incentives for primary care in relation to referrals to secondary care, access to secondary care is not reduced. One possible explanation for Malcolm's finding in New Zealand is that relatively poorer groups of the population with poorer access to primary care have higher, unplanned utilisation of secondary care, while more affluent groups of the population with good access to primary health care are more likely to then access secondary care services like specialist consultations and elective treatments.

Such insights do not appear at present to have influenced policy development, but would indicate the scope for improving access to primary care among deprived populations through budget holding.

Of course, like all policy instruments, budget holding by GPs is likely to generate a range of costs and benefits in comparison with the status quo. The most extensive experience and research have taken place in the UK are reviewed below.

There are differences between the UK and New Zealand primary health care systems that should be borne in mind when looking at the UK experience of funding and any lessons to be drawn out for New Zealand. In particular, the use of co-payments in New Zealand and budget holding by GP groupings (like Independent Practitioners' Associations) rather than individual GP practices may dilute some of the incentives associated with UK GP fundholding. Table 1 summarises the NZ and UK primary health care arrangements:

Table 1: Primary care and subsidies in UK and NZ

United Kingdom	New Zealand
Almost exclusively public finance	Largely private finance for GP consultations - NZ$30-$50 charge for an unsubsidised GP visit
GP visits and related primacy care free at point of use	Subsidies for low income, high use patients and under 6 years of age, otherwise unregulated out-of-pocket payments
Patients enrolled with GP, though free to change GP at any time	No enrolment at present
Pharmaceutical co-payment with exemptions	Pharmaceutical co-payment with exemptions

United Kingdom	New Zealand
All GPs paid a mix of capitation, fee-for-service and incentive payments	80% GPs fee-for-service; 20% some capitation
Practice staff allowances	Partial cost of staff allowances
All GPs in Primary Care Groups (since April 1999)	80% of GPs in Independent Practitioners' Associations
90%-95% of GPs income public	40%-45% of GPs income public
General Medical Subsidies and GP prescribing costs cash limited from April 1999	CHS cash limited. GMS and pharmaceutical subsidies open-ended, but targeted. Some pharmaceutical budget holding
GPs independent contractors to the NHS	GPs independent though traditionally not in a contractual relationship with government
GPs gatekeepers to secondary health care	GPs gatekeepers to secondary health care
Extensive experience with secondary care budget holding	Limited fundholding (laboratory tests and GP pharmaceutical subsidies)

The evidence on GP fundholding in the UK NHS

Under GP fundholding, volunteer practices were granted a budget to purchase a limited range of elective hospital and community health services in addition to managing their prescribing and practice staff costs from a single budget. Fundholders were free to shift resources between any parts of the budget. Their budgets were deducted from the allocations of the local health authorities. Fundholders could make 'savings' from their budgets which could be used either to purchase additional services from other providers or to improve facilities in the practice. Generally, fundholders negotiated a share of the savings with the local health authority, although legally they were entitled to retain the whole amount. Each fundholding practice was granted a fairly generous management allowance to cover the additional clerical and computing costs of managing the fund.

Fundholding GPs' reimbursement for the GMS that they provided to their enrolled patients remained separate from the fundholding scheme. Thus fundholding GPs were not directly at risk financially for the management of their budgets. Nonetheless, they were required to work to the budget as long as the practice remained in the scheme and they had strong incentives to make better use of their budgets in order to produce 'savings' for reinvestment.

Table 2 distils the research evidence on the impact of fundholding from 1991 to 1998 from a comprehensive review in Le Grand, Mays and Mulligan (1998). Most of the research focused on the processes of care and activity changes brought about by fundholding rather than changes in quality of care or patients' experiences of services. There is little doubt that GP fundholding, despite the criticism it received, fundamentally altered perceptions of how the NHS should be organised. The balance of power between community generalists and hospital specialists swung in favour of the former for the first

time since the advent of the NHS. Although fundholding has now been abolished by the Labour Government elected in May 1997, all GPs in each area are now involved in driving the health care purchasing process through large collectives known as Primary Care Groups (PCGs). In this sense, all GPs are now fundholders and the purchaser-provider separation has been retained.

Fundholding encouraged secondary care providers to become more responsive to the needs of individual patients and their GPs, to improve communication between secondary and primary care and to offer fundholders' patients shorter waiting times for elective surgery (Le Grand, Mays and Mulligan, 1998). It is generally accepted that this was brought about by the fact that fundholding GPs controlled resources which the hospitals and other specialist providers wished to retain rather than simply because the fundholders were, in some sense, 'over-funded'. Fundholding practices were comfortable taking responsibility for managing the budget for elective surgery for their patients. Fundholders purchased much of their elective surgery via cost per case contracts which were attractive to providers as an additional source of income alongside the cost and volume contracts used by the health authorities which, by contrast, shifted most of the financial risk onto the providers.

Fundholding enabled GPs to widen and improve the range of primary care and other (eg, specialist outpatient) services provided at practice level on the grounds that services should become more accessible to patients. Fundholders were able to reduce the rate of increase of their prescribing expenditure more than non-fundholders, particularly in the first two years of the scheme. Subsequently, the rate of increase of prescribing costs in the two groups appears to have converged though the fundholders' absolute level of spending remained lower. Fundholders were not generally higher prescribers before entering fundholding, so differential funding cannot explain these differences. These broadly beneficial effects appear to have been generated without signs of systematic cost-shifting or 'cream skimming'. However, the latter is notoriously difficult to detect. The fact that the GPs were not personally financially liable may have mitigated the pressure to discriminate against potentially high cost patients. There was no sign in studies that fundholders' patients made greater use of services outside the scope of the fundholding budget (eg, emergency admissions).

Table 2: Summary of research evidence on the impact of general practice fundholding

Evaluative criterion	Evidence
Efficiency	No direct research on technical or allocative efficiency, but research on related areas.
Prescribing costs	Considerable body of research showing reduced rate of growth of prescribing costs initially compared to non-fundholders (FHs), probably due to greater use of generics and less repeat prescribing, but not sustained. However, absolute difference between FHs and non-FHs persisted. Some non-FHs able to reduce rate of growth similarly.

Evaluative criterion	Evidence
Referral rates	Vast majority of studies showed little or no difference in trend of referrals compared with non-FH practices. No sign of effects of budgetary pressure or price sensitivity. No sign that FHs shifted costs to health authority (HA) by increasing emergency admissions (though they had an incentive to do so).
Shift in location of care	Growth in practice level services (eg, using savings) with smaller growth in non-FH practices. Mainly specialist outreach, but questions about cost-effectiveness of practice level specialist clinics.
Financial management and savings	Greater savings than HAs. Underspent each year 1991-96. Extent to which savings due to more efficient purchasing, economies, lower prices, more generous funding or healthier patients was not clear. Majority of savings spent on practice premises, facilities and staff rather than secondary care, thereby advantaging FH practices over non-FHs.
Transaction costs	Consensus that transaction costs rose, though no direct data, due to more complex contracts than HAs and large number of small purchasers. Crude estimates suggest that additional costs were more than FHs' savings.
Equity Level of funding	Evidence is mixed as to whether FHs were fairly funded versus HAs, though largely funded on basis of past spending. Likely that position varied across regions, though data were poor.
Access to care ('two-tierism')	Focus of most criticism and large amount of anecdote and case study information. Best study shows significant difference in waiting times in favour of FHs though not possible to tell if non-FHs' patients were worse off as a result. (possibility of spill-over benefits for patients of non-fundholding GPs). Believed to be result of greater market power of FHs as marginal purchasers with protected budgets (see Table 4).
'Cream skimming'	Major concern initially, but no empirical studies. Hard to study directly, but less likely than theory suggested.
Quality	Little attention and no comparisons with HA.

Evaluative criterion	Evidence
Quality of secondary care received	One study which showed little change pre/post FH.
Quality improvements in contracts with providers	Feature reported by FHs, HAs and locality commissioners, but FHs convinced that FH led to quality improvement in contracts (mainly better communication). No direct studies of service quality.
Quality of practice-based services	Increase in practice-level services (see above, *Efficiency*), but no empirical evidence on quality or substitution.
Choice and responsiveness	FHs more willing to offer patients choice of hospital, etc, but patients indifferent to this. Few patients knew if GP was FH or not. No direct evidence about choice, but FHs reluctant to change hospitals.
Accountability	Greater freedom than HAs. Accountability framework not introduced until 1994. This was criticised since still no assessment of value-for-money of FHs' purchasing.

Source: Goodwin (1998); Mays, Mulligan and Goodwin (2000)

On the other hand, the scheme had definite drawbacks. Since it only covered elective hospital services such as outpatient referrals and inpatient surgery, there was scope for cost shifting. However, there is no evidence that this occurred to any significant degree, perhaps because the GPs' incomes were not directly affected by the way in which they managed their funds. The scheme generated significant additional administrative costs since, despite the existence of multi-funds and fundholding consortia, many 'funds' were managed by single practices, which greatly increased the costs of the scheme. Not all fundholding practices proved to be effective change agents, despite the fact that a minority was outstandingly successful. Simply, holding a budget could not guarantee that local providers would be responsive. In addition, relatively few fundholders appeared to be price sensitive in relation to hospital care and they made only limited use of their ability to move contracts between providers to improve performance. Since larger practices were able to enter the scheme, particularly in the first few years, and since these tended to be better resourced and in less deprived areas, the advantages accruing to fundholders tended to exacerbate underlying inequities between practices in more and less deprived localities. This was a result of making the scheme voluntary and open initially to larger group practices only. Thus this effect was not intrinsic to GP fundholding.

Finally, fundholders were shown to be better at micro-level, 'spot purchasing' in response to the needs of individual patients than at bringing about more strategic local service developments.

The evidence from extensions to GP fundholding in the UK NHS

Although fundholding remained controversial (especially because of the accusation that it led to a 'two-tier' NHS), it was perceived to be sufficiently innovative and to have sufficient potential to be extended beyond elective services in a number of pilot projects. In addition, groups of non-fundholders began to work together to influence the purchasing of the local health authority in *locality or GP commissioning groups* with indicative or 'shadow' budgets. The more that such schemes resembled fundholding (ie, the more the practices were given devolved budgets over which they had control and could negotiate their own contracts with providers), the more likely they were to bring about the service changes they desired (Glennerster, Cohen and Bovell, 1998).

So called, 'total purchasing pilots' (TPPs) in which experienced fundholding practices or small groups of fundholding practices (average population size 30,000) took on responsibility for potentially all the hospital and community health services (Personal Health Services minus GMS in New Zealand terms) for their enrolled patients were the most ambitious extensions of fundholding. TPPs could choose which services they wished to take responsibility for, beyond the scope of the fundholding scheme. Each pilot was a sub-committee of the local health authority since the additional resources deployed by the TPP remained the legal responsibility of the health authority. As with standard fundholding, the GPs were not at personal financial risk under total purchasing, but, again, had incentives to make 'savings'.

The pilots demonstrated that volunteer TPP practices were motivated by their extended budgetary responsibility to develop a range of 'managed care' responses to improving the use of hospital resources, such as utilisation review by discharge planning nurses or investment in nursing home beds as a substitute for extended acute hospital stays (May, Goodwin, Killoran and Malbon, 1998; Goodwin, Mays, McLeod, Malbon and Raftery, 1998). TPPs further demonstrated that they were able to alter the pattern of use of unplanned, acute inpatient services by using such techniques where this was one of their priorities. In the first 'live' year of total purchasing (1996/97), 28 out of the 53 pilots had one or more purchasing objectives either to reduce acute emergency admissions or reduce length of stay. Twenty-one of the 28 performed better than matched local practice populations and the remainder of the health authority population in this regard (Raftery and McLeod, 1999). For example, if rates of admission in all three populations were rising, the TPP rate was rising the most slowly, or static, or falling. Thirteen of the TPPs had a main objective to reduce their emergency admission rate and ten were 'successful' (ie, they performed better than their comparators). Sixteen had a main purchasing objective to reduce length of acute hospital stay and 9 were 'successful' (ie, they performed better than their comparators). However, most of the TPPs were unable to negotiate the length of stay-sensitive pricing which was necessary to be able to shift resources out of the acute sector and improve overall resource use. Acute providers were reluctant to see any reduction in their incomes and health authorities generally refrained from intervening to support their TPPs.

Although the TPP evaluation shows that GPs can be successful in altering the use of services outside their direct influence as clinicians, where this is a particular priority, the same study also showed that the GP purchasers as a whole were most sure-footed in purchasing and developing services which were close to primary care and community health services. TPPs found negotiating service changes with specialist hospital providers more taxing, particularly in mental health (Mays, Goodwin, Killoran and Malbon, 1998). This suggests that there may be a limit to the range of services which GP purchasers should be given responsibility for negotiating. If so, this poses a dilemma, since, to avoid cost shifting, it is generally argued that devolved purchaser-providers should have as near to a fully integrated budget as possible.

In the long run, the larger TPPs appeared to be more successful in bringing about desired service changes and developments than the smaller, single practice projects, but it took the multi-practice pilots considerably longer to become sufficiently organised to do so. In the first, 'live' year, the small projects were significantly more successful (Goodwin, Mays, McLeod, Malbon and Raftery, 1998). As with fundholding, having budgetary autonomy was necessary for the practices to be taken seriously by providers, but it was not sufficient for effective purchasing. The TPPs needed to develop a robust management infrastructure, particularly information systems and means for linking practices and engaging as many GPs as possible in decision making on priorities and resource use (Bevan, Baxter and Bachmann, 1998).

The evidence from IPA budget holding in New Zealand

IPAs have the advantage over developments such as GP fundholding in the NHS of having developed spontaneously rather than following a government design so that they are owned and run by the GPs themselves. However, it has meant that primary care budget holding has tended to become associated with GP-dominated organisations. They are changing the face of New Zealand general practice rapidly away from single handed practitioners working in competition with one another to larger groups capable of taking on greater responsibility for more integrated forms of health care delivery. Seventy per cent or more of GPs are currently involved in budget holding for their pharmaceutical expenditure. A lower, but rising proportion has become involved in budget holding for the costs of their laboratory tests and investigations (Malcom, 1998a). However, there is little or no budget holding for hospital outpatient day case or inpatient services. Thus incentives to cost shift remain, in theory. Budget holding generally takes place through IPAs with the budget held at IPA rather than practice level. IPAs' budgets for laboratory and pharmaceutical expenditure have largely been set on a historical basis with in-built adjustments for growth trends and additional cash (at least initially) for 'development costs' (ie, the costs of implementing budget holding at IPA level) (Malcolm, 1998b). Thus budgets appear to have been generous in most cases and possibly higher than previous spending. In most budget holding ventures, the IPAs have been able to keep all or a significant proportion of any 'savings' made to provide additional services to their patients. Schemes vary in terms of who carries the risk of over-spending. In many cases, the IPA has not borne the risk of over-spending.

Some concerns have been expressed that the former RHAs and latterly the HFA have been left with potentially all or most of the risk and that the IPAs have been granted access as local monopolies to all the potential 'savings' plus the opportunity to make them by cost shifting and with no clear indication of how the savings should be used. Critics have argued that such imbalanced arrangements are inevitably ineffective in terms of the weak economic incentives facing the GPs and the danger that the national purchaser will face cost over-runs. Some proponents have argued that IPAs cannot ethically manage the full risk, that the GPs involved are not primarily motivated by personal gain and that they do not need to bear full risk in order to generate improvements in resource use (Malcolm, Wright and Barnett, 1999 and 2000). Others have pointed out that IPAs need time to develop before assuming major responsibility for managing financial risk. Current arrangements for IPA budget holding are similar to GP fundholding and total purchasing pilots in the UK in that risk is shared with the main purchaser/funder on terms advantageous to the GPs in order to encourage GPs to take part and to begin to test out the potential of budget holding. Over time, it may be feasible and desirable to make the IPAs bear more of the financial risk and to move from historic budgets to fairer forms of capitation. In the meantime, the effects of IPA budget holding have been important in identifying the scope for further policy change to deliver better, more-cost effective care, rather than representing the end-point of policy development. For example, care would have to be taken if budget holding in primary care were to be extended to other organisations (eg, Maori primary care providers) without considering the potential for cost shifting if budgets continue not to include any allowance for hospital services.

The most discussed effect of IPA budget holding has been the ability of many IPAs to make 'savings' in their laboratory and prescribing budgets. Large savings in laboratory expenditure have been reported, particularly in the first year of budget holding (eg, Pegasus IPA in Christchurch reported a 23% 'saving' against its baseline by reducing unnecessary tests accompanied by a reduction in inter-practice variation in spending). It is not clear how sustainable these 'savings' have been. The larger number of IPAs with extensive experience of pharmaceutical budget holding appeared to have been able to save between 5% and 10% on the best available estimates against national upward trends in spending in 1995/96 (Malcolm, 1997). These 'savings' are more modest than the laboratory savings reported, but greater than fundholding 'savings' on prescribing in the UK. Given the difficulty of establishing the true level of pre-budget holding expenditure, it is wise to assume that savings have been smaller than some of the more spectacular results reported.

An indirect and, in the long run, possibly more significant consequence of granting budgets to IPAs for their practitioners' laboratory and pharmaceutical expenditure has been to reveal big variations both between IPAs and between practices within IPAs in their spending on these services (Malcolm, 1998c) (See Table 3). These differences appear to be due to *volume* rather than price differences. The differences seem to be unrelated to the needs of the patients served since more deprived populations tend to be lower utilisers of laboratory tests and GP pharmaceuticals and higher users of more costly hospital

services. For example, research comparing practices within the South-Med IPA in Auckland indicates that lower use of primary care resources in more deprived areas appeared to be associated with higher use of the public hospitals (Malcolm, 1997). Budget holding appears to have had relatively little effect on reducing these variations between practices so far. Since there does not appear to be any evidence that the higher use practices are offering a better standard of health care (in fact, if anything, the reverse is likely to be true), the implication is that there is considerable scope for providing more and better services by reallocating spending between practices and between IPAs. Alternatively, money could be used elsewhere in the health system. The important point is that IPA budget holding provides a means of redistributing resources between IPAs, between practices and between different sectors of health care (eg, between secondary and primary care).

Table 3: Average mean total and percentage changes in expenditure of the bottom and top members of ProCare, South-Med and Pegasus IPAs, 1995-96

	Mean total cost, 1995 in $000	Mean total cost, 1996 in $000	Percentage change
ProCare			
Mean	198.9	174.8	–12
Bottom 15	43.5	26.8	–38
Bottom 30	51.0	42.4	–17
Top 15	402.9	362.2	–10
Top 30	452.6	409.0	–10
South-Med			
Mean	207.9	191.4	–8
Bottom 10	53.7	39.5	–27
Top 10	374.6	359.9	–4
Pegasus			
Mean	240./1	214.2	–14
Bottom 15	61.6	47.8	–22
Bottom 30	105.7	82.0	–23
Top 15	510.9	435.7	–15
Top 30	440.4	379.2	–14

Source: Malcolm (1997)

A third consequence of IPA budget holding has been the development of practice guidelines and personalised feed back to GPs on their prescribing and laboratory test use organised by the IPA in order to help realise 'savings' (though there is no intrinsic reason why such information cannot be provided to non-budget-holding GPs). This is a marked change in the highly individualistic culture of general practice and shows that incentives to change resource use can be generated even when money is used to improve patient services rather than to improve GP remuneration. This indicates that IPAs as private entities can potentially manage public funds to achieve public goals. A

recent survey of IPA leaders indicates that there is broad support not only for capitation budgets for laboratory tests and pharmaceuticals, but also for GMS payment (formerly fees for items of service) (Malcolm, Wright and Barnett, 2000). There is also support in some quarters for IPAs to experiment with taking budgetary responsibility for hospital outpatient and elective inpatient services on the grounds that GPs' referral behaviour is directly responsible for the use made of these services.

Overall assessment of the pros and cons of devolved budget holding by GP practices and other primary care providers

Having reviewed experience in the NHS with fundholding and in New Zealand with budget holding by IPAs, it is possible to make an overall assessment of the strengths and weaknesses of devolving budgetary responsibility to GPs and other primary care organisations (PCOs). Table 4, below, summarises the arguments for and against primary care budget holding.

