

CONTRACTING FOR HEALTH SERVICES

LESSONS FROM
NEW ZEALAND



WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR THE WESTERN PACIFIC

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FOREWORD

Health is complex and multidimensional. As we learn more about factors that are associated with health and ill-health, our need to be able to draw on the knowledge and skills in different fields also increases.

This is reflected in the development and operation of health systems. To ensure that these complex systems work well and that services are able to be delivered equitably, safely, efficiently and effectively to meet people's needs, we must engage the knowledge and skills of an increasing array of different disciplines. As part of this, publicly owned and funded health systems are now struggling with combining more modern approaches to public management into their systems and with managing an increasing array of participants, both public and private. Therefore, many different mechanisms and tools are being used to try to ensure the effective and safe delivery of health services.

Contracting is one of those tools, and it is playing an increasing role in many health systems. Not only is it being used within the private sector, but it is also being used by the public sector to make effective use of the private sector, as well as within the public sector between purchasing agencies and the providers of services.

Although contracting has the potential to add benefits to health systems, it also adds further complexity. Health professionals and health sector managers need to develop new skills and to understand areas with which few have concerned themselves in the past, particularly in relation to the legal aspects of contracts.

We are therefore pleased to be able to share this research report, in the hope that the experience that New Zealand has gained and the lessons that were learned in the application of contracting throughout their health sector can benefit other countries that may also be considering the use of contracts in their health systems.

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KEY POINTS

- **Contracting** has become a central part of the management of the health system in New Zealand, particularly since the introduction of the purchaser/provider split in 1993.
- **The contracting process** improved focus on costs and volumes; led to greater clarity through specification of services; encouraged providers to focus on methods to improve quality; and enabled new styles of service provision from providers that had not traditionally received public funds for health services.
- On the other hand, **the legal framework** encouraged an adversarial approach, and there were high transaction costs associated with contracting, particularly in the early years when there were four regional public purchasers with different contracting and monitoring processes. A lack of good information, especially on costs and volumes, and quality, made monitoring and accountability more difficult.
- Competition between providers was limited. Some private providers argued that it was difficult for them to win contracts because (a) they did not have information about the risk profile of patients previously treated in the public sector, and (b) the government did not want to undermine the financial viability of public providers.
- The **regulatory** environment was complex. Competition law concerns were often at odds with other objectives and interests of patients were often under-represented in contractual processes.

-
- In relation to **contract content and form**, development of a standard set of terms and conditions under a national purchasing framework made contracting simpler and less costly. Specification of services also became more detailed and, although costly, was regarded as a good investment for understanding service delivery. Language changed to become more simple over time.
 - The duration of contracts increased over time; but the ability of purchasers to negotiate long-term contracts was limited by competition law and the existence of annual funding agreements between the Minister and purchasers.
 - The inclusion of quality measures in contracts contributed towards the development of a culture of quality in service provision.
 - In terms of **relationships**, purchasers were widely regarded as having the greater power; and purchasers and providers consistently interpreted their relationships differently. However, over time they worked more closely together and relationships generally improved. *Good relationships are seen as the key to successful contracting.* However, development of effective relationships could be seriously interrupted by continual organizational restructuring and changes in key personnel.
 - A variety of approaches were used to **monitor** contract performance. Providers expressed concerns over the quantity of information required by purchasers and a view that information provided disappeared into a black hole. Purchasers considered that good relationships with providers were as important in ensuring contract performance as any formal contract monitoring arrangement.
 - The ability to hold providers to **account** was affected by the political and market environments in which contracting takes place. The overall approach to contracting, the degree of competition, the financial position of providers and the commitment of politicians in a public system will all affect the role of contracts in improving accountability.

INTRODUCTION

In the last decade of the last century, New Zealand initiated substantial reforms within its health sector. The planning for the most significant of these reforms commenced in 1991, when a ministerial taskforce recommended the restructuring of the public health sector to establish “buyers” and “sellers” through the separation of the roles of purchasing and providing services (that is, a purchaser-provider “split”), using contracts to secure services. The main objectives of the restructuring were to improve the efficiency, flexibility and innovation of health care delivery; reduce waiting times, and widen the choice of hospitals and health services for consumers (Upton 1991). The reforms were in line with the market-oriented reforms that had been taking place in the wider New Zealand economy.

These health reforms were implemented in 1993 and contracting became a central part of the management of the health system in New Zealand. Although the use of contracts in the sector had started in earlier periods, as a result of these reforms contracts were used much more extensively and became the main mechanism for buying services using public funds, irrespective of whether the provider of the services was publicly-owned or private.

It is worth recognizing that this report primarily focuses on the ten year period 1990-2000, when the use of contracts in the New Zealand health system was most extensive, particularly within the public health system. Readers should understand that since this time, a change in government has resulted in a further restructuring of the health sector, with the establishment of local District Health Boards responsible for organising health care in their districts. More general service agreements are used between the Minister and the District Health Boards, but the formal purchaser-provider

split has been removed for secondary care services delivered by publicly-owned hospitals. This has resulted in much reduced use of contracts as formal mechanisms within the public sector. Contracting remains between District Health Boards and community-based providers, including primary care providers, although the contracting approach that will be used by these Boards has not yet been fully developed. Despite these recent changes, the experience that New Zealand has gained during this earlier period is worth studying, in order to identify lessons that may be of value to others.

This report focuses on (a) contracts, rather than sub-contracts, and (b) contracts for clinical services rather than for either non-clinical services or for components of services. Information in this report comes primarily from three separate sets of interviews with key contracting personnel, covering both purchasers and providers. A brief summary of these three sources of information is provided in the annex on methods on page 77.