Table 4: Potential pros and cons of primary care budget holding

Potential pros	Potential cons
Enables clinical and resource use decisions to be brought together at the same point in the system as primary care doctors and nurses can act to manage demand within capitated budgets – brings GPs into the 'mainstream' of resource management building on their traditional role as referral agents.	Reduces patients' trust in their GPs as their advocates because of their new rationing role on behalf of government.
Potential for more efficient use of overall resources because GPs and other primary care workers face incentives to make 'savings' to use to develop new services and to substitute less for more costly forms of care (eg, averting hospital admission through using tools of 'managed care'). Bureaucratic purchasers do not face such clear incentives.	Risk of 'cream skimming' of high cost patients if PCOs are financially at risk for budgets. Risk-adjusted capitation formulae cannot totally remove this possibility, however sophisticated, though much depends on resources available per patient. However, budgets can be set over more than one year to smooth out demand fluctuations.
GPs and other primary care workers 'closer to patients' than large purchasers and knowledgeable about local providers.	Risk of 'under-service' or quality reductions as PCOs try to make 'savings' to re-deploy. Important to monitor what is being provided to patients or allow them some choice of PCOs.
Alters the balance of power between hospitals/specialists and extramural or generalist care.	As private, self-employed contractors, GPs may be regarded as too self-interested to be charged with managing large amounts of public money. However, budgets could be allocated to PCOs which, in turn, contract with GPs.
Enables one group of clinicians to develop an organisation which can exert influence on another group of clinicians rather than bureaucrats in purchasing agencies.	Risk of cost-shifting onto other budgets unless PCO given extensively or fully integrated budget (though they may not be capable of managing full range of purchasing).

Potential pros	Potential cons
Enables some patient choice of purchaser if patients free to enrol with any practice/PCO.	Tends to increase the number of purchasers which may lead to fragmentation and inconsistency of decision making, as well as higher transaction costs. Higher costs may be judged as outweighing potential benefits.
Leads to greater GP collegiality, accountability for resource use, peer review of performance based on shared information systems.	May encourage GPs and related staff to offer services which they are not best placed to provide (ie, bias towards primary care solutions).
	Most GPs are not interested in a wider purchasing role so organisations will tend to be run by a few practitioners.
	GP-led organisations not good traditionally at patient and public involvement, but this would argue for a different form of more broadly based PCO to receive the budget.
	Unless on large scale, PCOs may lack expertise to act as effective counter weight to influential provider organisations. If large scale, may lead to bi-lateral monopoly problems in primary care which currently exist mainly in secondary sector.

Prerequisites for primary care budget holding

There are a number of prerequisites for effective GP or primary care-based budget holding which do not apply to the simpler regional or district population-based approaches to purchasing (see above). In all cases, the prerequisites become more taxing if PCOs are directly in competition with one another.

Patient enrolment

The first is a system of patient enrolment with a specific budget holding organisation, preferably for a defined period of time. The easiest way to organise this is normally to encourage patients to enrol with a particular GP or group practice or PCO which is part of the budget holding group, although it is possible to separate enrolment with the budget holder from enrolment with a specific practitioner. The issue of the accuracy of enrolment data depends on the degree to which the budget holder is risk bearing, the size of the risk pool (ie, the size of the enrolled population) and whether the PCOs are in competition with one another.

Fair method for setting a capitation budget

The second prerequisite is a fair mechanism for setting the capitation budget of each budget holding entity. It is important that the PCO can relate its activities reasonably closely (if not perfectly) to a defined set of enrolees. Capitation encourages the PCO to focus on maintaining its population as

healthy as possible by the most cost-effective blend of professional staff time and other resources at its disposal. Capitation, in whole or in part, appears to be supported by most of the IPAs as their preferred method of financing primary care in the future rather than fees-for-service in order to ensure fair funding between PCOs and, thereby, practitioners (Malcolm, Wright and Barnett, 2000). However, like all funding methods it creates some undesirable incentives; in this case, to under-provide services and to enrol individuals with above-average health. Hence the need for a means of risk-adjusting capitation payments. The sophistication of the approach depends on how large the population is, the extent to which financial risk is being borne by the PCO and the precise incentives facing the individual practitioners (for example, to under-serve their patients). Generally, systems of GP budget holding have used relatively simple approaches to budget estimation based on aggregate data on the socio-demographic and/or health characteristics of the population served, as against the methods of individual risk-rating used by US managed care organisations to estimate the likely future costs of individual enrolees. Although capitating the budget holding entity does not, in itself, determine the method of remuneration of the health professionals, it makes it difficult, but not impossible, to manage fee-for-service reimbursement against a fixed budget constraint. In these circumstances, it may make greater sense to put teams of professionals onto capitated reimbursement arrangements with fees for particular activities which the PCO particularly wishes to encourage.

Open enrolment

The third prerequisite, which is familiar to those who have considered the implementation of competitive managed care organisations (see below), is for open enrolment; ie, a budget holding group cannot refuse any patient who wishes to enrol. This supports the effect of a fair system of capitation and should largely prevent discrimination against potentially high cost, sick patients, but cannot remove it entirely. The alternative is to make PCOs geographic monopolies and require them to look after all the patients within a specific areas. The extent to which high cost patients require protection depends, in part, on the next prerequisite – the level of risk borne by the PCO.

Risk and surplus sharing agreements

The fourth prerequisite is an agreement on the responsibility for bearing financial risk and using any surplus or 'savings' generated by more efficient demand management or purchasing. One of the consequences of GPs coalescing into larger groupings is that it makes it feasible for them to bear financial risk in a way which is not possible with solo practitioners. Yet the IPAs have shown reluctance, to date, to bear financial risk. Seventeen of 28 respondents to a recent survey of all 30 IPAs in August 1998 were opposed to taking on the risk of going over budget (a lower proportion than in earlier surveys) and 26/28 were opposed to retaining savings as personal benefits (Malcolm, Wright and Barnett, 1999 and 2000). This is similar to the position of managed care organisations in the USA, few of which have succeeded in persuading clinical teams to take on all the financial risk despite strong competitive pressures (Roberts, 1998). Despite this, there is ample scope for negotiating risk (and 'savings') sharing arrangements between the larger GP

groups or other PCOs and the HFA. These can include fairly simple 'stop-loss' arrangements which protect the PCO from costs over a certain limit per patient per year or blended payment systems in which the bulk of reimbursement comes from capitation and the balance from fee-for-service and incentive payments. Indeed, risk-sharing rather than full risk transfer to the PCO may be preferable on the grounds that it should reduce the incentive to under-service and risk selection. In this way, the doctors and others can be persuaded to enter the scheme while they retain a level of resource consciousness that should encourage more efficient deployment of resources. The larger the organisations, the easier it should be for them to manage financial risk for a reasonably wide range of services, but this would inevitably reduce their sensitivity to local variations in population needs.

Wide budgetary scope

The fifth prerequisite, is that the PCO accepts budgetary responsibility for a wide range of primary and secondary service use by its patients. Otherwise, there is always a risk of cost-shifting. For example, a PCO might reduce its prescribing costs in order to invest in other primary care services which it can provide directly and be reimbursed for, but do so by referring patients unnecessarily to hospital if secondary care were outside the scope of its budget.

Options for developing GP or primary care organisation budget holding

The options set out below differ in terms of the degree of integration of the budget which is managed by the GP-led or primary care-based organisation. It is assumed that, in each case, the budget holding consortium of practices, or IPA, or Maori provider or other new form of primary care organisation, has a cash-limited budget derived from a needs-weighted capitation formula. The HFA enters into contracts with the consortia or IPAs or primary care organisation. Each primary core organisation can then decide how it wishes to relate to, and reimburse, the range of providers it requires to deliver the package of services and standards set out in its HFA contract. Thus an organisation might employ certain staff, sub-contract on a capitation basis with other teams and pay for certain services on a fee-for-service basis. Patients would normally be able to choose the budget holding group with which they wish to be registered and, within the group, the practice team/practitioners (including nurse practitioner) who would be their principal source of GMS. In certain circumstances, such as remote rural areas, PCOs might be geographically-based including responsibility for all people in a catchment area without the need for enrolment. Local monopolies are permissible as long as groups do not exceed a particular percentage of the patients in an area. Financial risk is shared with the HFA (or possibly other local budget holding groups) on a clear basis and, likewise, any 'savings' made from efficient purchasing and budgetary management are shared. Risk sharing might include the retention of some elements of fee-for-service payment for specific services. Very costly tertiary services might be excluded altogether. The more risk the entity assumes, the more of the 'savings' it could retain to use as it saw fit. A decision would need to be taken as to whether, and if so, on what basis, GPs and other professionals may benefit personally from any savings

made. The population size of the entity will depend on local circumstances, the degree of risk sharing and the scope of purchasing responsibility, but is unlikely to be smaller than 30-40,000 people.

Important policy issues raised by a number of the models of PCO budget holding concern the relation between the different funding streams within Vote: Health and, particularly, the distinction between the means-tested subsidy regime for GMS and universal free at the point of service hospital and related services. There is inconsistency in having substantial user fees for most patients in primary care (which has the potential to contain demand for hospital care) and no user fees in the public hospitals. Budget holding PCOs would be sure to wish to address this at local level in order to make the best use of their resources.

Assuming no increase in public funding for health care, it is possible for GP groups and PCOs to be required to administer the current level of subsidy for GP visits which is targeted, at present, on those on low incomes with Community Service Cards; ie, their capitation budgets would be based partly on their patients' historic aggregate use of subsidies).However, as GP consultations are significantly privately financed under current arrangements (ie, around half the New Zealand population pays fully for GP consultations through cash payments or private health insurance), capitating existing subsidies increases the risk of 'cream-skimming' and will limit the extent to which government can exert influence over general practice through payment mechanisms.

Alternatively, and far preferably, PCOs could be funded on the basis of their needs-weighted 'fair' share of the total Personal Health budget. They would then be free to use their budgets as they saw fit which could include widening the scope of free-at-the-point-of-use GP services, particularly if they could potentially make compensating 'savings' in their patients' use of hospital services. This would mitigate some of the drawbacks of the current system that is predicated on the assumption that all those on low incomes take up Community Service Cards (CSCs). It is known that this does not happen. Widening the scope of free GP services would also reduce the inequity in the current system in which those with incomes just above the CSC threshold pay as much for GP services as people with high incomes. The current pattern of GMS subsidy is also justified on the basis that user charges are necessary and effective in deterring inappropriate or trivial use of the GP's time. Unfortunately, it appears that user charges also reduce appropriate and inappropriate demand equally, making them both inefficient and inequitable (Chalkley and Robinson, 1997). An unfortunate corollary of the deterrent effect of GP visit fees for those with low incomes is the likelihood that such people will go directly to the hospital rather than visiting their GP, thereby *increasing* the inappropriate use of health services, and at greater cost. By making more flexible use of a more integrated budget, GP groups could develop patterns of provision free-at-the-point-of-use, which reduce the current incentives to by-pass the GP and make better use of overall resources. They might also be freed to pilot more sensitive systems of cost-sharing that, for example, relate charges more closely to income and/or inversely to the cost-effectiveness of drugs and treatments.

Non-hospital budget holding

Under this model, GP groups or other PCOs take budgetary responsibility for primary (including GMS and practice nurse costs) and community health services, GP prescribing and routine laboratory tests and investigations, but not for hospital care. This is similar to most current IPA budget holding arrangements, but the capitation budget would include GMS and other primary care services, so that the GPs would be remunerated from the capitation sum which is not the case with current IPAs. It would be up to the group to decide the basis of allocation of funds to individual GPs, perhaps influenced by government policy objectives. A strong contender would be to allocate funds to practices according to some mixture of capitation, an allowance for practice expenses and additional payments dependent on achieving specific targets set by government (eg, changes towards more cost-effective prescribing, higher immunisation coverage, etc). This combination of payment methods should balance the risks of over- and under-treatment inherent in either fee-for-service or purely capitated environments. If capitation became the dominant source of GP income, this should encourage GPs and the wider practice team to develop more preventive health and 'wellness' services.

While this option would have the advantage of giving GPs and primary care workers responsibility for the resources which their own clinical behaviour directly affects and which they probably understand best, it does nothing to encourage GPs to consider their patients' wider use of hospital and other specialist services. Thus there is the risk of cost shifting through referrals which are costless to the PCO. The contract between the HFA and the GP group/IPA/PCO could include a performance element related to maintaining hospital utilisation rates within some acceptable range, allowing for the age, sex and socio-economic profile of the population served in order to ameliorate this potential limitation. However, it would not be possible to eliminate the risk of cost-shifting fully without extending the budget to include hospital services (see below).

As well as being current HFA policy for groups with a minimum population of 30,000 (HFA, 1998), non-hospital service budget holding appeared to have the support of 70% of IPAs leaders in a recent survey (Malcolm, Wright and Barnett, 2000).

Although this model is presented here as an option for developing devolved *purchasing* of health services, it represents primarily a model of a capitated *provider* organisation sharing risk with the national purchaser (the HFA).

Primary care and chronic disease management

Under this option, GP consortia or IPAs or PCOs would take responsibility for budgets covering primary care and related community health services, GP prescribed drugs and laboratory tests as in the previous model, but with the addition of budgets for integrated health and social care for patients with specific chronic diseases such as asthma, diabetes, coronary heart disease, etc., or for particular vulnerable client groups such as people over 75 years of age. Where evidence-based 'care pathways' or comprehensive patterns of care can be defined with reasonable confidence, groups would be responsible for

securing such care which they would provide themselves at practice level and/or buy in from other providers as necessary. For example, the PCO might contract with specialists to review their management of patients with chronic conditions and to provide them with continuing medical education, while retaining control over the care of these patients in a 'case management' capacity. The approach would be similar to a number of the current Integrated Care Pilots, such as Elder Care Canterbury, which attempt to ensure less fragmented patterns of care for people with long term health or dependency needs.

This model would substantially reduce the scope for cost-shifting without giving the GPs and co-workers purchasing responsibility for services in which they might have no relative advantage as purchasers over the HFA or others. The approach should stimulate the development of a range of non-hospital care for patients with chronic conditions.

Fully integrated budget holding

Under this option, GP groups or other PCOs would take on budgetary responsibility for all, or nearly all, publicly funded health services for an enrolled population. This is similar to the arrangements for Primary Care Groups (PCGs) in the NHS in England, although the PCGs are geographic monopolies, whereas this need not necessarily be the case in New Zealand. It is likely that the enrolled population would need to be at least 50-60,000 to be able to manage this extent of risk. Highly specialised service purchasing could continue to be managed at national level by the HFA.

This model of budget holding is the strongest, in theory. Its comprehensiveness would guard against incentives to cost-shift since the GP group or PCO would be responsible for a very wide range of services. On the other hand, the scope of budgetary responsibility (even with some risk-sharing) would tend to necessitate a fairly large population base, thereby reducing the likelihood that patients would be able to choose their purchaser in a number of less populous areas of the country.

In the August 1998 survey of IPA leaders, 11/24 supported taking on budgets to purchase secondary care, six were opposed to it and seven were undecided (Malcolm, Wright and Barnett, 2000). This suggests that a substantial minority of the current IPAs would be interested in piloting this form of budget holding.

Conclusions on primary care-based devolved purchasing

There is sufficient encouraging, if not revolutionary, evidence from New Zealand and the UK to indicate that primary care organisations involving GPs have considerable potential to improve resource use by building on their unique status as integrated purchaser-providers separate from the hospital sector. The ability of primary care-based purchasers to make 'savings' and to re-invest them appears to offer more powerful incentives to improve services than those which currently face other purchasers (eg, public authorities). It would appear that GPs and related PCOs do not have to be 100% at risk

financially to be motivated to make better use of resources, but can be influenced by professional incentives as well, as long as the additional costs of managing budgets are reimbursed. This is in line with other international evidence which shows that health systems that have more developed systems of primary care tend to produce better health outcomes at lower cost (Starfield, 1998).

However, further developments of primary care budget holding in New Zealand raise the issue of the status of GPs as private practitioners operating small businesses and receiving only limited public subsidies based mainly on fee-for-service. This model of practice does not sit easily with a move towards larger PCOs based on enrolled populations, funded via capitation and involving the services of a team of primary care professionals. It may also limit their ability to manage large amounts of public funds for health services. As long as New Zealand GPs remain largely dependent on private fee income and act as private entrepreneurs who can set their own fee rates without any external regulation, there will continue to be those who are extremely reluctant to see them allocated budgets which cover their patients' use of hospital services, despite the fact that this might guard against cost shifting. There will be reservations about the incentives on the GPs to under-serve their patients in order to make a 'profit'. This is in contrast to the UK NHS where GPs are legally in the same position (as independent contractors), but receive over 90% of their incomes from the NHS. This analysis suggests that, ultimately, the development of extensive PCO budget holding involving GPs is connected with changes to the way in which GMS is subsidised and the ways in which GPs are paid.

This section has shown that there is a range of possible models for primary care-based budget holding, related, in the main, to the scope of the services included in the budget and the size of population required to manage risk. In addition, it is possible to apply models to the general population or to specific sub-groups such as Maori and Pacific Islanders where they might be based on iwi, pan-iwi organisations or other community groups. Each model can be judged in relation to a range of performance criteria such, as its potential effect on:

- Management and transaction costs;
- Cost control and cost shifting;
- Sensitivity to local needs;
- Equity;
- Efficiency of resource use;
- Accountability to local people and upwards to central agencies;
- Effect on the stability of providers.

Assessed in this way, no single model appears likely to be superior on a priori grounds (Smith, 1997). Each model has a distinctive pattern of potential advantages and drawbacks.

Thus larger primary care-based purchasers will be able to manage a wider range of clinical risks, will reduce incentives to cost-shift, will have greater purchasing leverage, the ability to secure access to a higher level of purchasing expertise and should generate lower transaction costs. Between them, they may produce less variation in decisions about the level and nature of services to be purchased than the greater number of smaller purchasers. However, they will tend to become local monopolies, thereby reducing patient choice of purchaser. In addition, they are unlikely to be as sensitive to variations in needs between areas as smaller scale purchasers.

Larger groupings may also find it more difficult to encourage individual practitioners to identify with the collectivity and to develop incentives for clinical change at the practice level. The larger groups are likely to find it more challenging to prevent 'free rider' problems in which individual GPs benefit from the economies of scale produced by the multi-practice organisation (eg, by reducing their practice support services' costs) without participating in the management of a shared, cash limited budget.

While the wider scope of the budget managed by the larger groups should reduce the incentive to shift costs to other organisations, it is likely to mean that primary care professionals are required to purchase services with which they have relatively little personal knowledge or familiarity (though some models would exclude certain specialised services). In these circumstances, they are likely to rely heavily on the expertise of their advisers and managers. This, in turn, might tend to undermine the case for involving primary care professionals in purchasing in the first place since the organisation may be vulnerable to the same risks of poor performance as more bureaucratic forms of purchaser organisation.

In addition to these general trade-offs, local circumstances, such as the distribution of the population and the configuration of local providers, are likely to have a strong influence on the choice of the 'best' model of primary care-based purchasing.

National or Sub-National Competing Purchasers

Purchaser Competition

One alternative to a monopoly national purchaser is to allow individuals to choose between a number of purchasers (or insurers) that offer comprehensive publicly-funded coverage for health and disability services (ie, at least similar to the current publicly-funded coverage). This is an individually driven version of the employer-driven competition between private insurers generated by the 1999 changes to the financing of accident compensation. Early reports suggest that the advent of competition has reduced prices paid by employers markedly. However, it is difficult to compare the pre- and post-reform situation since the move to insurer competition has been accompanied by changes to accident insurance itself. In addition, the employers opting for private insurers in the early stages are unlikely to be typical of New Zealand employers (Dickinson, 1999).

This approach would involve purchaser competition, in which a number of purchasers compete to attract individuals or families, who enrol with the purchaser of their choice (there is also potential scope for purchaser competition without individual choice, eg, through franchising local monopolies to different purchasers) bringing with them a 'voucher' or capitation fee calculated by the government to equate to their fare share of the total public health care budget. Once enrolled, the purchaser is responsible for an enrolee's health and disability care. Such purchasers are likely to be non-governmental organisations although this is not inevitably so. They would bear all or most of the financial risk associated with providing comprehensive coverage for health and disability services, thereby transferring responsibility for such risk from the Crown to themselves. The Crown would continue in its roles as financier and deepen its role as regulator and monitor of the system.

The assumption underpinning this approach is that competition between purchasers for enrolees will produce incentives for better performance and that current monopoly purchase arrangements fail to ensure that purchasers have adequate incentives, skills, or resources to make efficient resource allocation decisions. Consumers will make choices about which purchaser to enrol with based on the quality of care offered by a purchaser, and potentially also on the basis of the service coverage offered and the premium charged (though this depends on the design features of any model of purchaser competition). In theory, those purchasers that offer high quality care at a lower price will expand their market share, and all purchasers will have incentives to provide cost-effective, high quality care and reduce costs (Cumming, 1998). Thus this system is qualitatively different from the others discussed in this paper in that it relies explicitly on individuals and families making their own decisions about the health care organisation which is most likely to best meet their requirements.

In a competitive market, however, profit-maximising purchasers (or insurers) would charge consumers premiums based on individual and family risk or limit consumers' entitlements proportionately. This would raise significant issues about the affordability and coverage of health care for high risk individuals or groups of the population, and thus equity concerns. Consequently, there is usually a high degree of government involvement, at least in the OECD, in the financing of, and payment to purchasers and providers for, health care services. This involvement is either by collecting premiums through taxes or social insurance schemes and allocating them to purchasers and providers through a separate process, or by requiring "community rating" of premiums charged by purchasers (ie, premiums are not based on individual or family risk).