As a final point, it is important to note that the New Zealand health system, like all health systems, has a history and country context and a number of specific organizational names and other terms. Some knowledge of these factors is necessary in order to understand more fully the analysis of the issues presented in this report. Readers are therefore urged to first read through the list of abbreviations (page 9), the glossary of key terms (page 13), and the country health system context in chapter 1 (page 15), before being tempted to delve directly into specific sections of this report. A more comprehensive understanding of the issues will be gained if the report is read in the order presented.

ABBREVIATIONS

ACC

Accident Compensation Corporation. ACC is the state-owned insurer that administers New Zealand's accident compensation scheme that provides 24-hour no-fault personal accident insurance cover for all New Zealand citizens, residents and temporary visitors to New Zealand. Part of ACC's role is to buy health and disability support services to treat, care for and rehabilitate eligible injured people. (Further information: <http://www.acc.org.nz>.)

AHBs

Area Health Boards. Prior to 1993 when they were disestablished, fourteen AHBs were provided with block budgets to provide secondary and tertiary services and public health services for the people within their geographic areas.

CCMAU

The Crown Company Monitoring Advisory Unit – responsible for monitoring the performance of Crown Health Enterprises (CHEs). As part of the most recent reforms, on 1 August 2000 CCMAU's health ownership monitoring functions were transferred to the Ministry of Health. (Further information: <http://www.ccm.au.govt.nz>)

CHEs

Crown Health Enterprises. State-owned organizations established in 1993 which provided hospital-based services, a selection of community-based services and (sometimes) a range of public health services. Renamed hospital and health services (HHSs) in 1997.

DRGs

Diagnosis related groups. A measure of case mix in which hospital episodes of care are classified according to their expected resource use.

DHBs

District Health Boards. Each of the 21 DHBs is responsible for organising the provision of health services for its local population in a specific geographical area. They purchase community-based services and provide hospital and some other services through hospitals they own (formally CHes and HHSs, now called the provider-arm of DHBs). The DHBs have existed since 1 January 2001 when the New Zealand Public Health and Disability Act 2000 came into force. (Further information on DHBs can be obtained through the Ministry of Health website: <http://www.moh.govt.nz/>)

GPs

General practitioners (family doctors). GPs are registered medical practitioners who provide community-based, first level general medical care to service users (patients), often referring service users on to other primary care providers for diagnostic services, such as X-rays and laboratory services, for pharmaceuticals dispensed by community pharmacies, as well as for hospital care.

HBL

Health Benefits Ltd. A national organization that manages the payment process for primary care services. Providers fill in claim forms or electronically claim payments that HBL then pays out to providers. HBL is now part of a group called Health Payments, Agreements and Compliance (HealthPAC). (Further information: <http://www.hbl.co.nz> or <http://www.moh.govt.nz/healthpac>)

HHSs

Hospital and Health Services The name given to state-owned hospitals between 1997 and 2000. Previously called CHes and, from 2001, the provider-arm of DHBs.

IPAs

Independent Practitioner Associations. Umbrella organizations representing groups of general practitioners (and sometimes other primary health providers), with whom purchasers negotiate contracts in general practice and primary care.

NGOs

Non-government organizations. Most of these are funded partly by the government and partly privately, often through donations. In New Zealand, the term applies to not-for-profit non-government organizations.

PHARMAC

The Pharmaceutical Management Agency. A Crown-owned entity responsible for managing the New Zealand Pharmaceutical Schedule on behalf of the Crown. (Further information: <http://www.pharmac.govt.nz>)

PHC

The Public Health Commission. Responsible for purchasing public health services between 1993 and 1995, when it was disestablished and the Ministry of Health and the RHAs took over its various functions.

RFP

Request for Proposal. A method used by purchasers to invite providers to tender for services.

RHAs

Regional Health Authorities. Four regional purchasing organizations, in place between 1993 and 1997. In 1997, the four RHAs were merged into one purchaser, the Health Funding Authority (HFA), which existed until December 2000 when its policy functions were transferred to the Ministry of Health and its purchasing functions were transferred to new district health boards (DHBs).



GLOSSARY OF KEY TERMS

Agreements and Contracts – This document has attempted to distinguish, for the clarity and benefit of the reader, between an ‘agreement’ and a ‘contract’. A ‘contract’ is a legally enforceable agreement, and therefore a contract is regarded as legally binding and specifies consequences for a breach of contract, etc; where it is not legally enforceable, ‘agreement’ has been used. The term ‘**contracting**’, however, has also been used in a generic sense in this document, and basically refers to the process of reaching an agreement between the parties, irrespective of whether a contract or an agreement is the specific outcome of the contracting process.

Base contract – The part of a contract that includes standard terms and conditions, often applying across many providers. Each provider would then have a unique service schedule attached to the base contract setting out service specifications and prices. Schedules could be negotiated more frequently than base contract terms and conditions.

Block budget/Block contract/Block grant – A provider is paid a global/total amount to provide services for a fixed period of time (usually one year).

Capitation – A provider is paid a flat amount for each person registered with them. Capitated payments are usually weighted so that providers receive a higher amount for people with higher needs (e.g. young children, older adults).

Contestable purchasing – Where a purchaser enables a number of providers to tender for a contract to provide services.

Copayments – Charges paid by patients when they obtain a health service. These are charged in primary care for general practitioner services and pharmaceuticals.