Consequently, purchaser competition in health care policy is widely referred to as "regulated competition", as a significant regulatory framework for purchasers is usually considered necessary to promote equity and market efficiency.

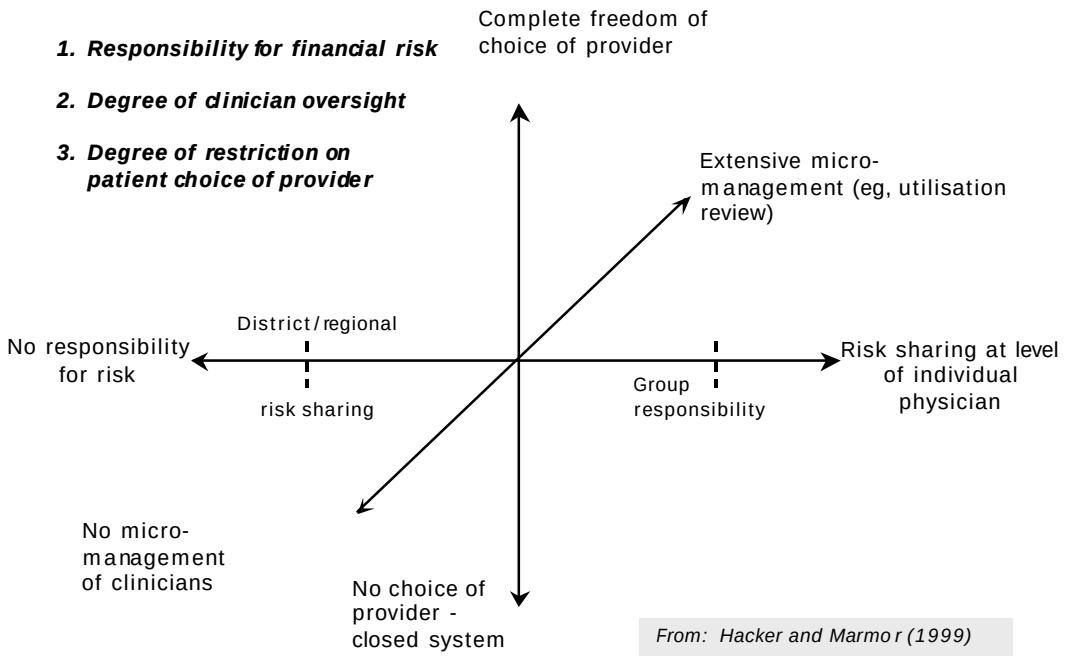
"Regulated" competition has developed primarily in the United States as part of the shift away from traditional third party payer indemnity insurance based on fee-for-service reimbursement at cost, though other countries have adopted

limited aspects of regulated competition (eg, Netherlands). The most developed proposals for purchaser competition, therefore, tend to originate from the US. A well-known example is the US Health Maintenance Organisation (HMO), better known as a pre-paid health plan, of which there are a number of distinct models. There are few examples in publicly funded or social insurance based health care systems of risk bearing, comprehensive health care organisations which compete for individual enrolments.

Organisational forms

There are numerous different ways of organising regulated competition between 'health plans'. Purchasers may be quite distinct from providers, as with the current separation between the HFA and service providers (ie, the HFA and service providers are separate legal entities whose relationship is governed by contract, with no mutual employment or ownership interests). Alternatively, there may be increasing degrees of "vertical integration" between purchasers and providers; that is, competing purchasers may contract solely with, employ, or even own, some or all of the providers through which they provide health care coverage. There is generally integration between primary and secondary providers, so that patients are required to receive their first contact care from a specified team which acts as gatekeeper to other more specialised services rather than having free choice of provider (see Figure 1). Clinicians may be micro-managed by the health plan to varying degrees whenever their decisions involve resources and they may take varying degrees of responsibility for financial risk. There has been considerable debate and successive changes of policy by managed care organisations as to the appropriate level and combination of managerial scrutiny and financial incentives which individual clinicians should face. Currently, managed care organisations appear to be retreating from expensive and intrusive micro-management, preferring to rely on getting clinicians to work within broad budget limits and retrospective feed back of comparative data on quality and outcomes of care to individual doctors in order to influence their behaviour (Anonymous, 1999).

Figure 1: Three Dimensions of 'Health Plan' Organisation



In the US, proposals for managed competition have been based on health benefit intermediary (HBI) organisations that act as insurers/purchasers of health care services on behalf of their membership. The HFA in New Zealand, therefore, bears some similarity to the HBI, except that there is no patient choice of HFA. The different forms of managed care organisations (MCOs) are distinguished by the extent to which HBI and service provider functions are integrated and providers deal exclusively or non-exclusively with a particular HBI (Robinson and Steiner, 1998). In New Zealand, a few proposals for 'integrated care' have involved integrated care organisations (ICOs). Notionally, these have been similar to MCOs, but, organisationally, they are based solely on contracts between a purchaser and providers, and not to the exclusion of other purchasers contracting with the same providers. The small number and lack of choice of hospital providers in New Zealand makes it unlikely that exclusive relations could be sustained here.

Proposals for managed competition in publicly funded health care vary, but usually involve the following key features:

- consumer choice of purchaser or health care plan (ie, competition between purchasers or health plans for consumers);
- health plans with a strong primary care 'gate-keeping' role;
- consumers normally have an opportunity to switch plans once a year or less frequently;
- close relationships between purchasers and providers of health care services, often with vertically integrated purchaser-providers (ie, health care plans or ICOs). Purchasers and providers may be integrated into the same organisation (through purchaser ownership or employment of the provider) or there may be strong contractual arrangements linking purchasers and providers, or preferred provider, or network arrangements;
- open enrolment – arrangements to ensure that purchasers or health plans: take on all individuals who wish to enrol, cover all individuals, and do not exclude individuals on the basis, for example, of pre-existing health conditions, unlike most private insurers;
- standard packages of coverage or health benefits to be offered by purchasers or plans, in order to prevent risk selection by purchasers/plans. This potentially limits the benefits of consumer choice;
- financing arrangements in which individuals, employers or the government (as in the case of Medicare in the US) pay premiums which are community rated, ie, premiums that are the same within broad population age-gender bands, or where variations in premiums are limited;
- pre-paid capitation payments (a fixed fee by every enrolee that is weighted according to such characteristics as age, gender, ethnicity, socio-economic status, health status) to health plans in order to encourage efficiency in the use of resources. Below the level of the plan, payment arrangements with providers use a variety of approaches including capitation and fee-for-service;

- purchasing co-operatives to pool the risk of smaller health purchasers or plans, achieve economies-of-scale (eg, in administrative costs), and regulate the health purchaser/plan market, including provision of consumer information;
- purchasing co-operatives to monitor the performance of health plans. Such co-operatives are primarily a feature of the US health care market.

How purchaser competition might operate in New Zealand

We can now sketch the likely features of competitive purchasing for comprehensive health and disability care coverage in New Zealand.

This model assumes that the current public financing arrangements, and the total level of public financing, for health and disability care services in New Zealand remain the same, (that is, financing is predominantly by the government through general taxation, with out-of-pocket payments for some services, particularly primary care, and scope for people to take out private health insurance). However, the relationship between public and private insurance could change under purchaser competition. At present, private health insurance is predominantly 'double cover' insurance to provide faster access to services also provided in the public system (eg, elective surgery). If health plans competed for individual patient enrolments, a "core" range of publicly funded services would have to be defined to ensure fair competition and fair coverage. At this point it would be possible to allow patients either to pay out of pocket or to insure privately for services *not* in the "core". Allowing 'topping up' for services which the purchaser would be expected to make available to all patients (the 'core') would be inadvisable since it would greatly increase the attractiveness of better off patients to the purchasers and reduce equity of access to the 'core'. The extent to which existing financing arrangements can or should remain completely unaffected and the relation between public and private financing would require further investigation if regulated competition were to be introduced. However, the main benefits (or efficiency gains) from the model are, therefore, expected to be in terms of improvements in the delivery of health care services, improvements in the volume of services and financial savings, rather than changes to overall funding levels.

Competitive Purchasing Model

The key features would probably include:

- competing purchaser organisations operating across the country that provide comprehensive health and disability services coverage, similar to the current publicly-funded coverage, but possibly excluding some services, (eg, national purchasing of tertiary health care services might continue);
- a standard or "core" service coverage offered by all purchasers to enrolees (to prevent risk selection and promote meaningful consumer choice of purchaser). The standardised package of services would most probably be determined by a regulatory agency. The extent to which purchasers should be permitted to offer supplementary private insurance coverage beyond the

basic package, or 'double cover' to provide preferential treatment for services within the "core" package or, indeed, other products (eg, car insurance) would have to be determined, as would the ability of the purchaser to levy patient co-payments;

- individuals and/or families would enrol with a purchaser of their choice, and arrangements to ensure "open enrolment" would be necessary (see section on risk selection);
- national purchasers would sub-contract with providers for the delivery of health and disability services. Contracts between some (possibly many) providers and more than one purchaser would be necessary to promote competition. The potential for vertical integration of secondary and tertiary health care services (ie, purchasers and public hospitals) is likely to be extremely limited as different purchasers would require access to the same providers of hospital services, which are largely local monopolies. The extent to which purchasers could therefore own or exclusively contract with, or employ, a specific provider would need to be carefully evaluated;
- purchasers could be paid by the government on a needs-based (ie, weighted) capitation basis. In this situation, the value of the payment would not be visible to the enrolee and hence they would not be price sensitive. An alternative might be to provide enrolees with a voucher which they then paid to a purchaser. Either way, competition would be on quality grounds, not price;
- the government would need to regulate the market for health care purchasers, including such aspects as registration of purchasers, monitoring and evaluation of purchasers, regulation of purchaser marketing and production of standardised consumer information. This last would be particularly important if patient choice were to lead to efficiency improvements (see below).

Key pre-requisites for this model would include:

- the willingness of potential purchasers to enter the market and provide comprehensive service coverage, preferably on a national basis (eg, a potential purchaser might be prepared to enter the market in large urban areas, but not provide coverage in smaller towns or rural areas);
- sufficient purchasers to sustain competition;
- providers contracting with all purchasers;
- the HFA acting as a purchaser of last resort, or as an alternative purchaser with whom patients could enrol (eg, as in the accident compensation insurance market from July 1999) if private purchasers proved unable to offer a health plan in particular parts of the country on a competitive basis; and
- a risk-adjusted capitation payment method capable of mitigating the incentives to risk selection and under-service in a competitive model of purchasing based on patient enrolment.

Competitive purchasers are most likely to be nation-wide non-governmental organisations in a New Zealand context. To offer comprehensive coverage to any potential enrolee, purchasers will need to have a national presence or identity, and will have to contract with providers throughout the country.

Purchasers are also likely to be relatively large organisations if they are to be effective purchasers of health care. Purchasers will have to be of sufficient scale to have the expertise and infrastructure to contract successfully and to monitor/evaluate provider performance, as well as invest in information systems to support these activities and monitor enrolees' health status (see Light 1998; Cumming 1998).

Purchasers will also require a minimum critical enrolee membership to enable them adequately to spread the financial risk associated with providing comprehensive service coverage. The small size of New Zealand's population (approximately 3.8 million people) and its geographical dispersion is likely to limit the potential for competition where purchasers are required to provide comprehensive coverage.

Number of Competitive Purchasers

At least three national purchasers or ICOs are likely to be required to promote purchaser competition (Cumming 1998; Kronick, Goodman, et al. 1993). A United States study used the ratio of physicians to enrolees in large staff-model HMOs to estimate the population required to support health organisations with various types of health care services (Kronick, Goodman, et al 1993). The study assumed US levels of health care spending and three health care plans to facilitate competition. It concluded that:

- a health care services market with at least 1.2 million could support three fully independent plans (ie, each plan would own its hospitals and exclusively employ all its own staff);
- a population of at least 360,000 people could support three plans that independently provided most hospital services, but they would have to share hospital facilities and contract for tertiary services;
- a population of 180,000 people could support three plans that provided primary care and many basic specialty services, but which shared inpatient cardiology and urology services and engaged in substantial sharing of inpatient facilities with other plans.

Using these figures, Cumming (1998) estimated that:

- only the Auckland region (about 27 per cent of the population) could sustain competition of the first and second kinds. However, individuals would potentially face significant travel times to providers;
- Christchurch and Wellington fall just below the 360,000 population mark, so may also be able to sustain competition of the second kind (increasing coverage to 45.6 per cent of the population);

- populations between 140,000 to 180,000 might also allow competition in the Hamilton-Cambridge-Te Awamutu region (adding a further 4.4 per cent of the population). Reducing the level to 100,000 would also add Napier-Hastings and Dunedin (a further 6 per cent).

At most, New Zealand could sustain competition of the third kind (ie, three competing plans providing primary care and basic specialty services) for only 56 per cent of the population. One implication is, therefore, that the HFA or franchised local monopolies might have to purchase for the remaining 44% of the population and for the remaining services.

These are rough estimates and, further work would be required robustly to establish the enrolee membership necessary to spread financial risk adequately, and the number of purchasers necessary to facilitate competition. These calculations are crucial for the future development of any model of purchaser competition. Better estimates would need to include the likelihood that New Zealand health plans would be required to offer DSS as well as Personal Health Services. However, it is unlikely that the wider scope of New Zealand health plans would enable them to function on a smaller population base than the rough estimates indicate. Thus the provisional conclusion is that only greater Auckland could sustain three health plans offering broadly comprehensive health and disability support services.

Provider Competition

The likely extent and effect of provider competition is also a key consideration in examining the scope for purchaser competition.

New Zealand has a large number of health and disability care providers, predominantly providers of primary or community-based health and disability services. However, the number of providers of secondary health care services is relatively small in comparison, and there are very few providers of tertiary health care services (both of which are predominantly government-owned). In some instances there are also few providers of health and disability services in rural or provincial localities (eg, West Coast). To some extent this reflects the small size of New Zealand's population, which means that only a limited number of secondary and tertiary health care service providers will be clinically viable. The small size of the population means that incident rate of conditions requiring specialised clinical procedures is low and the subsequent clinical throughput may only support a limited number of clinicians.

This raises questions about the likely extent of provider competition and the degree of influence that purchasers may have over some providers' behaviour. It is highly likely that most providers would have to contract with more than one purchaser (at least for some specialties and in smaller towns), as a prerequisite to encouraging competition between purchasers. Under such circumstances, people in smaller towns might have a choice of plan for a less than comprehensive range of services, but little choice of provider given current provision arrangements. This would also weaken the ability of the purchasers to influence the behaviour of hospitals.

One response to the lack of hospital competition is to break the hospital into competing units or clinical teams either by direct physician contracting or by splitting the hospital's facilities from the clinical services which it provides and tendering for those services either as a whole or in parcels related to clinical teams. There may be scope for pursuing such options in order to give purchasers greater opportunities to make efficiency gains.

However, there may be higher transaction costs where competing purchasers contract for comprehensive care with individual clinical teams (unless there is further integration of providers). The HFA entered into 4580 contracts with providers in 1997/98. A similar or higher level of contracting may, therefore, be necessary for each purchaser or ICO to buy comprehensive coverage for its enrolees (ie, a total of over 13,000 contracts at a minimum for three purchasers).

The above discussion suggests that setting policy objectives for purchasing will involve important trade-offs, for example between:

- opting for large-scale purchasers that can adequately manage the risk associated with providing comprehensive health care coverage;
- the scope for more significant competition where the service coverage offered by competing purchasers or ICOs is more limited;
- the efficiency gains which may result from demand and supply side competition versus the costs of bringing this system about.

Advantages of Purchaser Competition

The potential benefits of purchaser competition in New Zealand are difficult to gauge. The design features of any model of purchaser competition are likely to have an important bearing on how well competing purchasers perform. The extent to which purchaser competition promotes efficiency, innovation and choice for consumers will depend not only on how purchasers compete and how they contract with providers, but on the extent to which competition can develop for different population groups, including high risk groups and those in geographically isolated communities, and how much freedom purchasers have to vary what they provide (within national parameters) to meet the needs of specific population sub-groups.

Most of the experience and evidence about purchaser competition comes from the United States. This evidence largely compares the performance of MCOs, which attempt in a wide variety of ways to avoid the 'moral hazard' problems of third party insurers, compared with traditional fee-for-service private indemnity insurance in the US. Consequently, it does not directly tell us how purchaser competition in New Zealand might compare with the status quo (ie, mainly tax finance, macro cost controls, a national monopoly purchaser and mainly salaried professional providers), or how competing health care plans and providers compare with the current situation of many bilateral monopolies (ie, between the HFA and HHSs). Any extrapolation of the benefits of regulated competition to the New Zealand situation has to be carefully qualified.

The traditional US insurance arrangements are widely considered to have generated excess capacity (ie, over-supply of hospitals and clinicians) and supplier-induced demand. Managed care has achieved results through the introduction *inter alia* of techniques such as capitated budgets and a clinical "gate-keeping" function. New Zealand is already well advanced with respect to such arrangements (eg, publicly-funded health care has a capped budget, gate-keeping is well-established, 25% of GPs are capitated for GMS and virtually all IPAs budget-hold for laboratory tests and pharmaceuticals), and, therefore, the benefits from their introduction in the US cannot be expected to accrue in New Zealand where they already exist (Robinson & Steiner 1998).

Furthermore, most of the evidence about managed care examines the effects of managed care organisations and does not isolate and analyse the influence of specific financial and other management techniques used in managed care. As Robinson and Steiner note, it is, therefore, uncertain "what precisely it is about managed care that has had the strongest impact on utilization and quality of care" (Robinson & Steiner 1998). Consequently, specific management techniques (eg, utilisation review) may yield benefits in the absence of competition between purchasers / managed care organisations.

We can, nonetheless, make some judgements about the potential advantages of the model of purchaser competition outlined above. The potential advantages, none of which are necessarily exclusive to this model, include:

- incentives on health plans to improve the efficiency and cost-effectiveness of health care services since they have to attract and retain patients while maintaining financial viability (unlike monopoly purchasers for whom patients and budgets are guaranteed);
- consumer choice of purchaser;
- risk-rated payments (ie, weighted capitation) which more accurately reflect the costs of consumers' health care;
- further integration of the existing publicly-funded budgets for health and disability services (ie, personal health, disability support services and public health services), as health plans take a "voucher" for all or a wide range of health care needs for each enrolee.

Improvements in Efficiency and Cost-Effectiveness

Robinson and Steiner (1998) have undertaken the most recent and systematic review of the performance of managed care organisations (compared with fee-for-service indemnity insurers) on a number of key performance dimensions (see Table 5). They show that the evidence is broadly favourable with respect to MCOs, but that findings for some indicators, are difficult to interpret. Public opinion is largely hostile and users' views seem to be less positive than for fee-for-service plans. It appears that patients value additional services even if these do not contribute to better quality of care or outcomes. Their findings together with a recent update (Robinson, 1999) are summarised in Table 5.

Table 5: Performance of US Managed Care Organisations (compared to FFS plans)

Performance Dimension	Assessment	Summary
Utilisation	Evidence suggests MCOs achieve lower levels of utilisation. Reductions in hospital administration, length of hospital stays, and use of expensive tests, procedures and treatments. Inconclusive evidence about doctors' visits and drug prescriptions received.	Positive
Expenditure and Charges	Evidence on the relative performance of MCOs is highly inconclusive. A consistent pattern is no difference between MCOs and FFS plans regarding hospital charges per inpatient stay.	Inconclusive
Preventive Screening and Health Promotion	Evidence strongly indicates MCOs perform better, ie, deliver more preventive care. Evidence supports the assumption that MCOs have an incentive to keep patients well through preventive care and promotion.	Positive
Quality of Care	Evidence suggests no significant difference between MCOs and FFS plans. Important finding as the *a priori* expectation is that reduced resource use would result in lower quality outcomes or satisfaction with care.	Neutral
Enrolee Satisfaction	Evidence indicates that MCOs performance poorly on enrolee satisfaction (constantly lower ratings than FFS), but evidence is of poor quality.	Negative
Equity of Care (between specific groups)	Evidence is either inconclusive or suggests no difference between MCOs and FFS plans for children, low-income women or elderly.	Neutral

Source: Robinson and Steiner (1998); Robinson (1999)

Consumer Choice of Purchaser

A key question is what effects (including benefits) will consumer choice of purchaser have, given standardised service coverage and third-party payment? From a policy perspective, the question is about the potential effects of consumer choice on improving purchaser efficiency. However, choice can also be valued for itself, irrespective of its consequences, on the theoretical grounds that consumers must know better than the government or health professionals what their health needs are.