The Crown – New Zealand’s head of State is the King or Queen of England, represented in New Zealand by the Governor-General. Thus, the Crown is the term used in New Zealand for the State. However, it should be

distinguished that the State is not the government of the day for the State is politically neutral, but it is the government of the day that makes commitments on behalf of the Crown.

Cultural safety – Where organizations or services are delivered in ways that recognise that people have different understandings and needs depending on their culture. This is particularly important in relation to delivering services to Māori.

Evergreen contract – A core part of a contract that continues on for many years with little or no renegotiation of clauses. Usually evergreen base contracts contain general clauses pertaining to service delivery and other requirements. They are then accompanied by Schedules that are renegotiated more frequently, usually containing clauses relating to the price and volume of services. Evergreen base contracts reduce transaction costs by putting ongoing requirements into a contract that does not need to be renegotiated each year.

Funding agreements – Agreements between the Minister of Health and the purchasing authorities.

Funding authorities or **Purchasing authorities** – Generic terms that refer to RHAs, the PHC, the HFA, ACC and DHBs.

Māori – The indigenous people of New Zealand. Relationships between Māori and the Crown are governed by a Treaty, The Treaty of Waitangi, which gives Māori particular rights in New Zealand.

Public providers – Publicly-owned providers, that is, AHBs, CHEs, HHSs and provider-arms of DHBs.

Provider-arm of DHBs – The organizational part of a DHB that is responsible for providing health care services.

Purchaser-arm of DHBs – The organizational part of a DHB that is responsible for purchasing health care services for the people in its district.

Purchaser/provider split – The separation of purchasing and provision functions, formerly undertaken by one organization, into separate organizations. Aimed at ensuring agencies have a focus on only one set of activities and at facilitating arms-length contracting and increased competition between providers for contracts.

COUNTRY CONTEXT

1.1 Background

New Zealand is located in the south west Pacific region, about 2000 kilometres off the south east coast of Australia. It has a population of almost 4 million, about 80% of whom are of European (mostly British) descent. The indigenous Māori people and their descendants make up almost 15% of the population, while Asians and Pacific Island Polynesians make up 6.6% and 6.4% respectively. The health status of both Māori and Pacific Island people is generally poorer than that of the rest of the population.

A tax-funded public health system has been in place since 1938. Most hospital services are provided free of charge in a network of state-owned hospitals. There are in addition numerous small private hospitals that provide mainly long-term care for the elderly and privately-funded elective surgery. Doctors and other health professionals working in public hospitals are salaried. Most specialists also work part-time as private consultants on a fee-for-service basis. They have their own separate consulting rooms outside the public hospitals, and use private hospitals or facilities when they need to undertake operations or procedures.

Primary medical services are delivered by general practitioners (GPs, also known as family doctors), mainly on a fee-for-service basis. GP services are fully subsidised by the State for children aged under 6 years and partially subsidised for low income groups and high users. GPs act as the principal gatekeepers for referral to the public hospital

system and to other fully or partially subsidised services such as laboratory tests, pharmaceuticals, physiotherapy and diagnostic imaging. Primary health services are also provided by various allied health professionals such as midwives, independent nurse practitioners and public health nurses. Non-government organizations (NGOs) provide a variety of community-based services including well-child care, disability-support (i.e. social care) services, and various types of consumer support services.¹

The public health system has been completely restructured twice over the past decade, first in 1993 and again in 2001. Although some contracting for clinical and non-clinical services took place prior to 1993, the primary focus of this study is on the seven year period between the two rounds of reform. During this period, the use of contracts and agreements substantially increased as the principal way in which public funds could be used to secure services for the public, irrespective of whether a service was provided by a public or private provider.

New Zealand has a separate compulsory social insurance system for funding accident-related care. The Accident Compensation Corporation (ACC) funds medical care for accident-related injuries. ACC has also in recent years established clearer contractual arrangements with providers of health services for accident-related injuries.

1.2 Organization of health services before 1993

Prior to 1993, fourteen area health boards (AHBs) were provided with population-based block budgets to provide secondary and tertiary services and public health services for the people within their geographic areas. Boards were governed by majority-elected members and had a high degree of autonomy. Primary health services and NGOs were funded separately by the Department of Health, the former primarily on a fee-for-service basis and the latter through block grants. Other services, such as long-term residential care, were funded partially through social security subsidies means-tested to the patient, with the same subsidy levels being paid for patients in both for-profit or not-for-profit organizations.

¹ Examples include the New Zealand Family Planning Association, the Society for the Intellectually Handicapped, the New Zealand Plunket Society (which provides well child services for infants) and the Royal New Zealand Foundation for the Blind.

During the late 1980s and early 1990s, the government implemented a programme of rapid and significant economic and social reform, the general trend being towards deregulation and a greater reliance on market mechanisms. Major initiatives included the removal of industrial and export subsidies, and deregulation of the labour and capital markets. In the public sector, state trading departments were corporatised (i.e. turned into profit-focused but still government-owned organizations) or privatised (i.e. sold from public ownership into private ownership). Other government departments were restructured and new accountability mechanisms were introduced. For those entities that remained part of the public sector (notably the government departments), the reforms allowed more autonomy over day to day decisions, but held chief executives more tightly to account with a focus on performance and linking expenditure to agreed outputs.