For consumers to make choices based on efficiency, they will require information about the cost-effectiveness of the purchaser (ie, the level of outcomes produced given the resources available), the quality of care offered (including the appropriateness of care, the cultural acceptability of care, the quality of facilities, the availability of services) and the *value* of the particular quality of care (ie, how quality relates to the outcomes deemed important by the patient). Assuming that consumers will not be paying directly for their

care, but bringing an implicit government "voucher" upon enrolment, consumers will not require to know the price of the services. Instead, the government or its regulator will need to set fair prices to enable plans to offer services to different types of users, while subject to some pressure to contain cost.

High quality information about the relative quality and cost-effectiveness of purchasers will need to be provided, probably by an independent agency, otherwise consumers will only have access to proxies such as the physical quality of facilities which may do little to help them drive efficiency and cost-effectiveness of services. The model presumes that purchasers/plans will be at risk financially in a way which HFA/RHAs could never be and will, therefore, have underlying incentives to control costs and improve efficiency.

Risk-rated payments and budget integration

Risk-rated payments (weighted capitation) to purchasers for enrolees will encourage:

- payments that reflect the actual financial risk associated with providing comprehensive care for types of consumers, rather than payments for individual services based on historic costs; and
- purchasers to compete on the basis of efficiency and quality (rather than to engage in risk-selection).

Weighted capitation payments for enrolees will also integrate the existing personal health, disability support and public health budgets, thereby allowing purchasers greater flexibility in determining the most cost-effective mix of services, within the coverage they are required to provide.

Role Clarity

Proponents of 'regulated competition' argue that it would have the advantage of taking government entirely out of both purchase and provision of health care. This would enhance role clarity, enabling government to focus on more appropriate tasks of financing, regulating and monitoring health services (Blair, 1999) and avoid the conflicts of interest which dog government purchaser-provider relations at present. It is also argued that role separation would also allow for the introduction of non-government purchasers/health plans that were fully at risk financially for the performance of their plan. This is contrasted with the public purchasers that are said to lack clear incentives to perform well since they are unable to go out of business and would prefer to argue for more money rather than improve cost control and efficiency of their providers.

Disadvantages of Purchaser Competition

The potential disadvantages of the model of purchaser competition outlined above are more apparent. However, some of them exist under current arrangements too. The potential drawbacks include:

- higher transaction costs (eg, from contracting);
- higher regulatory and administrative costs;

- risk selection or "cream skimming";
- ineffective patient choice;
- cost shifting;
- reduced purchaser influence over providers (ie, reduced bargaining power); and
- likely pressure for higher than planned spending due to individual entitlement to coverage driving up utilisation.

Higher Transaction Costs

As noted above, many providers will require multiple contracts with all purchasers, if purchasers are expected to provide comprehensive coverage on a national basis compared with the current arrangements with a single purchaser. Higher overall health system costs are likely, therefore, to result from the duplication in administrative and contracting arrangements. Significant benefits (efficiency and health outcome gains) from a system of competing purchasers will be necessary to off-set such costs together with the other regulatory and administrative costs needed to make the market work efficiently (see below). Similar additional transaction costs are likely with the other forms of primary care-based purchasing discussed above. There are currently no estimates available of transaction costs under different forms of purchasing in New Zealand.

Regulatory and Administrative Costs

There are likely to be higher costs from the administrative and/or regulatory arrangements required to make a competitive purchaser market work effectively and efficiently.

For example, consumers need good quality, independent information on the quality of services offered by different plans. Government has to establish market structures and rules. Plans have to advertise and market their services to consumers. These costs result from arrangements to prevent risk selection, cost-shifting and poor purchaser performance. These are briefly outlined below.

Risk Selection (or "cream-skimming")

Risk selection occurs when purchasers or providers (either deliberately or by chance) enrol a favourable mix of members, ie, individuals with a lower risk of making a claim or needing care than the average person within any broad risk pool (eg, a particular age-gender pool). This is likely to be more of a problem where capitated payments are made to purchasers competing for individual patient enrolments and these payments for an individual's care do not necessarily equate with *ex ante* or *ex post* financial risk (ie, there is an opportunity for the purchaser to make profits/surpluses from selecting patients, rather than competing on the basis of efficiency or quality).

- contracts with providers are on a capitation or budget-holding basis and the capitation rates used to calculate the capitation payment do not equate with the financial risk associated with the individual; and
- there is competition between providers or ICOs. The extent of the problem will depend on the degree of competition between purchasers and the extent to which purchasers are unable to manage the costs of high risk patients.

The strategies by which purchasers might risk-select, and the approaches to addressing risk selection are summarised in the Annex. In general, proposals for competitive purchasing, in publicly financed systems where equity of access is a prime goal of policy, will require purchasers to:

- cover all pre-existing conditions, or at least limit the time period during which pre-existing conditions are excluded from coverage (eg, to say six months after enrolment);
- take on all those who apply for care to be covered by any particular plan (known as open enrolment);
- market their plan(s) throughout the country, not just in affluent areas;
- guarantee that all individuals may remain with a plan even if their utilisation or costs rise or their health status deteriorates (known as guaranteed renewal);
- monitor and publicise rates of disenrolment, consumer complaints and consumer satisfaction;
- allow the monitoring of plan performance and publication of information about the quality of care provided by purchasers; and
- provide a standard benefit package which is intelligible to users so that purchasers compete on quality of services and outcomes, not selective coverage.

Some degree of risk sharing rather than transfer of total financial risk to the purchaser by the funder, is also generally recommended as a means of mitigating the tendency to risk selection.

Ineffective patient choice

It is fundamental to the model of purchaser competition that individuals have the ability to make choices between health plans which are likely to be in their best interests. Economists tend to assume that consumers know what they want and can pursue what they want in a rational manner (two significant assumptions). The only barrier to this, which is typically conceded to exist, is the possibility that there may be inefficiently low levels of information in particular markets, especially those for health services. The solution is to give patients more information, thereby permitting efficient competition. Assuming that information and choice are available, do consumers use them? Most studies to date, even in the USA, suggest that there is remarkably little 'consumerist' behaviour in health care markets (Hoerger and Howard, 1995). This may be rational, given that, in any one year, the vast majority of health

care use and expenditure is generated by a small minority of the population. In the USA, approximately 40% of costs are devoted to less than 2% of the population. Most people, most of the time, are not health care consumers (in contrast to their consumption of retail electricity and food, for example).

People tend not to use information in selecting their source of care. Furthermore, even when given information, for example on the extent of cost - sharing (ie, user charges) between insurance plans, this does not appear to influence behaviour. Hibbard and Weekes (1989) found that cost information, even among those who claimed that costs were a financial burden, had no effect on behaviour, or costs incurred, in their sample of government employees and Medicare beneficiaries in Oregon in the mid 1980s.

Rice (1998) argues:

'The increased importance of managed care and capitation in the U.S. health system brings with it many challenges for consumers. To make the most appropriate choices about health plans, consumers need to understand such concepts as primary care gate keeping, financial incentives to providers, and other plan characteristics that affect the type of care patients receive. Unfortunately, there is little evidence that consumers do understand these concepts.' (page 71)

This is even more likely to be the case in New Zealand, where patients are unfamiliar with having to make such choices.

One potential solution to such difficulties is to set up an independent agency to prepare standardised "report cards" on each health care plan. Much is made by advocates of purchaser competition of the US National Committee on Quality Assurance's Health Plan Employer Data and Information Set (HEDIS) which measures plan performance in areas such as patient satisfaction, appropriateness of care for particular conditions and extent of preventive services. Yet, research on HEDIS suggests that consumers rely heavily on the user satisfaction indictors which they believe they understand and ignore the more technical measures of the quality of care for particular conditions (eg, rates of eye examinations among diabetics) (Hibbard and Jewett, 1997). This indicates that, beyond information dissemination, consumers will need *education* about the type and quality of care offered by different plans. For this, there would need to be an organised consumer movement in health care, which does not currently exist in New Zealand.

If individuals find choice difficult, how will health plans fare in New Zealand? In brief, they are likely to face many of the same restrictions on choice of provider, especially in the acute hospital sector, currently faced by the HFA. There are many natural monopolies given the population size and geography of the country.

Cost-Shifting

Cost-shifting occurs when costs are charged against a budget which differs from that intended, or from that traditionally charged. The risk of cost shifting increases, the less comprehensive the budgetary responsibility of a purchaser or provider.

The key risks associated with purchaser cost-shifting are also potentially numerous and include:

- increased government expenditure on votes other than Vote: Health;
- increased expenditure for publicly-owned purchaser and provider organisations where costs and patients are shifted to other publicly-owned purchasers and providers;
- increased private expenditure and resource use where purchasing authorities make decisions which shift responsibility for financing on to private budgets; and
- shifting costs to society by under-investment in preventive care if health plans judge that individuals are unlikely to be enrolled for a substantial period of time.

If the competing purchasers are required to cover a reasonably comprehensive range of services, cost-shifting will be less of a risk. However, in the New Zealand context, there will be inevitable efforts by health plans and accident insurers to cost shift across the Vote: Health-accident compensation budget boundary. In addition, health plans will have an incentive to 're-badge' activities as either outside the 'core' or as non-health care and, therefore, directly chargeable to patients. This raises questions as to whether health plans should be permitted to charge patients and/or to encourage them to 'top up' their publicly financed 'vouchers' and, if so, whether the cover resulting can be used for any services already contained in the publicly financed 'core'.

Reduced Purchaser Bargaining Power

Current purchase arrangements mean that the HFA wields substantial market power in negotiating with providers as the dominant or monopoly buyer of many health and disability support goods and services. Multiple purchasers may wield less bargaining power, in some instances, particularly where providers are market-dominant or constitute local or national monopolies, or alternative providers take time to emerge. This is particularly likely to be the case in relation to large acute hospitals.

Individual Entitlements

Purchase (or insurance) arrangements in the United States are traditionally characterised by individual entitlement, ie, once covered by an insurer, individuals can expect to receive services relatively quickly, including elective surgery (ie, there is a fundamental difference in health system goals – health gain versus responding to individual demand). This differs from the New Zealand situation in which individual access to publicly funded health care services is rationed through gate-keeping mechanisms, and individual priority for services, such as elective surgery, is determined by clinical priority criteria. Purchaser competition raises issues about whether health care can continue to be rationed in this way. The risk is that competing purchasers will use the fact that budgets are finite to shift costs on to, or under-service, consumers rather than improve efficiency. Alternatively, health plans may turn to government for more money arguing that they cannot offer comprehensive cover for the amounts contained in the capitation payments they receive. In this, they are

likely to be backed up by a new patient expectation that patients should receive the specified coverage of services in a timely manner at a particular level of quality. While this may be good for patients, it could impose major strains on the agreed health budget and crowd out other social spending.

Conclusions on purchaser competition

Competing purchasers or ICOs will constitute a very different health care system from the current internal market, and would require major development of new arrangements and regulatory systems before such a system would be feasible. Given the extent and pace of change in the health sector in recent years, it seems unlikely that there would be support for a shift directly from a single national purchaser to purchaser competition. In practical terms, demand side competition is only likely to develop if New Zealand were to move initially towards an intermediate system of devolved purchasing in which the national purchaser passed its responsibilities progressively to other intermediate organisations. If these devolved purchasers were non-governmental and particularly if they involved insurers (eg, accident compensation insurers), they *might* provide the basis for the evolution of health plans. However, such a development is not inevitable and would require an explicit policy decision by government.

It would also take time before any gains would be realised from a system of demand side competition. These gains would have to be set against the considerable upfront and continuing costs of running a regulated competition system for publicly funded services. The weakest aspects of the model in New Zealand relate to competition; both that driven by individual patients between plans on grounds of quality; and that driven by providers competing for the business of health plans. The strongest aspects, in theory, concern the consequences of permitting non-governmental organisations to accept major responsibility for purchaser risk as an alternative to the former RHAs or HFA. If competition in the market is a non-starter, the model might be more accurately seen as a periodic tendering of the purchasing function, with competition between a residual public purchaser (necessary if private purchasers get into financial difficulties) and a range of private purchasers to purchase for defined populations. Government would need to regulate and monitor the performance of these private monopolies. Though this system would distance government still further from the purchasing role, it would not protect it from lobbying by the purchasers concerning the level of funding available. It would still be in the interests of purchasers to argue for higher levels of funding rather than to restrict the spending of influential clinician groups. At present, government only has to deal with a single state-owned purchaser. Under a model of competing purchasers, it would have to deal with several.

Specialist Purchasers

Rationale

Purchasers that specialise in providing coverage for specific types of services (eg, mental health services) or specific population groups (eg, Maori) are potential alternatives to organisations that purchase a comprehensive range of health and disability services for their membership. Such purchasers might compete with others, eg, multiple purchasers of support services for older people. Alternatively, there might be only one purchaser, for example, a single purchaser of oncology services within a geographical region. The potential options are wide ranging, but specialist purchasers would need to be of sufficient scale and benefit to justify the likely additional costs of such arrangements. One justification is that a specialist purchaser, for example, for a patient group with a specific chronic condition such as diabetes, could purchase across the full range of services required for the effective management of the condition, thereby, for example, integrating drug therapies with other treatment and disability support in new ways. The purchaser would also build up expertise in the field sufficient to negotiate contracts with providers on more equal terms than generic purchasers.

Pharmac is an obvious current example of a specialist purchasing organisation covering a specific set of pharmaceutical technologies rather than services or populations.

How specialist purchasing might operate in New Zealand

Given New Zealand's current purchase arrangements, the likely scenario for specialist purchasing would involve:

- the Health Funding Authority sub-contracting with, or delegating its responsibilities to, other organisations to provide specific service coverage for a particular population. The HFA would, therefore, act as regulator of the specialist purchaser through a contract with, or delegation to, the sub-purchaser. Alternatively, the Crown could choose to contract directly with specialist purchasers by using the Health and Disability Services Act to establish "alternative funders";
- the population to be covered by the sub-purchaser would need to be clearly defined. This may require individual enrolment with purchasers, particularly where there is choice of competing specialist purchasers. Enrolment may be unnecessary where a purchaser is a geographical monopoly;
- the service coverage to be offered by a sub-purchaser would need to be clearly specified to: provide a basis for monitoring purchaser performance and prevent under-servicing of patients; and to prevent sub-purchasers from shifting costs to other purchasers (including the HFA) and providers. The HFA would most likely specify the service coverage to be provided;

- specialist purchasers would be paid by the HFA on a risk-rated (ie, weighted) capitation basis, rather than historic cost, to reflect the financial risk associated with the population to be covered by the sub-purchaser. The value of the payment might be revealed to individuals so that consumers could choose between sub-purchasers and price competition might be encouraged. However, this variant would need careful design. (For example, if a client chose a low cost purchaser, should they be allowed to keep the 'savings' made to spend on something else or could they only buy more health care?);
- the HFA would monitor the performance of sub-purchasers, including (dis)aggregated outputs and health outcomes; and
- the HFA would continue to purchase all other publicly funded health and disability services for the New Zealand population.

New Zealand Examples

In addition to Pharmac, the HFA is currently purchasing various integrated care projects that have the potential to be specialist purchasers, but at this stage they only exist in embryonic form. The current pilots are provider organisations, focusing on co-ordination of services rather than taking full budgetary responsibility for meeting all the needs of a population with a specific condition. These include Eldercare Canterbury, an integrated care project that co-ordinates all services for older people within Christchurch, and Tui Ora, a network of providers covering a specific Taranaki population, with a lead provider influencing the nature of service provision.

Advantages of Specialist Purchasing

Purchaser Expertise

An obvious advantage relates to the extent to which specialist purchasers possess greater expertise to purchase services for a specific population or a particular condition. It is assumed that this would result in better health outcomes at an individual and population level than would be the case with a generic purchaser like the HFA. This presumes that specialist knowledge is a key factor in effectively purchasing specific services for a particular population. There is some experience to back this up (Light, 1998).

Co-ordination/Integration of Services

Specialist purchasing offers the potential for greater horizontal and vertical co-ordination and integration, both between individual providers and between a purchaser and providers, ultimately leading to specialised ICOs for particular disease conditions like cancer, or even for population groups such as Maori. In the case of Maori, the attraction is to be able to integrate health care with a wide range of other social services to tackle some of the wider determinants of poor health, rather than in order to develop specialist expertise in relation to particular health problems. The benefits will depend on the extent to which greater co-ordination and integration result in improved efficiency or cost-effectiveness in the delivery of services. (For example, through more timely and appropriate patient diagnosis and treatment).

Risk Sharing

Specialist purchasers present the opportunity for the HFA to share the financial risks of specific service coverage with other parties, both purchasers and providers, and, thereby, improve specialised purchaser and provider focus on the cost-effectiveness and efficiency of health and disability care services. The scope for risk sharing with specialist purchasers may be limited due to the potentially smaller number of consumers/patients over whom they would be able to spread financial risk.

Consumer Choice

Consumer choice of specialist purchaser will depend on the extent to which competing specialist purchasers that offer the same coverage are possible. Many of the issues outlined in the section on competitive purchasers (above) would then arise.

Disadvantages of Specialist Purchasing

The potential disadvantages of specialist purchasing include the following risks:

- cost-shifting from specialist purchasers to both the HFA (or other purchasers) and providers;
- under-servicing of patients;
- risk selection where there are competitive specialist purchasers (and they are paid on a weighted capitation basis);
- potential fragmentation of care where patients/consumers require integrated sets of services beyond those provided by a specialist purchaser. This is more probable where a specialist purchaser only buys a narrow range of services. For example, despite the good work that Pharmac has undertaken to select for subsidy only the most cost-effective drugs within broad therapeutic categories, including assessing the opportunity costs to the health sector as a whole of particular drugs, it is not able to make its own substitution decisions between pharmaceutical and non-pharmaceutical responses. IPAs that hold drug budgets are in a better position to begin this task, but they are partially constrained by the range of drugs which Pharmac is prepared to subsidise; and
- greater market concentration where provider and/or purchaser integration leads to greater market dominance or monopoly.

The first three risks will not result exclusively from specialist purchasing per se, but rather from the incentives generated by payment arrangements (ie, weighted capitation) and the extent of competition between specialist purchasers. However, specialist purchasing organisations would exacerbate the tendency for purchasers with less than comprehensive budgets deliberately

or inadvertently to shift costs onto other agencies and budgets. As outlined in the previous section on competing purchasers, these risks can be ameliorated, but not removed, by the extent to which:

- service coverage boundaries (eg, between the HFA and specialist purchasers) are clear;
- weighted capitation reflects the financial risk associated with the covered population; and
- HFA monitoring prevents under-servicing.

Conclusions on Specialist Purchasing

Specialist purchasing for specific services would be likely to lead to excessive fragmentation of service delivery and cost shifting between purchasers. It could make it difficult for patients to identify who was responsible for purchasing the services which they needed and could make it difficult to establish the responsibilities and, therefore, the funding to be allocated to each purchaser. Providers would have to have multiple contracts, sometimes for the same services, depending on the identity and other needs of the patients being served.

The strengths of the model would appear to relate to specialist purchasing of high cost, low volume services on a national basis (eg, organ transplants), on the one hand, and, on the other, specialist purchasing of services for specific ethnic groups with distinctive requirements for services, such as 'for Maori by Maori' organisations. The latter approach overlaps with the model of purchasing based on primary care organisations, discussed above. The former could exist in conjunction with any of the options for devolved, sub-national purchasing. Smaller, more local purchasing agencies than the HFA might spontaneously wish to collaborate to set up a specialist agency to procure highly specialised or rarely required services.

Abolishing the Separation of Purchaser and Provider – Vertical Integration through Territorial Health Services and the Role of Local Democracy

Rationale

Critics of the attempt to use quasi-markets in publicly financed health services argue on theoretical and practical grounds that more traditional hierarchical bureaucratic relationships should replace the experiment with a separation between purchase and provision. On theoretical grounds, following Williamson (1975), they argue that most, if not all, health care is a weak candidate for purchaser-provider contracting. Health services tend to be complex, are difficult to define in clear contractual terms, exhibit marked information asymmetries between buyer and seller, involve the exercise of professional discretion, require lengthy training to deliver, frequently rest on long term relationships between patients and professionals and, for some services, are subject to major problems of local monopoly. These are all features which

would tend to increase the costs of purchaser-provider transactions in health care and favour forms of vertical integration (Bartlett and Le Grand, 1993). This insight suggests that the core rationale for quasi-markets in health care lies rather in the desire to set up separate purchasers as a counter-weight to the traditionally dominant professional suppliers of health services, despite the difficulties inherent in this approach.

For services such as those of large, near-monopoly public hospitals, it is argued on empirical grounds that the attempt to simulate market conditions by a strict separation between public purchase and public provision along the lines of State Owned Enterprises (SOEs) has been insufficiently successful to justify the additional transaction costs involved. If eventual privatisation is not intended (SOEs in other sectors were set up with eventual private ownership in mind), it is argued that the setting up of hospitals and related services as Crown Companies is unnecessary and simply increases the complexity of reconciling purchaser and producer interests in the health sector.

One approach to abolishing the strict separation of purchasing and providing would entail rolling the HFA's planning responsibilities into the Ministry of Health and setting up territorial health service organisations across the country which would embrace both local purchase and delivery functions and incorporate the current HHSs. A distinction within the organisation of the territorial health service could continue to be made between managers responsible for purchase and those responsible for service delivery. Most moves to return to a vertically integrated health system would also include an increase in the level of public involvement in heath services' decision making by introducing some form of elected local representation on the boards of any new territorial organisations. However, this is not an intrinsic part of any shift back to a more vertically integrated health system. Both vertical integration and local democratic control are discussed in this section.

While it is relatively clear what an advocate of vertical integration would do with the current HHSs, this does not necessarily indicate that vertical integration is suitable or politically feasible for all health and social care services. The development of the 'mixed economy' of public and private provision in the 1980s and 1990s will be difficult to reverse even if it were regarded as desirable to do so. Presumably, for example, any new territorial health services organisation would have to develop a new contractual relationship with GPs, and possibly other primary care providers, in order to manage an integrated budget for Personal Health Services. However, it is less clear what effect the abolition of the purchaser-provider split would have on most DSS and many mental health services, which are currently provided by non-governmental organisations, both for-profit and not-for-profit. Presumably, the territorial health service body would need to continue to purchase these services from largely the same providers and negotiate legal contracts to do so. About half the resources of Vote: Health is currently contracted to private providers, including GPs.

Thus one justification for the abolition of the purchaser-provider separation is that it saves on transaction costs, but it is likely that not all of these costs can so easily be removed in the New Zealand context. It is generally assumed that

the costs of running a system of integrated purchase and provision in a single organisation are lower than those incurred in more formal arm's length relationships. Abolition can also be justified when services are difficult to specify, are tailored to individual needs on a discretionary basis, and where providers tend to have a higher level of expertise than purchasers. In these circumstances, formal contracts are a blunt tool for determining the pattern of service and the case for vertical integration is strong, though longer term and 'relational' contracting are one possible way of retaining the advantages of contractual relations in such a context. Likewise, where local monopolies are the norm and the costs of entry to the market are high, the supply side competition sought by the separation of purchase and provision becomes only a remote possibility. Many acute hospital services exhibit all these features. Other services, such as residential care for the elderly, certain aspects of primary care (eg, immunisation) and elective surgery may be more suitable for purchaser-provider contracting.

If the above analysis is correct, it would tend to indicate that the case for vertical integration cannot necessarily be made on a blanket basis. Each service area and each local context should be treated flexibly on its merits. This sort of thinking was largely absent from the critique of the status quo which led to the current purchaser-provider split in 1993 and is in danger of being absent from proposals to 'abolish the internal market'. Instead, there is a tendency to argue in general terms either for or against a split and propose changes accordingly, as if all the services provided from the resources within Vote: Health exhibit the same properties.

The public hospital and related community health services were managed on a vertically integrated basis by the former AHBs until 1993 and lessons can be drawn from this experience to assess the merits of different forms of vertical integration. However, future vertically integrated arrangements need not embody a literal 'return to the AHBs'. Indeed, there are good reasons why they should not, as discussed below.

The problems of the Area Health Board era

The structure, governance, funding and role of the AHBs were described in Part 1 above (see section on the rationale for the New Zealand purchaser-provider split). The experience of the period was also discussed, in the section on sub-national monopoly public purchasing agencies. It is important when considering New Zealand's most recent experience of managing a more vertically integrated publicly funded health system to distinguish clearly between the different sorts of problems which AHBs encountered and generated in order to be able to distinguish between those which are relevant today and those which have been resolved in other ways in the interim.

The problems identified with the AHB model at the time fell into three types: those concerned with the lack of obvious incentives on the AHBs to secure the most cost-effective services for the patients within their boundaries; those related to the complex governance and accountability arrangements of the Boards; and those related to the fact that the AHBs did not have responsibility for GMS, other primary care subsidies or DSS. There were other difficulties such as those related to poor information for management (eg, on the

distribution of costs and activity) and weak population needs assessment, which would not necessarily apply today and which were not intrinsic to the AHB model. For example, it was difficult for central agencies to track where and how resources allocated to the Boards were being used. Capital was also a 'free good' to AHBs which, it was claimed, led to poor investment decisions. Similarly, AHBs appeared to manage deficits by deferring maintenance of buildings and plant that would eventually need to be attended to. These problems would be less likely to recur in the same way under vertical integration in the future because of reforms in public sector management and, particularly, in how public sector bodies account for their use of resources.

Incentives

The intention behind allocating each AHB a global budget determined from a needs-weighted capitation formula was that this would control health care costs while encouraging the Board to use its limited funds in the most cost-effective way on behalf of the community. Despite some evidence of efficiency gains, particularly in the early 1990s, this did not satisfy critics who were concerned about the lack of obvious incentives to improve quality and efficiency faced by the Boards. The root of the incentive problem was perceived to lie in the twin facts that the Boards were responsible for both planning services and managing the provider organisations, and that they lacked clear rewards for improved performance. Put another way, Boards would receive their budgets even if their performance were unsatisfactory, unlike firms in a private market. In addition, there was little or nothing which individual patients could do to prompt the Boards to improve services. Boards were geographic monopolies (as, of course, the RHAs and HFA and, in most cases, the HSSs turned out to be). Boards were thus perceived to be more likely to administer the status quo than to drive improvements in quality and efficiency. The link between planning (ie, deciding what to purchase) and operations meant *de facto* that the concerns of the public hospitals dominated the priorities of the Boards, particularly since the Boards faced legal obstacles to leasing facilities or tendering services to the private sector or other alternative providers. In addition, a number of Boards had elected members who were also local health professionals, thereby reinforcing the tendency of the Boards to identify their interests with those of the local health care institutions.

Hence, there was interest in distinguishing the Government's 'ownership' interest in the health system from its interest in securing a particular pattern of health services. As a result, over time, AHB contracts with the Minister of Health were developed, influenced by the example of the State Owned Enterprises Act, which began to distinguish more clearly the Government's twin interests in the publicly funded health system.

Despite these developments, it was unclear, from a central government perspective, what sanctions Ministers could wield in response to poor performance except to remove the Board members and replace them, appoint new Board members, issue directives or cut budgets. Cutting budgets would harm patients not Board members. Ministers did not have access to any incentives or rewards to recognise good AHB performance, making the task of

managing them a thankless one. Monitoring performance against key indicators was regarded as costly, difficult to operate and open to 'gaming' by the Boards.

Accountability and Governance

Boards were defined geographically, thus having a local identity, which was greatly reinforced by the fact that a proportion of their members was locally elected. This was justified on the grounds that Boards should be sensitive to local variations in population needs and that locally elected representatives would have better information and motivation to make decisions than central government agents. Thus Boards saw it as their role to reflect the preferences of their local communities, as well as having to account to central government via the Minister of Health for their use of public money. Their upward accountability was thus relatively broad, being concerned mainly with input controls since the quality of service was perceived to be a local responsibility. The system was moderately decentralised as a result and AHBs did not necessarily act in all cases to contribute to goals desired by Ministers, despite the fact that all AHB funding came from the centre.

However, this behaviour did not necessarily mean that AHB performance was under strong local scrutiny. The local accountability of AHBs to their electorates depended on the level of interest which local people exhibited in the actions of the Boards. Since the resources managed by the Boards were not raised from the local electors, the local electorates did not show great interest in the performance of Board members. Turn-out in Board elections was lower than for local authority elections, suggesting that local people were not closely involved in the affairs of their local Boards. Central funding and upward accountability may have worked against strong local involvement.

In the late 1980s, AHBs were placed under more direct accountability to the Minister of Health through contracts which began to specify the outputs which the Boards were to provide, thereby emphasising the fact that the Boards were upwardly accountable in crucial respects. In return, they were given more freedom over their day-to-day operations. The principal criticism of these arrangements was that the attempt to combine local (downward) and (upward) national accountability in a single body, and for many of the same functions, led to continuing confusion and conflict between central government and the AHBs, even when tighter contracts with Ministers had been introduced, since funding still came from central government. This was likely to have been exacerbated by having locally elected representatives on Boards. There were also criticisms that the objectives of the AHBs were not sufficiently clearly articulated, could potentially conflict with one another (eg, Boards were charged with protecting and promoting the public health as well as providing a range of health services) and were not necessarily within their control (eg, better public health was conditional on many factors outside the control of the AHBs), making upward accountability difficult to achieve. In addition, AHB managers' attempts to change practice in order to improve performance either financially or in service terms, appeared to be frustrated by local professional resistance. Management did not seem to have the levers to manage the organisations effectively.

Integration of Budgets

AHBs were only responsible for planning and delivering hospital and community health services. They had no responsibility for family practitioners, especially GPs, or for much of the social care (DSS) of older people and those with disabilities. This reflected the historical divisions within the New Zealand welfare state with their roots in the 1930s. The Boards were keen to broaden their responsibilities to include all locally delivered health services, including GMS subsidies, in order to be able to plan comprehensively for the needs of their populations. However, the GPs were suspicious of any form of external, local control, but especially when this involved control by locally elected Boards. This smacked of local government control which they had always resisted. The low likelihood of the AHBs reaching an agreed settlement with the GPs counted against them when proposals for radical change were mooted. Similar issues could arise again if a return to vertically integrated district or area bodies is proposed.

Learning from the AHB experience

It is striking how familiar the problems of the AHB era are ten years later, despite the major structural changes of 1993 designed to tackle them. This suggests that many of the issues faced by reformers in the 1980s are intrinsic to managing a health system financed through general taxation, delivered locally by influential professionals in response to local needs and accountable to Parliament for its use of public resources. The intellectual elegance of the attempt to separate the Government's ownership and purchase interests and to clarify lines of accountability could only ever be a partial practical solution to these sorts of issues.

Governance and Accountability

All health systems, which are centrally funded, but which have sub-national decision making bodies (as most do to avoid 'span of control' difficulties), face day-to-day central-local tensions. If there were not, then there would be no point having any distinct regional or district organisations since these bodies would not be exercising any independent judgement, but simply 'rubber stamping' central directives. These tensions appear to exist *equally* in vertically integrated and quasi-market systems. Rather than attempting to wish them away, the focus should be on *managing* the tensions while recognising that there will always be a gap between central government's directives and the way in which they are translated into action at the periphery. The later history of the AHBs showed that central Government was able to express its wishes more clearly and more forcibly without necessarily resorting to quasi-market reform, but that there would always be limits to this process.

The constitution of sub-national bodies, with executive authority to deploy resources, clearly influences the nature and degree of central-local tension. Since 1993, the emphasis in the health system has been on *appointing* both purchaser and CHE/HHS board members from the centre and recruiting board members with *technical* managerial skills and experience (eg, in business, law, accountancy, etc.) rather than members whose credentials are assessed in terms of the degree to which they are able to identify with the local community

served or the delivery of particular professional services. It has been clearly stated that the current board members are not intended to be representatives of any particular group, but are appointed for their individual expertise according to a rational-technical conception of the role of their organisations. This broad approach tends to reduce the intellectual 'distance' between the centre and the periphery and to produce a more homogeneous style of decision making. Although the HHS board has considerable day-to-day decision making autonomy, this broad approach is essentially one in which central government has *delegated* some of its responsibilities to a subordinate organisation, albeit one legally constituted as a company. However, the decisions of the subordinate body are always potentially subject to central government veto. This contrasts with *devolution* in which central government hands responsibility for a defined set of functions and decisions to a regional or local body. As long as the regional or local body confines itself to the agreed functions, generally it has complete freedom to make decisions as it sees fit without central government interference. The latter form of decentralisation would seem to be more congruent with the presence of elected representatives on sub-national boards/authorities.

Moving to more *representative* forms of sub-national decision making either by appointing some or all board members from local interest groups or by electing all or part of the board, alters the dynamic of the relationship between the centre and the periphery. To work well, it may require a change of emphasis away from delegation towards devolution of responsibilities. While current HHS board members are appointed to identify quite strongly with the interests of their particular organisation, they are held in check, to some degree, by the purchaser and are subject to the rules governing behaviour of company directors. Local representatives are likely to be far more resistant to having their precise role in the system set in advance.

It seems inevitable, therefore, that a greater emphasis on local representation at sub-national levels in a nationally financed and driven system with parliamentary accountability will increase the likelihood of conflict between the two levels. It is also likely to increase the degree to which such conflict turns on issues of value rather than technical judgements. Introducing locally *elected* representation will tend to further exacerbate any central-local tensions which arise, since locally elected representatives will be perceived as having greater local legitimacy than Ministerial appointees (see below for more on this).

Local representation will also, inevitably, reduce the scope for central government to set detailed goals and targets, particularly in terms of *how* outcomes are to be achieved. Government would have to be prepared to take criticism about local variations in the mix and style of services available across the country. For example, it may be possible to put pressure on a local board to improve health outcomes from a particular service, but less feasible, without conflict, to prevent the board from tendering the service to the private sector in order to do so. Yet, at Parliamentary level, the government may come in for criticism for permitting the 'privatisation' of the service since people care about *how* health services are delivered as well as what their outcomes are. *Ex ante* regulation may be required to prevent the local representatives altering

specific national policy settings (eg, a nationally consistent booking system for elective surgery).

The lesson is that local representation (and even some form of local democracy) will tend to come at the price of greater tension between Parliamentary and local notions of accountability. For this reason, for example, governments in the UK have resisted proposals to have elected health authorities rather than appointed bodies, or to turn the NHS over to local government control, on the grounds that this would confuse accountabilities, unless local authorities were permitted to raise some NHS revenue locally, which would, in turn, threaten the ideal of a national service.

Central-local tensions can be mitigated by working to clarify and define the limits of local responsibility and national control through codifying the 'rules of engagement' between the two tiers. For example, board members could be appointed from the local community, but with a clear job description setting out their responsibilities for the local implementation of national policies, taking account of the specific differences between areas recognised as legitimate through national policy making. It is probable that more could have been done before abolishing the AHBs in this regard, but there was a strong conviction at the centre that quasi-market relations and contracts could resolve the accountability issues more effectively.

The supposed confusion over the aims and objectives of the health system pre-1993, in particular, the dilemma as to whether the AHBs could realistically be held to account for delivering certain health outcomes rather than a specific range of services (outputs), has been reduced, to some degree, with the development of accountability agreements based primarily on outputs hypothesised to bear some relation to health outcomes. However, this tends to obscure the fact that there will never be a single, or even a small number, of mutually compatible measures against which the performance of the publicly funded health system can justifiably be assessed. For example, Maori and non-Maori concepts of health outcomes may differ. Again, this is an aspect of health systems to be recognised and managed rather than wished away through structural change.

Purchaser-Provider Relations

It is apparent from the history of the AHBs that they were increasingly encouraged to distinguish their planning/purchasing function from their service delivery function. However, the two roles were undertaken by separate divisions within a single organisation rather than by wholly separate bodies, as currently. While vertical integration has the attraction of removing some of the transaction costs associated with the negotiation, specification, monitoring and enforcement of legally binding contracts, it is highly likely (and probably necessary) that purchase and provision responsibilities would be located in separate parts of any integrated health service organisation. For example, the skills and experience required for day-to-day hospital management are different from those required to set priorities at the margin between competing new medical technologies. As a result, vertical integration *internalises* purchase and provision interests within the same organisation. While this may encourage more interaction, collegial relations and co-operation between the

two functions, it cannot conceal the fact that the provider side wishes to maximise its income and maintain its asset base while the purchaser wishes to maximise overall benefit at the lowest possible cost. Thus it is to be expected that conflicts of interest will arise as they did under the AHBs, but that they may be less extreme and less public than currently.

'Local Democracy' in Health Services

The Case for More 'Local Democracy'

All public funding for health care in New Zealand currently comes from general taxation. Thus 'upward' accountability to the Minister of Health and to Parliament for the use of these resources is essential and inevitable. Despite this fundamental principle of democratic control (which includes the involvement of locally elected representatives in the form of MPs), it is argued, here and elsewhere, that health systems constituted in this way suffer from a 'democratic deficit' (Klein and New, 1998). Though this term is rarely defined, it appears to relate to a cluster of concerns about the governance of health services by agents appointed by Ministers rather than by local representatives. It is also bound up with a rather different strand of thinking which sees government by elected representatives as inadequate because it fails to allow the people to exercise their influence directly. It is argued that such a system makes it difficult for local people to participate in decision making and encourages remote and insensitive decision making. As a result, the term 'local democracy' used in this section is a portmanteau expression for greater representation of, and direct participation by, local people in health services' decision making, *over and above* existing channels of democracy.

There are thus two main strands of argument for greater 'local democracy' the *decentralist* and the *participationist* perspective (Weale, 1998). Both tend to move the health system towards systems of *devolution* rather than *delegation* (see above). The *decentralist* position is based on the simple proposition that services are delivered locally to local populations and should, therefore, be controlled to some degree, locally, irrespective of how resources are raised. The *participationist* argument is typically made on the grounds that local democracy allows greater opportunities for public participation (which strengthens democracy in general). In practice, the two arguments tend to be interwoven. Thus local democracy is argued to increase participation, offer a counterweight to 'centralisation', be more responsive to local needs and wants (ie, the quality of public opinion brought to bear on issues will improve) and allow for innovation and diversity (ie, the development of justifiable variation in services between areas). A more general argument for decentralisation (with or without local democratic input) is that central government suffers from 'overload' and cannot exercise adequate scrutiny over all the services for which it is responsible. Therefore, some form of local accountability is inevitable. This is accepted in many systems and exists on the HHS side of the quasi-market in New Zealand at present, albeit without any local democratic input.

Arguments against more 'Local Democracy'

While it may seem perverse in a democratic society to argue against greater 'local democracy', there are drawbacks, as there are for most policy developments. At the simplest practical level, it may be difficult to recruit

sufficient well-qualified people prepared to stand for election as decision makers for a large number of local administrative units, thereby reducing the quality of decision making. Experience also shows that voter participation in elections for specialist local bodies like health or education authorities is low, even when these are combined with other elections. In part, this may be because at any one time, the vast majority of the population is not in regular contact with the health and disability support system. This would tend to compromise the mandate of locally elected representatives. Equally, it has been argued that representative bodies, which tend to be larger and more diverse in membership, find it difficult to take decisions, particularly in complex fields where there is no 'right' answer. Representative bodies (eg, local councils) tend to be larger than the current board memberships. Similarly, the best health outcomes for certain conditions may require services to be organised for populations of several million rather than several hundred thousand, thus preventing any meaningful 'local' involvement.

More fundamentally, it is argued that local democracy will not do away with political conflict, for example, about how limited resources should be allocated; rather these conflicts will be worked through in more different places than previously and in more diverse ways. The decisions reached in each local area will differ and the 'losers' (ie, specific patients' groups) will doubtless appeal to central government to arbitrate in their favour, pointing to the fact that other areas have made different judgements. This is likely to reintroduce the centre into the decision making process as arbitrator, creating conflict between two sets of elected representatives.

Equally fundamentally, local democracy implies a second line of accountability in addition to that which flows upwards to the political centre. The local health authority or board will be faced with two sets of political masters, perhaps with different priorities – a recipe for conflicting policy directions and highly complex streams of accountability. As long as central government provides the vast majority of local expenditure, it is difficult to avoid the conclusion that formal accountability will always have to be upward to the Minister and to Parliament. However, this then leaves a question mark over the status of the 'accountability' relationship between the locally elected health authority and its community.

Next, local democracy may come into direct conflict with other objectives which society holds to be important. In certain circumstances, these may legitimately override the case for local democracy. The most obvious are the notions of fairness and equity which are particularly salient in publicly financed health systems. Variations in access to particular services already exist for historic and other reasons. Strengthening local democratic control of the health system could make unfair variations *more* difficult to eradicate. Indeed, if local democracy is really to be effective, it *will* result in different forms of service in different localities, even if each local authority is allocated a fair budget in relation to the 'needs' (however defined) of its population. It is not necessarily the case that these variations will be justifiable in terms of nationally agreed policies. This will pose a dilemma for Ministers at central government level as to whether to intervene or not in the decisions of locally elected representatives.

Finally, if the case for local democracy is made simply on the grounds of central government 'overload', there is no reason why this cannot be remedied by having more local agents or appointees of central government charged with oversight of local operations.

Alternatives to Local Democracy: New Forms of Participation

The above assessment shows that, in a centrally financed health system, which is already accountable to Parliament, local democratic control of health services by locally elected representatives brings with it a member of implementation problems, principally the risk that it would lead to confused accountability for the use of public funds. On the other hand, this rebuttal is unlikely to satisfy '*participationists'* who come from a tradition of political theory which stresses the importance of the civic engagement of citizens in shaping their collective life through participation in tasks of collective decision making (Weale, 1998). For them, leaving everything to political representatives, whether at national or local levels, is insufficient. In turn, the standard critique of this form of participation is to point out that modern societies are simply too large to allow for participation on any significant scale.