In line with these public sector reforms, at the end of 1989 a *New Zealand Health Charter* was introduced, which laid out a set of principles to guide the public health system (Clark 1989). At the same time, a set of *New Zealand Health Goals and Targets* was published, which identified health status objectives in key areas. From 1990, each AHB was required to sign an agreement with the Minister that specified the range of services they planned to provide, together with a set of performance indicators. The purpose of these agreements was to ensure that the AHBs' activities were consistent with both the charter and the goals and targets, and to improve the general accountability of the boards. This did not mean that expenditure would be linked to a board's level of output: while the agreement did include some rather crude measures of particular outputs, most service outputs remained unspecified and unmonitored, and quality measures were absent. Instead the agreements were based on operating plans agreed with the Minister, which were consistent with the boards' five-year strategic plans. Thus a key objective of this contracting process was to make explicit the planning, as opposed to the actual provision, of services. A board's performance was then measured against the agreed plan.

The Department of Health also began to draw up more formal contracts with some NGOs. These contracts specified (in broad terms): the relationship between the parties, a broad description of the services to be provided, the price to be paid and manner of payment, and reporting requirements to the Department of Health. Most contracts

were block contracts in which levels of provision were specified in terms of inputs – usually the amount of time to be provided by different types of health professionals – rather than outputs. Thus wage rates were effectively set by the government as the purchasing agent. Contracts could then be monitored simply through a review of wage records.

By the end of the 1980s the Department of Health moved increasingly towards the linking of expenditure with outputs in these agreements and contracts in line with the state sector reforms more generally. By 1991/92, both price and volume of services were negotiated with all independent service providers. Volumes were usually determined according to historic trends rather than by any explicit decisions by the Department to shift resources across services. Much of the detail about the nature and quality of service was left to the discretion of the provider. The Department had neither the information systems nor the resources to monitor effectively the performance of contracted providers.

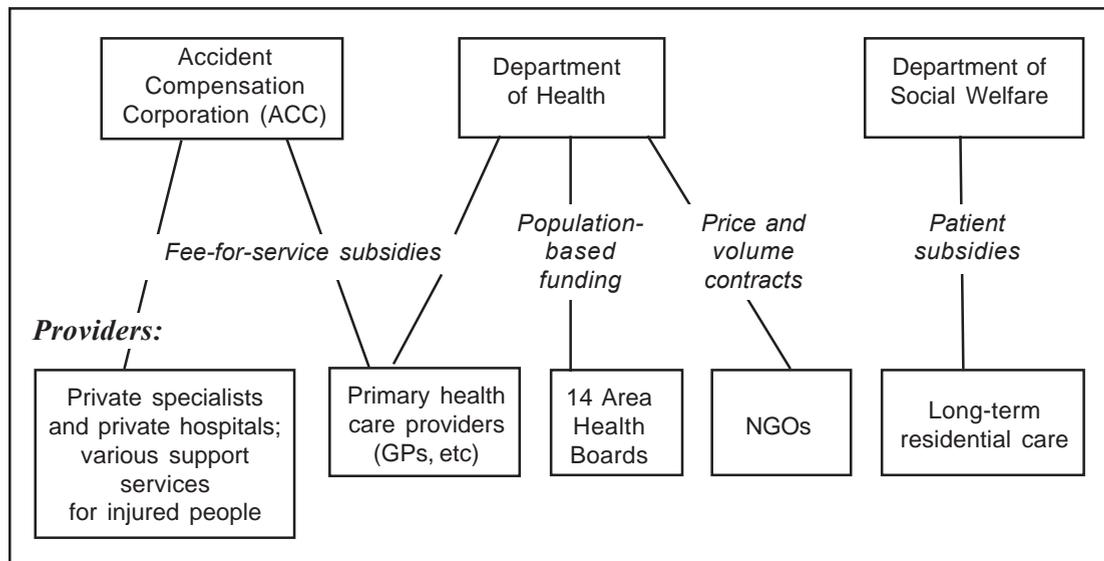
Change was also taking place in the funding of primary care. Since 1941 fee-for-service subsidies had been paid for GP consultations, pursuant to social security regulations.² In 1990, the Minister of Health introduced voluntary contracts for GPs, which offered inflation-indexed subsidies for general practice consultations (excluding those related to injured patients, which had been paid for separately since 1971 with the introduction of the ACC scheme). In return, GPs agreed to keep patient copayments below a set of maximum limits, and to provide the government with specific information about utilisation rates within their practice. The General Practitioners' Association saw the move as an attempt to control their clinical and economic freedom and urged GPs to reject the offer outright. Take-up was slow initially but gradually began to accelerate. By November 1990 when a general election took place it was estimated that almost 10% of GPs had signed contracts. However the election brought a change of government and the incoming Minister of Health immediately abolished these contracts. All GPs returned to the previous non-inflation-indexed subsidy arrangements.

² A small percentage of GPs choose to have their patient subsidies paid in the form of capitation payments rather than on a fee-for-service basis.

The new Minister also appointed a taskforce to review the structure of the public health system. The recommendations of the taskforce were included in a Ministerial policy statement presented on budget night in

July 1991 (Upton 1991) and the elected area health boards were summarily dismissed. After two hectic years of preparation, the restructured system was introduced in July 1993.

Figure 1: Structure of the Public Health System Before 1993



1.3 The 1993 reforms

The recommendations of the taskforce were in line with the market-oriented reforms that had been taking place in the wider economy. The central feature of the restructuring was the establishment of “buyers” and “sellers” through the separation of the roles of purchasing and providing services. The main objectives of the restructuring were to improve the efficiency, flexibility and innovation of health care delivery; reduce waiting times, and widen the choice of hospitals and health services for consumers (Upton 1991).