However, is there a way of accommodating these different perspectives? Is it possible to build new methods of consultation and public participation within the existing framework of parliamentary government? The answer appears to be, 'Yes, within limits'. Recently, '*participationists'* have been developing new ways of getting *samples* of the local population together to discuss, deliberate and produce either recommendations or a firm decision to resolve contentious local issues in public policy. The two principal methods used are 'citizens' *juries*' and '*deliberative polls*'. In each case, the members of the public are involved, not so much to express an opinion, but to act as policy *arbitrators*. In each case, members of the public are selected to form part of a sample rather than putting themselves forward for office and/or election in order to represent a particular point of view or interest. Since each method involves a relatively smaller number of people at any one time, but in a focused way, they are designed to take into account the fact that most people, most of the time will rationally choose *not* to be involved in local health care politics. Rather than reorganising the governance of health services to engineer local political involvement, it may be possible to make far greater use of these techniques, adapted for the New Zealand context.

Citizens' Juries

A citizens' jury is a small, randomly selected group of members of the public brought together for a limited time to deliberate on a specific policy decision. Juries hear evidence from experts, witnesses and other interested parties and are then expected to make a recommendation that is unanimous and consensual. There is an expectation that the body organising the jury will take its recommendation seriously. Experience to date in health services has shown that juries can tackle difficult and important issues in an intelligent way.

As deliberative bodies, citizens' juries are limited by the requirement to reach a consensus. As consultative bodies, they suffer from the fact that with 12 to

16 members, they are not large enough to be able to make reliable inferences as to what the wider population might think.

Deliberative Polling

Deliberative polls overcome the two disadvantages of citizens' juries, discussed above, in that they do not require a consensus and the number of participants is large enough, usually between 300 and 400, to allow statistical inference. A deliberative poll takes place when a random sample of the electorate is removed from its normal environment and immersed in an issue by receiving carefully balanced briefing materials, taking part in intensive small group discussions and being given the opportunity to question experts, politicians and others. The sample then votes on the issue at stake.

For both citizens' juries and deliberative polling a stratified random selection would be necessary to ensure that the sample was representative of the population. Moreover, both mechanisms are likely to involve some commitment in time and efforts by participants. This will have cost implications if all potential citizens' are to be fairly offered an opportunity to participate, for example, payment for participants' time and childcare costs.

Conclusions on Local Democracy

Both deliberative polling and citizens' juries provide the local decision-maker with the benefit of input from an informed, representative group of local people that has had an opportunity to discuss an issue thoroughly. It is presumed that this exposure will improve the quality of subsequent decisions. This contrasts with the data derived from opinion polls and referenda. Experience to date shows that exposure to information and debate via these two approaches does change people's opinions. On the other hand, neither method can answer the participationist's yearning for the active Athenian involvement of all citizens in the making of decisions.

However, ultimately, modern democratic societies are based not on random selection for political office, but on the electoral principle, or at least, delegated authority from those who have been elected. As a result, techniques such as citizens' juries and deliberative polls can only be *supplements* to established methods of decision-making. They are ways of broadening the range of inputs to a decision, but not replacing the existing decision making process. As long as the bulk of public funds for health services come from general taxation, there has to be clear upward accountability to the elected government of the day for the use of those resources, irrespective of the degree of local involvement in specific decisions. The challenge is to be able to incorporate new ways of consulting and involving local people in decision-making, without misleading them into thinking that there is an easy alternative to Parliamentary accountability. Although the case for individual user choice of purchaser through a system in which each person brings a 'voucher' or agreed sum of public money with them upon enrolment with their chosen health care organisation, is usually promoted on grounds of consumer responsiveness, it is also another means for attempting to reconcile national and local/personal forms of involvement and accountability.

Issues in the Implementation of Purchasing Options

General Issues

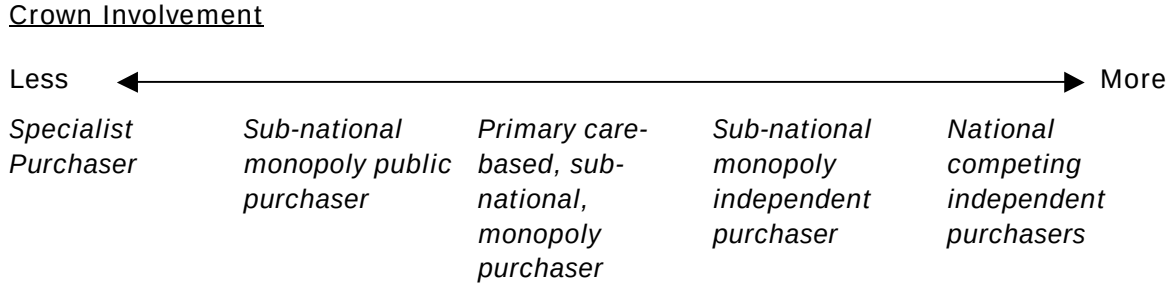
The key policy issues associated with implementation of the purchasing options described above are:

- service coverage (ie, scope of services to be included in the budget of the purchaser, including access/entitlement conditions);
- enrolment and other means of defining the population to be served;
- pricing of payments to purchasers (including risk-adjustment methods);
- public ownership issues, particularly in relation to public hospitals, but also relating to the identity of the purchaser and whether for-profit, or not, if independent of government; and
- monitoring and evaluation of purchaser performance.

The technical complexities of these policy issues, and the extent to which Ministers and officials, in addition to the HFA, may need to be involved in decisions about them, will vary depending on the purchasing option in question. In practice, it has proved to be very difficult to separate decision-making about health care policy from health care purchasing. Decisions about the strategic direction of health care purchasing - for example, about major integrated care proposals - are invariably also decisions about the direction of national health care policy.

It seems likely that Ministerial involvement in decision-making about purchasing arrangements will increase as the welfare, financial and political risks associated with the proposed purchasing arrangement rise. This spectrum of involvement is represented in Figure 2, below. In this context, decisions about specialist purchasing arrangements would be likely to be made primarily by the HFA, operating within its existing accountability arrangements to government. With sub-national monopoly purchasing arrangements, we would expect the Crown to take an increasingly close interest, particularly where private entities are involved. Ideally, under current purchasing arrangements, the HFA should take the lead in developing such proposals, with appropriate consultation with departments (eg, the Ministry of Health, Treasury and CCMAU).

Figure 2: Level of likely Crown involvement in developing and regulating different models of purchasing



Issues Specific to Competing Purchasers

The option of competitive national (or sub-national) purchasers driven by patient choice (vouchers) and covering all services presents significantly greater design and implementation issues than the other options, greater uncertainty about net benefits and much greater risk of unmanageable failure if private purchasers should fail. Such an approach represents a significantly different type of health system compared with current arrangements since it relies heavily on individual user choice to drive purchasing.

There are additional policy issues that would need specifically to be considered to implement a system of competitive national or sub-national purchasers. These include:

- registration or accreditation of purchasers (who may enter the market);
- agreement on appropriate forms of purchaser marketing to consumers;
- agreement on the specified package of services to be made available at a minimum;
- protection of access for vulnerable groups and 'default' purchaser for these groups;
- ethical standards (eg, freedom for clinicians to 'speak out' on quality of care issues);
- consumer information about purchasers (this is vital for success); and
- the Health Funding Authority's role (ie, regulator and/or residual purchaser).

The Crown is likely to have to take a pro-active role where private purchasers are involved and/or there are competitive arrangements, including having to define service coverage through regulation. This reflects the fact that service coverage issues need to be more explicitly defined where there is no longer government ownership of the purchaser.

Other Issues Raised by Changes to Current Purchasing Arrangements

Financing

More broadly, the financing of health care in New Zealand, in particular the relationship between public and private financing and the targeting of public subsidies, would need to be re-considered with both competitive purchasers or sub-national, monopoly purchasers that offer significant or comprehensive service coverage (eg, all primary; all primary plus some secondary; all primary and secondary health care services) for their populations. For example, it could be left to purchasers to decide how to use the money currently available for targeting through the CSC and HUHC as part of their capitation payments. Limitations might need to be placed on GPs' freedom to charge their patients what they judge appropriate to prevent cost-shifting and widening inequities between areas or purchasers.

Legal Dimensions

Under the Health and Disability Services Act 1993, the intention of Parliament is that the HFA should be the *dominant* purchaser of publicly funded health and disability services, and will have purchase agreements with HHSs. Consequently, a key constraint on any alternative purchasing arrangements will be the extent to which other purchasers could detract from the HFA's role in the purchasing of publicly funded health and disability services, or prevent it from contracting with HHSs. The wording of the H&DS Act, therefore, presents the risk that alternative purchasing arrangements (for example, a sub-national public monopoly) might be challenged in the Courts. Legislative change may, therefore, be required to facilitate most of the purchasing options discussed above, with the exception of specialist purchasers.

Monopoly purchase and provision issues will also have Commerce Act implications. Some of the purchasing options outlined earlier may increase market concentration through horizontal and vertical integration, thereby reducing market competition or contestability, which is counter to the intentions of the Act. The Commerce Commission may grant exemptions from such Commerce Act requirements having reviewed a specific proposal on the grounds that they were likely to improve the efficiency of health services, etc., albeit through non-competitive means. Consequently, the merits of specific purchase arrangements would need to be considered on a case-by-case basis.

Enrolment

Under current purchasing arrangements, this issue could largely be left with the HFA, within the monitoring arrangements administered by the Ministry of Health. With competing purchasers, there is an issue about ensuring that all New Zealanders are registered or enrolled with a purchaser, or that there is a purchaser they can fall back on. One way of making this happen would be to 'fine' competing purchasers for the number of unregistered consumers who require care.

Crown Ownership Issues

The role of the HFA, in particular, would have to be re-considered by the Government under different purchase arrangements. Would it be encouraged to be a competitive purchaser, a residual or last resort purchaser, or a regulatory body or some combination?

Responsibilities for Implementation

With the caveat that responsibility for the publicly funded health system will ultimately reside with the Crown, principally through the Minister of Health, we can nonetheless describe:

- to what extent the HFA is likely to take lead responsibility for the policy issues associated with each purchasing option; and
- the key mechanism(s) by which that policy issue could be implemented.

Table 6, overleaf, attempts to address these two issues by mapping the policy issues to purchasing options. The table excludes the option of vertical integration. In each intersecting box of the matrix, the lead agency or agencies are described in the top left-hand corner, either as “HFA”, “HFA / Crown” or “Crown” (Crown includes both Ministers and departments, currently the Ministry of Health, Treasury and CCMAU). In the right-hand corner of each box, the key mechanism by which the policy issue could be implemented is described, for example, as “contract” or “regulation”.

Table 6: Summary of responsibilities for policy elements and mechanisms for their implementation under different purchasing options

	PURCHASING OPTION					
POLICY ELEMENTS	***Single national public purchaser (status quo – HFA)***	***Sub-national monopoly public purchaser***	***Sub-national monopoly independent purchaser***	***Primary care-based, sub-national, monopoly purchaser***	***National or sub-national competing purchasers***	***Specialist purchasers***
Service Coverage	Crown *Contract - HFA Funding Agreement(FA)*	HFA, within terms of FA *Contract*	HFA / Crown *Contract / Regulation*	HFA / Crown *Contract / Regulation*	Crown *Regulation*	HFA within terms of FA *Contract*
Enrolment	Not applicable	HFA, within terms of FA *Contract*	HFA, within terms of FA *Contract*	HFA, within terms of FA *Contract*	HFA / Crown *Contract / Regulation*	HFA, within terms of FA *Contract*
Pricing of purchaser payments	Crown *FA*	HFA, within terms of FA *Contract*	HFA / Crown *Contract*	HFA / Crown *Contract*	HFA / Crown *Contract*	HFA, within terms of FA *Contract*
Crown ownership interests	Crown *FA, Ministerial / Shareholder Direction*	Crown *FA, Ministerial / Shareholder Direction*	Crown *?*	HFA *?*	Crown *?*	HFA / Crown *?*
Monitoring and evaluation of purchaser performance	Crown	HFA/Crown	HFA/Crown	HFA/Crown	Crown and/or new independent regulatory agency	HFA

POLICY ELEMENTS	PURCHASING OPTION					
	Single national public purchaser (status quo – HFA)	***Sub-national monopoly public purchaser***	***Sub-national monopoly independent purchaser***	***Primary care-based, sub-national, monopoly purchaser***	***National or sub-national competing purchasers***	***Specialist purchasers***
	Contract	*Contract / Regulation*	*Contract / Regulation*	*Contract / Regulation*	*Information / Regulation*	*Contract*
Purchaser registration and marketing	Not applicable	Not applicable	Not applicable	Not applicable	Crown/and or new independent regulatory agency *Regulation*	HFA (especially if specialist purchasers compete) *Contract*
Consumer information	HFA *Contract*	HFA *Contract*	HFA *Contract*	HFA *Contract*	Crown/and or new independent regulatory agency *Contract /Regulation*	HFA *Contract*
Sector financing, including targeting of public subsidies	Crown *Contract/ Regulation*	Crown *Contract/ Regulation*	Crown *Contract/ Regulation*	Crown *Contract/ Regulation*	Crown *Contract/ Regulation*	Crown *Contract/ Regulation*
Legal dimensions, particularly multiple purchasers	Not applicable	Crown	Crown	Crown	Crown	HFA
Strategic planning and accountability	Not applicable	Crown	Crown	Crown	Crown	Not applicable

POLICY ELEMENTS	PURCHASING OPTION					
	Single national public purchaser (status quo – HFA)	***Sub-national monopoly public purchaser*** ?	***Sub-national monopoly independent purchaser*** ?	***Primary care-based, sub-national, monopoly purchaser*** ?	***National or sub-national competing purchasers*** ?	***Specialist purchasers***

Conclusions on the Options

This paper has reviewed the rationale for purchaser-provider separation, recent experience, the range of options available in New Zealand and their potential costs and benefits.

Experience with the purchaser-provider split in New Zealand

The benefits

The analysis has shown that there are benefits from the separation of purchaser and provider within the publicly financed system. The separation of purchase from provision *has* allowed a range of new non-governmental providers to enter the system, mostly providing services to deprived Maori and Pacific populations. Although there was some shift in this direction before 1993, these providers would have found it far more difficult under the previous vertically integrated regime to obtain funding. Indeed, the entry of new providers appears to be one of the most unequivocal benefits to government of purchaser-provider contracting – it breaks the link between the purchasing or planning function and the particular, inherited institutional form of provision. This allows the government, in certain circumstances, to take strategic decisions that would otherwise be extremely difficult. However, it is undoubtedly the case that the entry of new providers has been almost exclusively outside the hospital sector. The purchaser-provider separation has also produced greater clarity and better information about *what* is being provided at tax payers' expense.

The limitations

On the other hand, the experience to date in New Zealand and elsewhere has shown that monopsony purchasers in quasi-market systems generally have fewer levers and incentives to influence health and social care providers than the architects of such systems may have expected. For contracting out to work well, the purchaser has to be able to specify and monitor the cost and quality of the service at reasonable cost. This is difficult to do in many health and disability support services. Providers tend to have superior knowledge about 'best practice' (particularly in relation to hospital medical and surgical services) and, again, in the case of the public hospital sector, monopoly power. In the case of public hospitals, entry to the market is extremely costly with high asset specificity and incumbents have major advantages. Hospital staff also tend to have greater perceived legitimacy in the eyes of the public than public or non-governmental purchasers and hospitals are motivated and effective lobbies for additional public spending on health care. By contrast, it is difficult to identify the direct incentives operating on monopsony purchasers which would motivate them to take decisions which might be unpopular with established providers in order to improve the performance of the system. Purchasers are further handicapped by the inevitable pressures on publicly financed systems in democratic societies to pursue multiple, complex and sometimes incompatible goals on behalf of the public (see below).

Purchasers appear to stand a better chance of exercising influence over services such as residential and domiciliary care for older people than over most hospital services. This is principally because market entry and purchaser choice are easier to accomplish and the purchaser is in a reasonably good position to assess the quality of care delivered at reasonable cost. This observation would tend towards a conclusion that the purchaser-provider separation should be determined on a service-by-service basis by those best able to determine the balance of advantage between vertical integration or quasi-market relations between purchaser and providers. A private firm would reach a series of judgements about in-house versus contracted out services. However, the quasi-market system *compels* the purchaser to opt for a strict separation of purchase from supply, irrespective of the nature of the service. Indeed, a single, national purchaser is probably unable practically to do anything else. Under a more flexible system, with more local purchasers, individual purchasers might decide to reintegrate with acute hospitals for non-elective services, for example, while tendering or operating a 'spot' market for some or all electives and purchasing all or most DSS from the private and/or voluntary sectors.

The position of monopsony purchasers in New Zealand has been further complicated by the fact that they have been negotiating hospital contracts with firms that are also Crown owned, but operating as if they are private companies. Having the Government on both sides of the relationship between purchaser and provider may have reduced the ability of the purchaser to make the market contestable since the Government has wished to avoid putting public hospitals into financial difficulty. Deficit funding of public hospitals has also reduced the power of purchasers dramatically. On the other hand, even in countries where hospitals are not publicly owned, governments find it politically difficult to alter their patterns of funding. Private ownership of assets is no panacea for public purchaser freedom of decision making (see below for more on this).

It is also intrinsically difficult to trace the direct contribution to health and social care quality or efficiency brought about by the separation of the purchasing function from the providing function. In addition, the separation of purchase from provision, especially where this involves legal contracts, is likely to increase transactions costs compared with vertically integrated health care arrangements.

The Interaction of Purchasing with Crown ownership of HHSs

One theoretical solution to the weakness of the purchaser role is simultaneously to reform both purchase and provision by privatising the public hospitals. In this way, hospitals would be directly at financial risk, at least in theory, if they did not satisfy the needs of purchasers. The argument is that public purchasing can never be effective in a publicly funded health system when the government simultaneously discharges ownership responsibilities in respect of the hospitals, which consume around half the current public spending. Under this analysis, the New Zealand quasi-market system may represent the worst of all possible worlds in that many of the transaction costs of private markets have been incurred through the sharp separation of

purchase and provision allied to the company status of hospitals, but few of the supposed benefits. A case can be made that the pre-conditions for effective purchasing are systematically undermined by the current arrangements for ownership which fuel political and public identification with the institutions of the system rather than the goals of the system. Current ownership gives hospitals implicit Crown guarantees of their future incomes and their ability to repay loans. This weakens the 'hard' budget constraint under which they are supposed to operate and encourages them to use over-spending as evidence of under-funding in future contract negotiations. Privatisation would, in theory, remove the financial guarantees and incentivise the hospitals to be responsive to the needs of the purchasers. Even monopsony purchasers would be empowered by this arrangement, it is argued.

However, whether ending public ownership of all health care providers is desirable in itself, or indeed, practical politics is quite another matter. Many countries with health systems which pursue similar overall goals are already in the apparently fortunate position (from a New Zealand perspective) of not owning many or any of the hospitals. This is the case, for example, in the Netherlands and Canada. However, it would be untrue to suggest that this, in itself, has encouraged inter-hospital competition, given purchasers a free hand, or removed government from involvement in the hospital sector. Hospitals still put pressure on governments and/or social insurers for more resources. As long as the government intervenes in the financing of health services, it tends to become involved in the welfare of the providing institutions as the embodiment of its commitment to protecting the public's health (Tuohy, 1999). In addition, a change of ownership of the hospitals is likely to replace a public monopoly with a private one in most parts of New Zealand. Thus there may be more potential for improving the effectiveness of purchasers in measures designed to increase the contestability of services such as direct physician contracting rather than changes to the ownership of hospitals (see below).

General issues relevant to assessing future options

In sum, the strictly economic case for a sharp purchaser-provider separation and contracting for publicly financed health services does not appear to be especially strong, especially for non-elective, hospital services. It appears stronger for community health services, primary care and disability support since these are generally provided in a decentralised way. The overall case for the separation appears to rest more heavily on the greater explicitness about what can be afforded, the higher level of information on the use to which public funds are put and the clearer accountability systems, which are associated with the purchaser-provider approach, than on its ability to encourage greater contestability between suppliers of services. On occasions, the distance between purchaser and provider may also enable government more easily to take tough decisions affecting professionals' self-interest, which are virtually impossible to take when purchase and provision are integrated in a single public body.

Thus the purchaser-provider split cannot be rejected out of hand. In addition, it may be possible to improve its working either by modifying the current arrangements, or by adopting one of the options for purchasing discussed above. However, before assessing the main options, in turn, against the status quo, there are a number of general points which should be borne in mind when trying to determine which model is preferable and why.

It appears from the foregoing analysis that there is no single model of the relationship between health and disability support services' delivery and planning/purchase which is likely to offer all the attributes desired by proponents of system change. The preferred model depends on trade-offs between goals such as local responsiveness to variations in need and consistency of access to services across the country. Other choices depend on the value attributed to individual user choice versus 'expe purchasing/planning agencies, or equity of access, as against other goals such as technical efficiency. Other considerations for central government include the trade-off between cost containment via a single national agency and the existence of a larger number of purchasing agents, each of which risks becoming a lobby for additional resources in pursuit of its 'fair' share of current resources. The full range of criteria which have been used at various points in this report to assess each of the potential options are set out in the left hand column of Table 7, below. The table then summarises an attempt to apply the criteria to each of the three most promising models of purchasing. Each model is assessed in comparison with the status quo (ie, it scores positively on a criterion if it is likely to improve the quality or effectiveness of purchasing and negatively if the reverse, compared with the relation between the HFA and the HHSs).

All models of purchasing publicly financed health services depend on the government being able to express the goals of the health system in a reasonably internally consistent and stable fashion over time so that the purchasers can identify a robust set of aims and objectives to pursue which are within their capacity to achieve. Irrespective of the model chosen, the experience of the OECD countries is that governments find this task extremely difficult and expect their purchasers to pursue a range of aims and objectives simultaneously, not all of which are mutually compatible if taken to their logical conclusion (the long list of assessment criteria in Table 7 underlines this point). Some of these objectives, such as technical and allocative efficiency, cost containment, public acceptability, responsiveness to individual patients' needs and equity of access, and the tensions they create for purchasing, were described earlier in this paper. For example, the current focus on using the elective surgical booking system to establish a single set of national thresholds for access to publicly financed surgery points towards a highly centralised approach to purchasing based on equal opportunity of access for equal need. By contrast, the policy to develop a range of integrated care pilots linking services and providers in innovative ways at local level in response to local conditions, points towards an increasingly devolved approach to purchasing for services other than elective surgery, which may or may not fulfil equity goals.

Whichever choice is made, it is extremely difficult to determine which model offers the best chance of directly contributing to improved population health outcomes. This is because the relation between the organisation of the purchasing or planning system and health is indirect and mediated by numerous other variables. Instead, choices about the best way of organising the demand side of the health system have to be taken on the balance of probability of reaching a range of valued intermediate outcomes and process-related goals, together with the risks inherent in each approach. As a result, Table 7, which summarises the assessment of the most convincing three broad options, does not include the contribution of each to improved health and disability outcomes as one of the assessment criteria.

Different approaches to organising the purchasing side of the health and disability support system also present different degrees of novelty, technical difficulty and, therefore, of risk. For example, there is little doubt that organising geographic monopoly purchase arrangements at regional or area level is a great deal more straightforward and predictable in a system devoted to equity of access to health services than developing arrangements based on individual enrolment and patient choice of purchaser. The former is familiar from the recent past and from the experience of many other countries. The latter has theoretical advantages in that it should generate both demand and supply side competition in the health system, but is largely untried (even in the Netherlands which has flirted with the approach) and requires a high degree of regulation to preserve equity of access to services. As a result, worldwide, the dominant trend in developing the purchasing or planning side of publicly financed health systems has tended in recent times towards trying to develop agencies which face clearer incentives to tackle embedded inefficiencies and inequities in health systems, but without sacrificing the equity goals on which most systems are based. A series of related steps has typically been taken:

- attempting to integrate formerly separate budgets, particularly those allocated to primary (non-hospital) and secondary (hospital) care;
- allocating the resulting comprehensive budget using some form of needs-weighted capitation formula; and
- expecting the purchaser/planner to manage within its budget, with some form of risk-sharing arrangement with government in order to encourage efficient use of resources.

This pattern of development explains the interest in a number of countries, including New Zealand, in basing some or all of the health care purchasing or planning function upon organisations with responsibility for primary care where services can be developed which may help in the management of the system as a whole. Integrating primary and secondary care and shifting the emphasis away from the hospital can be pursued both under internal market and more vertically integrated systems. However, given the level of change and change fatigue in the New Zealand Health system over the last decade and the relative newness of current arrangements put in place after the Coalition Health Agreement of 1996, any change to the structure and organisation of the health system needs to be carefully justified and introduced in the least disruptive way possible, preferably building on existing trends.

The final general observation is that some models of purchaser organisation can exist with others. Although the analysis in this paper has tended to treat each option in isolation, for clarity of exposition, there are potentially feasible combinations. The most obvious would be to combine devolved purchasing of the majority of frequently used services with a national agency to purchase or organise high cost, low volume tertiary services. Another combination discussed in a number of countries would be to establish a separate purchaser for mental health services and generic purchasers for the remaining health services. Similarly, if competition on the purchase side of the quasi-market were desired in New Zealand, it might be introduced, where feasible, in the main centres of population, with monopoly geographic agencies operating elsewhere. Perhaps the most likely combination of specialist and non-specialist purchasing agency in New Zealand would relate to Maori. It might well be desirable, in conjunction with each of the main options discussed below, to allow for the development of specialist sub-purchase organisations operated by and for Maori.

In general, it would appear that the case for specialist purchasing agencies rests on their ability to complement other models of purchasing rather than as a stand-alone option. Specialist purchasers for all the main diseases or for each specialty would appear impracticable since this would generate a large number of overlaps of responsibility and budget boundaries ripe for cost-shifting, not to mention the complexity for providers and patients. For these reasons, the option of specialist purchasing is not separately considered in what follows.

The main options for change are now discussed, in turn, followed by some ways in which a single national purchasing agency could be made to work better.

National or sub-national competing purchasers

This model has strong theoretical advantages for efficiency over systems based on monopoly purchasing and was the preferred destination for the New Zealand health system set out in the Green and White Paper of 1991 (Upton, 1991). In theory, the purchaser should be motivated by competitive pressures to respond to the needs and wants of consumers, thereby leading to improved individual accountability and gains in efficiency. At the same time, there should be a strong element of national accountability, since a political decision would have to be taken to determine the scope and value of the entitlement associated with the publicly financed voucher, which each patient takes to his/her chosen purchaser upon enrolment. It is argued that the voucher will bring greater explicitness as to what is and is not covered by the publicly financed health system, which will, in turn, improve the quality of debate and decisions about the proportion of national resources to be applied to financing health services in the public sector.

However, its implementation raises thorny equity issues relating to potential risk selection, calculating risk-adjusted capitation payment rates to mitigate risk selection, whether individuals should be permitted to ‘top up’ their public voucher, the permissible nature and likely extent of purchaser competition and

enrolment policies. Such difficulties either do not apply, or apply far less acutely, to the geographic and/or monopsony models in which purchasers largely do not compete with one another for patients. For example, under the geographic model, a formula is required to determine the fair expenditure share of the relevant purchaser's population, but it does not need to be as sophisticated as when funding depends on individual patient enrolments (Hurley, Hutchison, Giacomini, Birch, et al. 1999). The potential gains in efficiency and user responsiveness may be greater under competing purchase arrangements, but the risks of disadvantaging particular types of patients are considerably greater too.

Table 7: Summary assessment of potential purchasing options in terms of the features of a good purchasing system, compared with the current arrangements (HFA purchasing)

Features of a good purchasing system / purchaser of publicly financed health services[1]	**Purchasing option scored versus current arrangements[2]**		
	Devolved to non-competing PCOs	**Devolved to competing purchasers (health plans)**	**Vertically integrated (territorial health services)**
Bargaining power / strength vis-à-vis providers	–3 Assuming similar size to territorial health services	–1	–3 Assuming similar size to PCOs
Good relationships of trust with providers	+2	–2	+2
Willingness to stimulate competition / change providers if necessary	+2	+4	–2
Decisions command public and professional confidence (perceived legitimacy)	+3 Assuming clinician leadership	–2 Assuming commercial involvement in health plans	+1 Assuming local representation
Access to good information on cost and quality / benefits of services	+1 Assuming clinician input	+2 Assuming incentive to do this	0
Understanding of population needs and sensitivity to population diversity	+3	+2	+3
Expertise to develop a purchasing plan	–2 Current expertise spread more thinly	0	–2 Current expertise spread more thinly

1 Features derived from Light (1998) and Mays and Dixon (1996).

2 Explanation of scores: A score of zero represents no change from the current arrangements. A positive score represents an improvement and a negative score deterioration compared with the status quo. Scores range from –5 to +5.

Features of a good purchasing system / purchaser of publicly financed health services[1]	Purchasing option scored versus current arrangements[2]		
Knowledge to specify, negotiate and monitor range of contracts	+2 Assuming clinician input	0	–2 Assuming bureaucratic approach
Techniques to monitor outcomes, efficiency and equity of access	0	+2 Incentives to do this	0
Integrated budget (no incentive to cost shift)	+3 Assuming comprehensive responsibilities	–3 Incentive to attempt to cost shift	+3 Assuming competitive responsibilities
Acceptance of 'hard' budget constraint (no incentive to ask for more money rather than make the best of available resources)	–1	+2 Because NGOs/commercial organisations	–2 Especially if democratically elected
Ability to manage clinical and financial risk across a wide range of services (except for defined 'high cost – low volumes cases)	+1 Assuming similar size to territorial health service but clinician involvement	–1 Smaller than HFA and without clinician leadership of PCO	–2 Assuming similar size to PCO
Incentives to purchase highest quality services at lowest cost	+2 Assuming their surpluses can be re-invested	+3 Assuming competition	–2 Assuming directly responsible for HHSs/hospitals
Avoidance of "cream skimming" and "adverse selection"	0	–4 Assuming competition	0
Focus on public health as well as curative services	+2 Assuming GPs and public health physicians can work together	–1 Assuming short-term focus as patients enrol and dis-enrol	+3

Features of a good purchasing system / purchaser of publicly financed health services[1]	Purchasing option scored versus current arrangements[2]		
Individual user choice and responsiveness to individual needs/wants	+1	+5	0
Consistency of decisions between purchasers and across time (national standards, eg of access in relation to patient need)	–3 More scope for local idiosyncrasies	–2 Plans will wish to differentiate themselves	–2 Local boards will vary in their priorities
Upward accountability (to central government)	–2	–1	–3
Involvement of/accountability to population served	+1	+3	+2
Representation of wider public (not just users)	+1 More local then HFA, but depends on requirements placed on PCOs	–3 Will not occur unless mandated	+4 Assuming local democratic representation on boards
Low transaction costs	–2	–3	–1
Low central government regulatory costs	–3	–5	–2
Feasibility/disruption (versus status quo)	–1	–5	–3
Public acceptability	–1 Assumed scepticism of GPs' motives particularly	–5 Judged that public not in tune with this model	+3 Public dislike of central bureaucratic agencies

In addition, the evidence available on how patients choose health insurers and health plans, particularly from the USA, indicates that there is little likelihood that unsupported individual choice would, in practice, prove capable of driving improved purchaser performance. Table 7 summarises the overall pros and cons of the model. The model may also threaten cost containment, which is important from a government perspective, since it would tend to encourage a view that each enrolee had an *entitlement* to a defined package of health care, regardless of cost, based on the publicly financed 'voucher' which he/she brought to the health plan. This contrasts with the current management of the health system's finances which is based on trying to prioritise the most 'needy' patients in as transparent and fair a way as possible within a budget set in advance on the basis of broad political priorities between health services and other uses of public money.

The model suffers from the further drawback that it would only seem feasible to implement it for approximately half the population in the main centres of population. This does not rule out such a possibility, as long as people in the areas concerned were convinced that the chosen model suited the characteristics of their area. In the main centres, there could be competition *in* the market and, elsewhere, periodic competition *for* the market. However, this weakens its appeal in any health system aiming for national consistency.

The model of competitive purchasers is highly likely to generate higher administrative costs than monopsony purchasing since all or most providers would need to negotiate contracts with, or claim reimbursement from, all the purchasers. This would be similar to the arrangements for treatment of accident-related injuries since July 1999 in which health services providers have to claim reimbursement from a range of different private and public insurers.

Finally, to bring the model into being would involve major structural change and a further prolonged period of upheaval in a system which has been dealing with significant externally generated change since the early 1990s. This and the other disadvantages of purchaser competition would seem to rule out the option of moving directly to a health system driven by individual patient choice of health plan.

This leaves two basic options for change: either to develop a range of delegated or sub-purchasing organisations, contracted by the government (eg, by the HFA or, conceivably, the Ministry of Health); or to abolish the purchaser-provider separation in order to develop a series of territorial health and disability support services' organisations. The latter would most likely integrate HHSs with primary care services, such as those of GPs, in line with trends already visible in the New Zealand health sector. The latter would rule out any further development of individual choice of purchaser, while the former could evolve in time, if government so wished, into a system based on patient choice of purchaser or health plan. Devolved purchasing organisations would choose whether, and which services, to sub-contract for. This would enable some forms of specialist purchasing to occur, particularly by and for Maori.

Since the most taxing purchasing role relates to managing the demand for public hospital services, it would be highly desirable for both the territorial health services and the devolved sub-purchasers either to be based in primary care or to have responsibility for primary and secondary care services so that they could manage or purchase a comprehensive range of services inside and outside the hospital. Both the vertically integrated and primary care-based purchasing options thus depend crucially on establishing clear funding and accountability relationships with GPs and other primary care providers, a currently unresolved issue. Each of these options is now discussed in turn (see Table 7 for a summary of the assessment of each).

Primary care-based devolved models

The case for building on and continuing with experiments to devolve purchasing responsibility to risk-sharing sub-purchasing organisations with *fully* integrated, needs-weighted capitated budgets for Personal Health, Disability Support and Population-based (ie, public health) Services is strong, particularly if such organisations have a basis in primary care. This approach could be accommodated without major, system-wide upheaval since it would be building on trends already under way towards primary care-based budget holding by a range of different primary care organisations. It would allow individuals to continue to choose their own first contact care giver within the local area, but not their purchasing organisation. This mirrors current arrangements (eg, IPAs and Maori primary care organisations). It could even be reconciled with a shift to a more vertically integrated system if the resulting integrated purchaser-provider organisations included responsibility for primary care (see below).

A national purchaser may be regarded as too remote to be able to purchase local packages of Personal Health and Disability Support Services designed to keep elderly people out of hospital or residential care and, instead, supported in their own homes. Primary care providers could do this. Yet, at present, primary care providers have no reason to ensure that their elderly patients receive the most appropriate pattern of support for their personal needs since they cannot manage patients and resources across the primary-secondary care inter-face, nor do they have the ability to access the other supportive services necessary to maintain their frailer patients in the community.

Under this option, primary care-based purchasing organisations could have overall responsibility for managing all the public resources available for the health and social care of their enrolled patients in the most cost-effective manner possible (Glennerster, 1996). One way of implementing this approach would be for care managers to work at general practice level, taking advantage of the fact that GPs and practice nurses are in very frequent contact with their older patients. Practices could be required to assess their elderly patients periodically to prevent crises leading to admission to residential care. This could help in the management of the likely rising demand for disability support generated by an ageing population. These purchasers could also take responsibility in certain circumstances for budgets that extended beyond Vote: Health in order to influence the causes of ill-health which lie outside the health system and to facilitate collaboration with education, housing and other local

agencies. In addition, budgetary devolution to primary care organisations would be a means to develop primary care itself so that it could share in the better management of the overall health care budget.

Primary care provider organisations (importantly, not just groups of GPs) which are given the ability to make 'savings' by better use of their budgets are likely to be more powerfully motivated, have better knowledge and have better opportunities to alter the inherited use of resources by other providers than government purchasing agencies. There is considerable attraction to policy makers in encouraging one group of influential clinicians to shape the activities of other clinicians, given that both groups directly shape the deployment of resources in ways which managers and planners can rarely do. The evidence from experiments such as GP fundholding and total purchasing in the UK indicates the *potential* which this approach can offer, particularly if primary care purchasers are large enough to act as a counter weight to hospital providers. On the other hand, it has to be recognised that the culture and funding of general practice in New Zealand is different from the UK. Budget-holding at individual practice level has not been attempted and the existence of user charges provides an opportunity for cost-shifting to patients in ways which are not possible in the UK NHS.

However, in theory, models that involve giving budgets to clinician groups working in primary care, have the potential partially to redress the information and legitimacy imbalance, which currently exists between other more bureaucratic forms of purchasing and providers such as acute hospitals, particularly if changes can be made in the way GPs are paid. Primary care clinicians may be able to exert a stronger influence over, say, the public hospitals than the former RHAs or HFA have been able to achieve, but without the need for privatisation of the hospitals (see above). Primary care-based purchasers could employ staff with the expertise to purchase and/or organise disability support as well as personal health services.

Ultimately, the resource allocation decisions in health care are made by teams of clinicians. It is generally extremely difficult for others to do more than shape the broad resource limits in which they work. For example, the decision by a leading US managed care company in November 1999 to abandon micro-management of its clinicians and wind up its utilisation review (UR) department was prompted, among other things, by the fact that the department approved 97% of the requests from clinicians for resources to manage individual patients. Thus it is appropriate for responsibility for purchasing services within a budget to lie with organisations which are clinically led, but which operate within a national framework of objectives and quality standards.

GPs would not automatically *lead* such organisations. The current Integrated Care Pilots are small-scale, far from comprehensive prototypes for the sorts of organisations envisaged. Devolved, primary-based purchasers could just as easily be 'third sector' (Crampton, 1999) organisations including Maori primary care providers, rather than, say, based on IPAs. The likelihood is that they would compete periodically *for* the market rather than *in* the market (say every five to ten years), in order to obtain a purchasing franchise for a defined

period, for an area or a population sub-group. Purchasers would assume most, but not all of the financial risk and would not be competing on an ongoing basis. In this way, it should be possible to reduce the risk of "cream skimming" and under-service and take some pressure off the system of risk adjustment. The stronger the financial incentives operating on the purchasing organisation and on individual clinicians, the greater these risks, the greater the need for regulation and the greater cost of such regulation.

Inevitably there are drawbacks compared with the status quo as well as advantages. The advent of 30 or 40 (possibly more) sub-purchasers could increase transactions costs in the system as well as the monitoring costs incurred by the HFA or Ministry of Health, since an additional organisational layer would have been added. Each purchaser could become a vocal critic of the level of government funding, thereby increasing the political pressure to raise spending. It is certainly possible that clinically-led organisations would be less willing and potentially less able to manage within an allocated budget than a national purchaser. At the same time, it would probably become more difficult for central government to impose national strategies on a larger number of purchasing bodies each of which would have strong clinical input. More, smaller purchasing bodies would spread the available technical purchasing expertise more thinly. Local primary care-based monopolies might make inappropriate decisions about specialist services and invest in their own services out of self-interest.

However, seen in the light of the debate between proponents of some form of internal market and proponents of re-integration of purchase and supply of services, the devolved, primary care-based approach to purchasing has the attraction of offering some gains to both sides of the argument. This is because, under it, purchasing functions would be being devolved to organisations which also have a providing role, thereby reuniting purchase and provision, albeit probably at a more local level than if vertically integrated territorial health services were put in place. At the same time, the purchaser-provider separation and contracts would be maintained for services such as those of public hospitals where the primary care organisation would be in a strong position to judge the quality and appropriateness of care and, if it judged beneficial, to substitute its own or other ambulatory services for those of the hospitals. The primary care- based model would also facilitate a dialogue between two groups of clinicians since the negotiation of contracts could take place between professionally-led, or influenced, purchaser organisations and providers.

Finally, integrated capitated budgets would allow the primary care-based organisation to make more flexible use of *all* the public finance for health services available to a defined population. The organisation could, as a result, reduce the current eligibility for, and levels of, co-payments for primary care services and increase the amount of service provided free at the point of use. However, in order to do so, the purchaser would need to change the way in which GPs and others are remunerated.

Vertical Integration

Given that the high expectations of the internal market have not been realised, it is scarcely surprising that the case for reverting to a more vertically integrated system with purchase/planning and provider management functions largely located in the same organisation has been articulated. It is argued that vertical integration would also reduce the costs of managing the health system that have been inflated by attempting to adopt a commercial model of contracting. In the New Zealand context, calls for re-integration generally focus on the relations between the national purchaser (the HFA) and the HHSs. The change would presumably lead to a series of geographically based, equitably funded health services' organisations across the country responsible for planning and delivery of all or most hospital, community health and disability support services. However, there is no reason, in principle, why a greater emphasis on locally elected purchaser organisations could not be introduced while maintaining a purchaser-provider split. This would be accompanied by the absorption of the HFA's remaining functions into the Ministry of Health. The Ministry would also be responsible for defining and managing the performance objectives of the new local health services' structures on behalf of the Ministry of Health. Some proponents of vertical integration include a change in the governance of local health services' bodies away from ministerial appointees towards boards with either some or all members locally elected. This is a reaction to the emphasis placed by the architects of the internal market on generic managerial skills and experience at CHE/HHS board level, rather than local representation. The model has something in common with the way in which Boards of Trustees manage publicly funded schools. The difference is that school Boards are far more numerous and each administers a relatively modest budget compared with a local health authority.