The Department of Health became the Ministry of Health³, its focus to be on policy development. On the purchaser side, four Regional Health Authorities (RHAs) were set up to purchase all primary, secondary and tertiary health and disability support (i.e. social care) services. In effect, this meant that all government funding for personal health services was integrated into a single budget, and that this budget was capped, including the previously open-ended

³ For further information about the Ministry of Health and the New Zealand health sector, please refer to: <http://www.moh.govt.nz>

fee-for-service primary care payments. The funding for public health services was “unbundled” (i.e. separated out) from the old area health board budgets and a separate purchaser, the Public Health Commission (PHC), was established to purchase these services. However, the Public Health Commission was abolished after only two years in existence. Its roles were transferred to the RHAs and to a Public Health unit within the Ministry of Health.

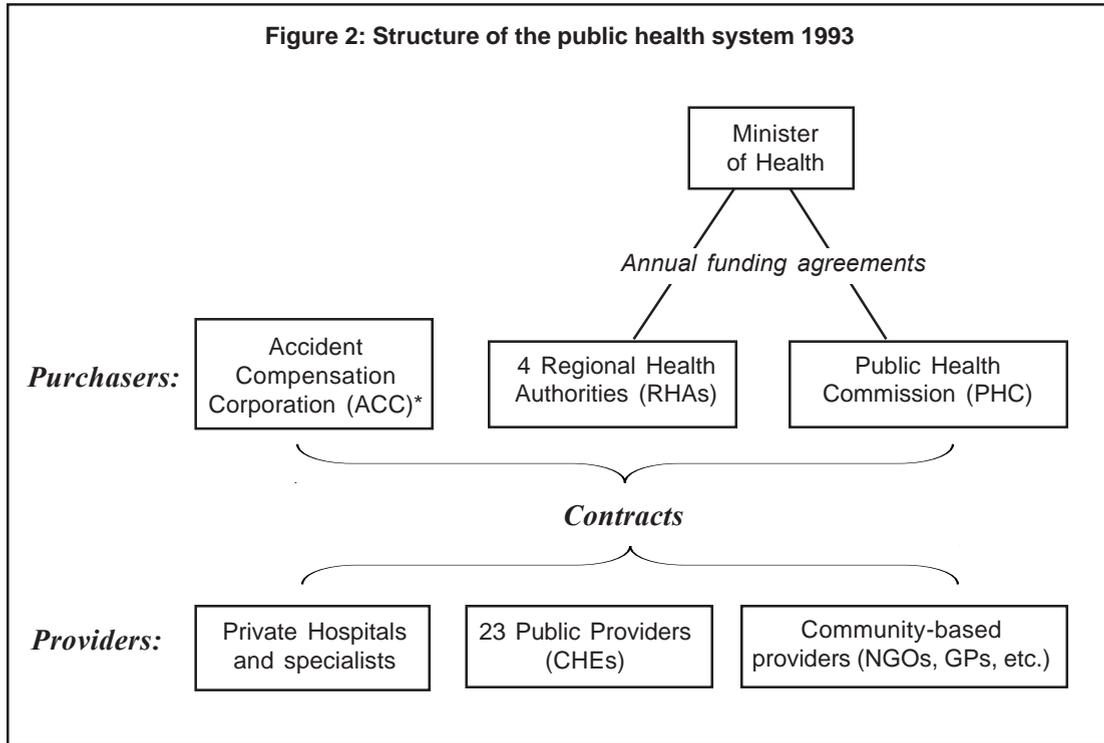
The original intention had been for the RHAs to take over responsibility for purchasing all ACC services (i.e. medical care for accident-related injuries). However, because the ACC also insures against income losses incurred as a result of an accident, it wished to maintain control over purchasing these services so as to ensure timely intervention, especially surgery, following an accident. Therefore ACC retained the right to buy services for injured people, and in addition ACC contributes to the costs of emergency care of injured people treated in public hospitals, through an annual payment back to the Crown for the estimated costs of this care.

On the provider side, the services previously provided by the 14 AHBs were reconfigured under 23 Crown Health Enterprises (CHEs) which were to contract with RHAs and the ACC to provide services alongside private hospitals and other private providers. CHEs were structured as for-profit companies and, under the Health and Disability Services Act 1993 (section 11), were required to “be as successful and efficient as comparable businesses that are not owned by the Crown”. All contracts were intended to be legally binding, including those between the public purchasers and public providers (i.e. CHEs).⁴

The separation of responsibilities between purchaser and provider extended up to the ministerial level, with the public purchasers being accountable to the Minister of Health and public providers (CHEs) being accountable to the Minister of Crown Health Enterprises. The Crown’s interest in the CHEs was vested in two shareholding ministers – the Minister of Finance and the Minister of Crown Health Enterprises. Political control was therefore separated into purchasing responsibilities through the Minister of Health, and ‘ownership’ responsibilities (ensuring CHEs operated as successful businesses) through the Ministers of Finance and Crown Health Enterprises. Each CHE had a board of directors appointed by the shareholding ministers.

⁴ The legislative framework is described in detail in Chapter 2.2.

Figure 2: Structure of the public health system 1993



(*Note: ACC continued to make a number of fee-for-service payments, pursuant to Regulations, where contracts were not put in place with providers.)

Private providers that contracted with purchasers for the provision of publicly-funded services included primary health providers as individuals or in group practices (general practitioners, pharmacists, community laboratories, dentists, etc.); NGOs; providers of long-term care for the elderly (i.e. rest homes and private geriatric hospitals); independent private specialists; and private hospitals. These providers could contract with the purchasers directly or via an umbrella organization, or sub-contract through other providers, especially CHEs.

1.4 Adjustments in 1997-1998

Some changes to this basic structure were made following another general election at the end of 1996, when the National government was returned to power, but with far fewer votes and only through the formation of a coalition government. The purchaser/provider split was retained, but any emphasis on what remained of competitive

contracting was removed. The four RHAs were disestablished in 1997 and replaced by a temporary organization (the Transitional Health Authority) to facilitate the merging of RHA purchasing responsibilities into a single national purchasing organization, the Health Funding Authority (HFA). The purpose of this was both to reduce the costs of contracting and to reduce regional inequities. The CHEs were also reconfigured into not-for-profit organizations called Hospitals and Health Services (HHSs) (still government-owned). The intention here was for the “principles of public service to replace commercial profit objectives” (Coalition Government 1996). However the HHSs still provided the same services and were still required to perform financially in the same way as not-for-profit private companies.

1.5 Reforms of 2000

At the end of 1999, following a general election, a new Labour-led coalition government came into power. The coalition partners were philosophically opposed to competition in the health sector and public confidence in the public health system was very low. A major policy plank of the Labour party was therefore to abandon what remained of competitive contracting for services between purchasers and providers and to return to democratically-elected local health boards.

The HHSs were therefore restructured into 21 District Health Boards (DHBs) which formally came into existence on 1 January 2001. The HFA was abolished in December 2000 and its roles were transferred to either the DHBs or the Ministry of Health. The DHBs will (from July 2003) be funded on a weighted population-basis, their role being either to purchase or to provide government-funded health services for a geographically defined population (Ministry of Health 2001). Thus while the purchaser/provider split has been abolished for services that are publicly-owned, the DHBs still purchase services from non-government providers through contracts. The Ministry of Health has initially retained responsibility for purchasing some services (such as public health services and disability support services). However the intention is to devolve responsibility for all services to DHBs over time. Medical care provided in hospitals for accident-related injuries will continue to be purchased separately by the ACC.

THE CONTRACTING PROCESS

2.1 Introduction

The ongoing changes that occurred in the structure of the New Zealand health system during the 1990s created a rather unstable contracting environment. The introduction of the purchaser/provider split in 1993, and the replacement of the four RHAs by the HFA in 1997/98, both resulted in changes of personnel in key positions, a breakdown of many established personal relationships, a loss of contracting skills and institutional knowledge and, most importantly, the introduction of new purchasing strategies. Contracting for health services in New Zealand has therefore featured a range of different approaches with national consistency across regions and across services gradually increasing over time.

Key factors that shaped the contracting environment and the processes within it were: the legal framework, funding constraints, and the cultural and professional norms of contracting personnel. While some of these personnel were people who had previously worked in the public health system (including some clinical staff) the new structures also brought in a new layer of management and legal personnel from the private sector, thus bringing a more commercial orientation into the health system.

2.2 The legal framework for contracting

The structure put into place in 1993 was governed by the Health and Disability Services Act 1993. The primary effect, in legal terms, of the Act was to formalise the

purchaser/provider split and to give independent legal status and contractual capacity to the new purchasing and providing agencies. The RHAs were established as separate legal entities from the Ministry of Health. Public hospitals became state owned enterprises incorporated under the Companies Act – the same legislation as governs privately-owned companies in New Zealand. Political controls were placed at a distance from purchasing decisions (ministerial objectives were set via funding agreements), and at arm’s length from service provision so that shareholding ministers would have input only via statements of corporate intent (i.e. business strategies developed by the public providers and signed off by the shareholding ministers).

The Minister of Health signaled key health objectives and other requirements to purchasing authorities through statements of objectives (called funding agreements). In certain circumstances such agreements could have been construed as contractual in a legal sense, but the relationships between the Minister and the purchasing authorities were in fact primarily political. Any disputes were resolved politically and with little public discussion. In contrast, the relationships between the purchasing authorities and providers of health and disability services were, at least initially, primarily legal ones. The Health and Disability Services Act *required* that those relationships should be governed by contractual mechanisms. Such contracts had full legal status, could be enforceable in the Courts, and were subject to New Zealand’s general competition law controls in the Commerce Act 1986.⁵ The ordinary private law of contract was to be the primary mechanism of accountability and control and the purchasers were to monitor performance of the agreements.

⁵ The Commerce Act provides for a number of potential regulatory interventions to control the inappropriate use of monopsony or monopoly power and/or to promote competition. It applies across all sectors of the economy, and gives power to an independent Commerce Commission (refer to <http://www.comcom.govt.nz/>) to take action against anticompetitive behaviour by any seller or buyer. The RHAs were exempt from this Act only for the first year of their operation.

The Health and Disability Services Act (section 40) also included the requirement that the public providers must provide a service if instructed to do so by the Minister, even if there was a dispute over the price paid for that service. The purpose of this was to ensure the provision of essential services in the event that other providers could not, or would not, provide them.