While re-integration in these terms is feasible, it is difficult to see how the purchaser-provider separation could be undone in respect of DSS (at least in the short term) when so much of the provision is in the private sector. Thus the health system would still need to retain a capacity to purchase DSS and would not, in practice, be able to remove all parts of the purchaser-provider separation. It seems highly unlikely that any government would choose to buy out private providers of DSS.

Furthermore, it is unclear what vertical integration between the purchaser and HHSs would mean for the relationship between GPs and other primary care providers (eg, Maori providers) and the wider health system. To justify the upheaval of another major reorganisation of the health system, it would be important to take advantage of the opportunity offered by the abolition of the internal market to re-negotiate these relationships, so that all the publicly funded and subsidised services in each area could be more closely co-ordinated than is currently the case. This approach would provide a link between the model of purchasing based on primary care, discussed above, and a more vertically integrated system. It would possibly necessitate a contractual relationship between primary care providers and the new territorial organisations.

However, the history of previous attempts to align GPs' activities more closely with the wider health system, including efforts to alter their method of reimbursement in order to encourage changes in the nature of the services which they offer and to develop links with local public bodies in health, is not auspicious. In the late 1980s, the former AHBs tried to take wider responsibility for the health services in their areas, including those of GPs (GMS), and were rebuffed. The GPs refused to work with them, principally because of a general fear of external bureaucratic control, but, particularly, because the AHBs included locally elected board members, which smacked of local government control. Although it is undoubtedly the case that circumstances have changed since the 1980s and GPs are more interested in partnership and collective working, they are still wary of direct external control. Control by local politicians is unlikely to be popular, which is a reason for thinking carefully about any proposal to re-introduce locally elected representation into the governance arrangements for vertically integrated health services' organisations. Citizens' juries and deliberative polls may offer a more constructive way of increasing public participation in local decision making, but without setting up conflicts of accountability between the Minister of Health and the local population (see above).

Other drawbacks of vertical integration in the shape of a series of local health services include a potential increase in the costs of managing the health system. The precise increase would depend on the number of local services created. Like the primary care-based option, discussed above, this approach would spread purchasing expertise more thinly than the status quo and increase the number of bodies within the health system with an interest in arguing for increased funding and criticising the allocation of resources between areas.

Furthermore, locally elected territorial health authorities/services are likely to confuse central and local accountability and generate increased conflict with central government, since locally elected members will tend to identify with the needs of their area rather than with the running of the system as a whole. As long as health services remain centrally financed, upward accountability to Parliament cannot be avoided, but sits uneasily with locally elected boards controlling health services.

In addition to more complex and potentially conflicting accountabilities, it is unclear what greater incentives territorial health organisations would face to challenge inherited patterns of service delivery in order to improve the efficiency and effectiveness of local services than the current national purchaser (the HFA). Indeed, if they were also directly responsible for the public provider organisations, they might find it more difficult to alter the inherited pattern of resource use. As now, the only sanction which government could use in the event of poor purchaser performance would be to remove board members and replace them with more effective individuals or to take direct control of the local health services. This would be more politically hazardous in the case of locally elected health authority members.

The option of abolishing the Crown Company status of the HHSs and incorporating them in some sort of local/district health service system, while abolishing the HFA and re-shaping the role of the Ministry of Health is further likely to impose a very significant upheaval on the publicly funded system. After all, the current arrangements for purchasing through the HFA are only two years old and are only now bedding down. It could be counter-productive in such circumstances to launch 'root-and-branch' changes to the system. Evidence from the recent past suggests that relatively simple structural solutions which largely ignore the *content* of health services and the motivation of key players are unlikely to deliver their anticipated benefits. This leaves a final option – to take opportunities within the purchaser-provider system to make improvements.

General Issues Relevant to Improving the Status Quo

As well as further experiments with tendering devolved purchasing to new sorts of organisations, there are opportunities to make the HFA's purchasing more economical, flexible and effective. It is highly likely that a number of the changes discussed below would emerge over time as the national purchaser matures.

The main avenues that should be actively considered are to:

- remove the historic 'ring fences' which protect certain budgets within Vote: Health, such as DSS, from any re-allocation. These are incompatible with mature purchasing organisations and would particularly hamper devolved purchasers. The logic, hitherto, has been that the RHAs and latterly the HFA have to demonstrate the ability to manage Vote: Health effectively within the current 'ring fences' before their removal can be contemplated. This was primarily to reduce the risk to the Crown by preventing purchasers managing the budget as a whole rather than managing smaller, fixed amounts. 'Ring fences' also simplify upward accountability for the use of specific bundles of resources. However, additional flexibility may be necessary for effective management of Vote: Health. In addition, devolved purchasers are likely to function best if they can take a budget which incorporates Personal Health, GMS subsidies and DSS, perhaps with pharmaceutical and laboratory subsidies and make purchasing decisions based on all the resources available to their populations. A decision would need to be taken as to whether to remove the earmarking of specific funds for waiting list surgery as part of this change of policy, despite its strategic importance in improving the 'shop window' of the publicly financed health system. Under a new approach, the HFA would negotiate new groups of services or classes of outputs in relation to its purchasing strategy and against which its purchasing could be assessed by the Ministry of Health, thereby maintaining accountability, but not tying it to out-dated divisions of the Vote;
- shift purchasing towards programmes of care and bundles of services which correspond to the needs of individual patients rather than historic divisions between budgets and/or funding sources;

- refrain from issuing strategic plans for the health sector which relate to particular institutional arrangements (eg, 'a hospital plan') rather than the requirement to make available particular types and volumes of services. The former hamper effective purchasing. Such a change would signal the end of policy goals which focus on the stability of the institutions delivering services as much as the services themselves;
- consider more closely aligning the work of Pharmac with that of the HFA and any devolved purchasers to ensure that the scope for substitution between pharmaceuticals and other interventions is appropriately factored into purchasing decisions. This is already beginning to happen, but more could be done;
- develop contracts (or hold back some resources in-year) which encourage providers to pursue the delivery of evidence-based service protocols or 'best practice' guidelines (eg, for programmes of care) and which reward providers, not for the volume of activity generated, but for health and functioning improvements in patients/clients. This too is just beginning and could be greatly extended;
- gradually alter the currency of accountability which is used between the Ministry of Health and the HFA to emphasise health outcomes rather than exclusively the delivery of contracted outputs;
- continue and accelerate the move towards longer term contracts for appropriate services (eg, for 80% of current funding, with the rest at risk from year to year) informed by refined 'benchmarks' of cost and quality for a wider range of services. At present, the range of performance measures is narrow and most are financial. Few have any direct bearing on the health services experienced by patients or the measures of performance that would engage clinicians in meaningful discussion about how to improve services. Longer term contracts per se are less important than the relationships and plans for the future which need to lie behind them (Dawson and Goddard, 1999). However, in a contractual environment, longer term contracts may be a means of signalling the commitment to a different form of relationship between purchaser and provider and appear to have the support of the sector;
- for resources not devoted to longer term contracts, consider developing a 'spot market' for elective surgery based on services-facilities splits and direct physician contracting (see below) in order to increase the responsiveness and efficiency of HHSs as providers of waiting list surgery;
- experiment with splitting some contracts into contracts for services and contracts with facilities for acute hospital services in order to focus contractual incentives directly on groups of clinicians delivering services. This may also allow greater contestability in service provision since 'out of area' clinicians could be invited to bid to use facilities. In turn, this might improve the position of purchasers vis-à-vis monopoly hospital providers;
- negotiate contracts on a rolling basis so that not all contracts require re-negotiation or oversight at the same time each year (or at longer intervals), thereby allowing greater attention to be given to the relationships with providers and the terms of each contract; and

- finally, now that private insurers are heavily involved in the provision of health services to those who have suffered workplace accidents, it is important that the HFA does not see its purchasing power diminished through cost-shifting by workplace accident insurers keen to maintain their profits while keeping premia to employers low. Given the difficulty, in many cases, of attributing precise causes to many chronic conditions, the risk of this occurring is heightened. The increased paper work for providers, such as GPs which is associated with work place accident claims may also encourage them to reclassify a certain amount of work, putting unwarranted pressure on Vote: Health. Monitoring trends in activity and claims in categories of service potentially prone to cost-shifting before and after the July 1999 changes to ACC will be essential.

References

Anonymous. (1999) HMOs: managed retreat. *Economist* 353(8145): 38.

Ashton T. Reform of the Health Services: Weighting up the costs and benefits. In: Boston J, Dalziel P, eds. *The decent society? essays in response to national's economic and social policies*. Auckland: Oxford University Press, 1992, 146-68.

Ashton T. (1998) Contracting for health services in New Zealand: a transaction cost analysis. *Social Science and Medicine* 46: 357-67.

Ashton T. The health reforms: to market and back? In: Boston J, Dalziel P, St John S, eds. *Redesigning the welfare state in New Zealand*. Auckland: Oxford University Press, 1999, 134-53.

Ashton T, Press D. (1997) Market concentration in secondary health services under a purchaser-provider split: the New Zealand experience. *Health Economics* 6: 43-56.

Audit Commission (1997) *Higher purchase: commissioning specialised services in the NHS*. London: Audit Commission.

Bachmann SS. (1996) Why do some states privatise mental health services? Six state experiences. *Journal of Health Politics, Policy and Law* 21: 807-24.

Bartlett W, Le Grand J. (1993) The theory of quasi-markets. In: Le Grand J,

Bartlett W, eds. *Quasi-markets and social policy*. London: Macmillan, 13-34.

Baxter K, Bachmann M, Bevan G. (1998) *Survey of budgetary and risk management of TPPs, 1996/97*. National Evaluation of Total Purchasing Pilot Projects Working Paper. London: King's Fund.

Chalkley M, Robinson R. (1997) *Theory and evidence on cost sharing in health care: an economic perspective*. London: Office of Health Economics.

Crampton P. (1999) *Third sector primary health care*. Primary Care Discussion Papers, September 1999. Wellington: National Health Committee.

Crengle S. (1999) *Maori primary care services*. Primary Care Discussion Papers, September 1999. Wellington: National Health Committee.

Crown Company Monitoring and Advisory Unit (CCMAU). (1996) *Report on CHE performance*. Wellington: CCMAU.

Cumming J. (1998) *The purchaser-provider split*. Research Report No. 12. Wellington: Health Services Research Centre, Wellington School of Medicine, University of Otago and Victoria University of Wellington.

Cumming J. (1998) Management of key purchaser risks in devolved purchase arrangements. Report prepared for the Treasury. Wellington: Health Services Research Centre, Victoria University of Wellington.

Cumming J, Scott CD. (1998) The role of outputs and outcomes in purchaser accountability: reflecting on New Zealand experiences. *Health Policy* 46: 53-68.

Dawson D, Goddard M. (1999) Long term contracts in the NHS: a solution in search of a problem? *Health Economics* 8: 709-20.

Dickinson F. (1999) *Impact on the health sector of the Accident Insurance Act 1998*. Presentation to the Wellington Health Economists' Group, 21 October 1999.

Glennerster H. (1996) *Caring for the very old: public and private solutions*. Welfare State Programme Discussion Paper WSP/126. London: The Toyota Centre, Suntory and Toyota International Centres for Economics and Related Disciplines, London School of Economics and Political Science.

Glennerster H, Cohen A, Bovell V. (1998) Alternatives to fundholding. *International Journal of Health Services* 28: 47-66.

Goodwin N. (1998) GP fundholding. In: Le Grand J, Mays N, Mulligan J-A, eds. *Learning from the NHS internal market: a review of the evidence*. London: King's Fund Publishing, 43-68.

Goodwin N, Mays N, McLeod H, Malbon G, Raftery J. (1998) Evaluation of total purchasing pilots in England and Scotland and implications for primary care groups: personal interviews and analysis of routine data. *BMJ* 317: 256-9.

Hacker J, Marmor T, (1999) The misleading language of managed care. *Journal of Health Politics, Policy and Law* 24: 1033-43

Health Funding Authority (1998) *The next five years in general practice*. Auckland: HFA.

Hibberd JH, Weeks EC. (1989) Does the dissemination of comparative data on physician fees affect consumer use of services? *Medical Care* 27: 1167-74.

Hoerger TJ, Howard LZ. (1995) Search behavior and choice of physician in the market for prenatal care. *Medical Care* 33: 332-49.

Hospitals and Related Services Taskforce. (1988) *Unshackling the hospitals: report of the Hospital and Related Services Taskforce*. Chairman: Alan Gibbs. Wellington: Hospital and Related Services Taskforce, 1988.

Hurley J, Hutchison B, Giacomini M, Birch S, Dorland J, Reid R, Pizzoferrato G. (1999) *Policy considerations in implementing capitation for integrated health systems*. Ottawa: Canadian Health Services Research Foundation.

Klein R, New B. (1998) *Two cheers? Reflections on the health of NHS democracy*. London: King's Fund Publishing.

Krasnick A, Groenewegen PP, Pedersen PA, Scholten P, Mooney G, Gottschau A, Flierman HA, Damsgaard MT. (1990) Changing remuneration systems: effects on activity in general practice. *BMJ* 360: 1698-701.

Kronick R, Goodman D C, Wennberg J, Wagner E. (1993) The market place in health care reform: the demographic limitations of managed competition. *New England Journal of Medicine* 328: 148-52.

Le Grand J, Mays N, Mulligan J-A, eds. (1998) *Learning from the NHS internal market: a review of the evidence*. London: King's Fund Publishing.

Light DW. (1998) *Effective commissioning: lessons from purchasing in American managed care*. London: Office of Health Economics.

Lomas J. (1997) Reluctant rationers: public input to health care priorities. *Journal of Health Services Research and Policy* 2: 103-11.

Malcolm L. (1997) *An evaluation of pharmaceutical management and budget holding in Independent Practice Associations and General Practices*. A confidential report prepared for the Transitional Health Authority and Pharmac. Lyttelton, Aotearoa Health.

Malcolm L. (1998a) Capitated primary care: policy, problems and prospects. *Health Manager* 5: 7-9.

Malcolm L. (1998b) Towards practice-led integrated healthcare in New Zealand. *Medical Journal of Australia* 169: 147-50.

Malcolm L. (1998c) *Progress in the development of Comprehensive Health Services*. Report prepared for Comprehensive Health Services. Lyttelton, Aotearoa Health.

Malcolm L, Wright L, Barnett P. (1999) *The development of primary care organisations in New Zealand.* A review undertaken for Treasury and the Ministry of Health. Wellington: Ministry of Health.

Malcolm L, Wright L, Barnett P. (2000) Emerging clinical governance: developments in independent practitioner associations in New Zealand. *New Zealand Medical Journal* 113: 33-6.

Mays N, Dixon J (1996) *Purchaser plurality in UK health care*. London: King's Fund Publishing.

Mays N, Goodwin N, Killoran A, Malbon G. (1998) *Total purchasing: a step towards Primary Care Groups*. London: King's Fund Publishing.

Mays N, Mulligan J-A, Goodwin N. (2000) The British quasi-market in health care: a balance sheet of the evidence. *Journal of Health Services Research and Policy* 5: 49-58.

National Advisory Committee on Core Health and Disability Support Services. (1994) *Core services for 1995/96*. Wellington: Ministry of Health.

Ovretveit J. (1995) *Purchasing for health*. Buckingham: Open University Press.

Raftery J, McLeod H. (1999) *Hospital activity changes and total purchasing in 1996/97*. National Evaluation of Total Purchasing Pilots Working Paper. London: King's Fund.

Reinhardt UE. (1998) *Accountable health care: is it compatible with social solidarity?* London: Office of Health Economics.

Rice T. (1998) *The economics of health reconsidered*. Chicago: Health Administration Press.

Roberts J. (1998) Primary care in an imperfect market. In: Pringle M, ed. *Primary care: core values*. London: BMJ Books, 31-9.

Robinson R, Steiner A. (1998) *Managed health care*. Buckingham: Open University Press.

Robinson R (1999) *Review of the US evidence on the performance of managed care and commentary on its relevance for New Zealand. Phase 1 report: update of US evidence*. London: London School of Economics and Political Science, unpublished report.

Rosen R, Mays N. (1998) The impact of the UK NHS purchaser-provider split on the 'rational' introduction of new medical technologies. *Health Policy* 43: 103-23.

Savas S, Sheiman I, Tragakes E, Maarse H. (1998) Contracting models and provider competition. In: Saltman R, Figueras J, Sakellarides C, eds. *Critical challenges for health care reform in Europe*. Buckingham: Open University Press, 157-78.

Secretaries of State for Health, Scotland, Wales and Northern Ireland. (1989) *Working for patients*. London: HMSO.

Scott, C. (1994) Reform of the New Zealand health care system. Health Policy 29: 1-16.

Sheldon T, Borowitz M. (1993) Changing the measure of quality in the NHS: from purchasing activity to purchasing protocols. *Quality in Health Care* 2: 149-50.

Shipley, J. (1991) *Social assistance, welfare that works: a statement of Government policy on social assistance.* Wellington: Government of New Zealand.

Smith P. (1997) *Devolved purchasing in health care: a review of the issues*. Nuffield Occasional Papers, Health Economics Series: Paper No. 2. London: The Nuffield Trust.

Starfield B. (1998) *Primary care: balancing needs, services and technology.* New York: Oxford University Press.

Stewart J. (1996) *Further innovation in democratic practice*. Birmingham: Institute of Local Government Studies, University of Birmingham.

Taskforce on the Funding and Provision of Health Services (1991) *Report to the Prime Ministerial Committee*. Wellington: Taskforce on the Funding and Provision of Health Services.

Tuohy CH. (1999) *Accidental logics: the dynamics of change in the health care arena in the United States, Britain and Canada.* New York: Oxford University Press.

Upton S. (1991) *Your health and the public health: a statement of government health policy.* Wellington: Minister of Health, 1991.

Weale A. (1998) *Should health policy be made democratically?* King's College London Annual Public Policy Lecture, 28 May 1998, unpublished mimeo.

Williamson O. (1975) Markets and hierarchies: analysis and antitrust implications. New York: The Free Press.

Annex: Purchaser Strategies for Risk Selection

Method	Description
Service Coverage	Specifying service coverage (eg, excluding pre-conditions; excluding / including specific services that attract low risk individuals); denying coverage to individuals or groups (eg, individuals employed in certain occupations); offering specific coverage at prohibitively expensive premiums.
Provider Contracting	Contracting with providers in particular ways (eg, not contracting with specialists known to specialise in high-risk conditions; recruiting new specialists with limited patient following); or contracting with providers in particular locations but avoiding others who practice in higher-risk localities (eg, inner-city areas)
Service Quality	Offering poor quality care, under-servicing, making patients wait for care or developing more stringent protocols for referring patients to specialists for some types of conditions, in order to drive consumers to another plan.
Marketing	Marketing in specific locations or to specific groups to attract good risks (eg, in gyms).

Key Approaches to Reducing Risk-Selection

Strategy	Explanation
Encouraging large risk pools	Allows risk to be spread across a greater number of people, and hence to reduce the effects that a few high cost patients have on overall risk. This should assist in making providers and plans indifferent to the utilisation and costs which might be associated with particular patients. Encouraging large risk pools is particularly important where purchasers are responsible for comprehensive coverage. In New Zealand, any policy approach which aimed to encourage large risk pools may also limit competition and local responsiveness.
Compensating for risk	The main approaches to compensating for a higher or lower than average risk are: ▪ Risk-rating capitated premiums. A number of tools have been developed to undertake such risk rating. ▪ Using a fee-for-service payment mechanism which includes levels of payments adjusted for complexity (as in the DRG approach used in secondary care)3 or moving to blended payment systems which ▪ combine elements of capitation and fee-for-service.

3 A disadvantage of this approach is that it compensates plans directly for what they do, with payment levels based on average existing costs, ie. incorporating any existing inefficiencies within them. ACG and DCG approaches also incorporate current service use information within them, for use in adjusting for higher levels of 'risk'.

Strategy	Explanation
Limiting risk	The following approaches can be used to limit risk, and hence to reduce the incentives to cream-skim: ▪ Establishing separate risk pools (including carve-outs) – may present a cost-shifting risk. ▪ Limiting financial risk[4]. In this case, a financial limit may be placed on the risk an individual provider or plan is responsible for in regards to particular patients. ▪ Establishing separate clinics (eg, those without insurance coverage in US can obtain emergency care from state-financed and state-owned hospitals).
Service specification (ie, a standard package/s of benefits)	Prevents plans or providers from specifying or offering services in ways that encourage particular groups to enrol or disenrol, or which discourage particular groups from enrolling. Hence, wherever there is competition between plans or providers where benefit design can influence risk selection, service specification is an important tool for reducing at least one avenue for cream-skimming5. A standard package of benefits is often viewed as an essential element of proposals which promote competition between purchasers.
Regulating the insurance or provider market (including enrolment regulations)	

4 Sometimes known as an outlier or reinsurance scheme.