The Commerce Act 1986, as it applied at that time, had important implications for the health sector. It rendered invalid any clauses in contracts that had the purpose of substantially lessening competition in the market. It was irrelevant for the purposes of the Act whether that was the *effect* of such clauses. In particular, contractual clauses

fixing, controlling, or maintaining prices were deemed substantially to lessen competition. Also of particular relevance to the health sector, the Commerce Act invalidated contractual clauses that were the product of two or more persons who were in competition with each other acting together for the purpose of restricting the supply or acquisition of goods or services (section 29). This provision impacted both on attempts by the RHAs to work together to contract for services and on providers' attempts to cooperate. They were each able to avail themselves of the exceptions in the Commerce Act although, in practice, a wider range of exceptions was available to providers than to the purchasers. The exceptions allowed entities to incorporate, form joint ventures or to cooperate in groups of 50 or more. The 4 RHAs were able to avail themselves of an exception by incorporating the Pharmaceutical Management Agency (PHARMAC) as a vehicle for making pharmaceutical subsidy decisions for all 4 RHAs. Providers had additional vehicles for collective action, being able to form, for example, Independent Practitioner Associations (IPAs) and umbrella groups through which to consult with purchasers.

The Health and Disability Services Act 1993 also provided a mechanism for the use of standard form contracts (section 51 of that Act). Section 51 allowed for the purchaser to specify terms and conditions without the agreement of, or prior negotiation with, any particular provider. These terms and conditions could be notified to individual providers or published generally. If a provider accepted any payment for specified services notified under a Section 51 notice, then the provider was deemed to have accepted those terms and conditions, and the Act deemed these arrangements to be contractual. This was used primarily to regulate relationships with GPs in the delivery of primary care, particularly in the initial stages of implementing the purchaser/provider split in 1993, because the previous legislation that enabled payments to general practitioners was repealed when the Health and Disability Services Act was passed into law.

The Health and Disability Services Act also placed a number of requirements on the purchasing authorities that later impacted on contracting. The most obvious was in relation to requirements for purchasing authorities to consult with communities about which services to provide. Such consultation is taken seriously in New Zealand, for

the Courts have found against those organizations that have not adequately consulted, or where there has been only token consultation.

Other relevant legislation

Other legislation that was not introduced specifically as part of the 1993 health reforms but which had some relevance for the contracting process includes:

- The Public Finance Act 1989. This includes financial reporting requirements that apply to both the purchasers and publicly owned providers. The Office of the Controller and Auditor General⁶ exercises authority under the Act. It has the power to monitor the contracting practices of any organization that is owned by the Crown and regularly reports on health contracting issues.
- The Ombudsmen Act 1962 and the Official Information Act 1982. The Ombudsmen⁷ exercise a complaints jurisdiction and monitoring role over “matters of administration” for the whole of Government, and this includes those health organizations that are owned by the Crown. Their role is to ensure that public decision making processes are fair. The Ombudsmen also oversee issues relating to official information, with the Official Information Act aimed at ensuring that information pertaining to government is reasonably accessible.
- The Health Information Privacy Code governs the collection and use of health information. The Privacy Commissioner⁸ exercises jurisdiction over the health information privacy code.
- The Code of Health and Disability Services Consumers’ Rights. The Health and Disability Commissioner⁹ hears complaints about standards of services actually delivered and about breaches of the Code. The Commissioner has no jurisdiction over issues of what services should be funded, however.

⁶ For further information, please refer to: <http://www.oag.govt.nz/>

⁷ For further information, please refer to: <http://www.ombudsmen.govt.nz/>

⁸ For further information, please refer to: <http://www.privacy.org.nz>

⁹ For further information, please refer to: <http://www.hdc.org.nz/>

2.3 Purchasing methods

The annual funding agreements that each of the purchasers (the four RHAs and the PHC) signed with the Minister were based upon a set of Crown objectives. These Crown objectives included:

- six principles upon which purchase decisions should be based: equity, effectiveness, efficiency, safety, acceptability, and risk management
- four health gain priority areas (child health, Māori health, mental health and physical environment health)
- a set of service obligations, which defined, in very broad terms:
 - the range of services to be purchased
 - coverage and/or terms of access to these services
 - standards for safety and quality.

Chapter 3.5 discusses the role these objectives played in contracting.

In addition, each purchaser was required to adhere to a set of Policy Guidelines drawn up annually by the Minister of Health (Upton 1992; Shipley 1994, undated-a, undated-b). Again, these were very broad guidelines that described some elements of the purchasing process. They included, for example, the purchasers' relationships with other public organizations, some implementation strategies (including strategies for quality improvement, provider development and exit by Public Providers¹⁰), and the monitoring and accountability requirements of the purchasing organizations.

While the Policy Guidelines provided some direction on the broad approaches to purchasing, purchasers were given very little assistance on how to go about purchasing services through contracts. For example, there were no national guidelines on how detailed service specifications should be for contract purposes, how to set prices, or how and when it might be appropriate to use contestable purchasing strategies. The RHAs and the PHC therefore had considerable freedom to set their own service priorities and to negotiate contracts and set reimbursement mechanisms as they saw fit. Thus each of the purchasers developed its own purchasing strategy.

¹⁰ Throughout the 1990 – 2000 reform period, the name of the public organizations (which provide hospital services, community services and some public health services) has changed four times from Area Health Boards (to 1993), to Crown Health Enterprises (1993 – 1997), to Hospitals and Health Services (1997 – 2000) and finally to the provider arm of the District Health Boards. To avoid confusion, these organizations will be referred to as Public Providers throughout the remainder of this report.

The tendency of the RHAs in the first couple of years was to look to commercial models of contracting for guidance. This resulted in very lengthy processes (sometimes as long as two years) in drafting contracts. It also resulted in styles of contracting that were often characterised by vigorous bargaining and adversarial relationships, especially with respect to the Public Providers where there were tight funding constraints. Contract negotiations were therefore more prolonged than had been anticipated and many providers continued to provide services, sometimes for some considerable length of time, without having signed any formal contract. The Ministry of Health attributed these delays in the contracting process to a number of factors including a slow start to the contracting process as RHAs established themselves and their procedures; a lack of cooperation in purchaser/provider relationships; and difficulties in service specification (Performance Monitoring and Review undated).

The approach to contracting changed somewhat following the replacement of the four RHAs with a single purchaser, the HFA. The HFA pursued a more relational style of contracting, working more closely with key provider groups to develop standard terms and conditions that could be applied nationally across a wide range of providers.

Contracting with Public Providers

In the first year (1993/94), roll-over arrangements applied for all of the Public Providers, with funding and service levels being based upon historical trends to allow for a settling in period. The Midland and Northern RHAs then adopted a two-stage approach to contracting for services provided by the Public Providers, with separate contracts being negotiated for each individual service. A base contract, which set out standard terms and conditions, was negotiated first. Once this had been agreed, a set of service schedules specifying volumes and prices was then negotiated.¹¹

The other two RHAs adopted a one-stage approach with details of the volumes and prices of individual services being specified either within the body of the main contract or as separate schedules. While the method of negotiation differed, the general outcome of these two approaches appeared to be very similar. For example, in all contracts there was some duplication and cross-referencing between

¹¹ Further details of the content of each section of the contracts are provided in Chapter 3.2.

the different parts of the contracts. In the Northern RHA where the base contracts were quite lengthy, the two-stage approach often resulted in long delays before the service agreements could be signed.

The establishment of the HFA in 1997/98 accelerated the trend towards greater national consistency in both service definitions and prices. The HFA developed (in consultation with providers) a National Service Framework that defined a common set of contract terms and conditions, service specifications, and a national pricing schedule based upon the estimated cost of “efficient” service provision. This standardisation of contract terms and conditions enabled Public Providers to sign up to a single base contract, with a set of schedules for each service.

Contracting with primary health care providers

One of the objectives of the purchaser/provider split was to control public spending on primary health services, which had historically been paid for on an open-ended, fee-for-service basis. Because the purchasers received a fixed amount of funding (i.e. they had “capped” budgets), they had a strong incentive to cap expenditure by providers. However Section 51 of the Health and Disability Services Act effectively allowed existing non-contractual fee-for-service payments to GPs and other primary health care providers to continue as before, until RHAs were able to negotiate specific contracts (see section 2.2 above). Contracting for many primary health care services therefore tended to develop relatively slowly, with a majority of primary health care providers continuing to operate under Section 51 agreements outside of the contracting regime.

Although some GPs volunteered to move to capitation payments, only one of the four RHAs made a concerted effort to encourage its general practitioners to accept capitation-based contracts. GPs in that region also expressed a willingness to move to a capitated payment regime. This one RHA and the GPs in that region were therefore able to work through the issues together in partnership, developing a pilot scheme that was acceptable to both parties. Other regional purchasers were less collaborative.

There were considerable delays in signing some of the contracts, and as a result rollover contracts (i.e. contracts with the same terms and conditions as previously agreed, which continue on with no new negotiations) or arrangements under Section 51 of the Health and Disability Services Act 1993 were sometimes in place for many months. Some GPs had no formal contract of any sort and so were continuing to provide services for a long time after their Section 51 agreements had expired.

Many GPs joined newly-established Independent Practitioner Associations (IPAs) which negotiated on behalf of GPs and which, as umbrella groups, helped to counter the imbalance in bargaining power between the GPs and the RHA as a single purchaser. Many of these IPAs negotiated “budget-holding” contracts that provided them with a pool of funds to cover the costs of some of the referred services prescribed by their members. Most of these budget-holding contracts covered only pharmaceuticals and/or laboratory services, but some also included related services such as practice nurse services, community nursing services, and minor elective surgical procedures.

Unlike the UK, where GP fundholding developed in a particular format following national guidelines, in New Zealand these budget-holding contracts were subject to few special regulations or guidelines. Each RHA was therefore free to negotiate with providers on such things as the setting of budgets, the size of budget-holding organizations, the coverage of budgets, or the use of savings. Although the intention was to move towards formula-based budgets as soon as possible, all RHAs calculated budgets according to historical expenditure. This was by necessity rather than by design, because only a minority of GPs had patient registers upon which capitated budgets could be based. Only one IPA carried the risk of overexpenditure. In all other cases, the risk stayed with the RHAs. However, in most (if not all) cases, savings (rather than losses) were made from these budget-holding contracts. These savings were usually shared between the purchaser and the provider, with use of the savings by providers being negotiated with the purchaser.

The move away from rigid, regulation-based fee-for-service payments that were only accessible by GPs (who are medically qualified) to contracts allowed new types of providers to bid for contracts. This was especially important for Māori providers and other community-based

organizations who wished to provide services that had not traditionally been publicly funded, or services that were more focused on prevention than on individual treatments. This also enabled some community-based organizations to engage GPs as their employees, to provide services in line with the organization's priorities, rather than having to have the GP as the principal party who collected subsidies for services rendered.

Contracting with non-government organizations (NGOs)

Contracting for services proved difficult for many NGOs (Performance Monitoring and Review undated). As not-for-profit organizations, which are often dependent upon voluntary donations and volunteer labour, they often did not have the information necessary to specify services in any detail or to determine service prices and volumes. They also often did not have the commercial orientation, the skills or the money to participate in a contestable contracting process.

The larger NGOs that provided services nationally found themselves negotiating with four different purchasers, each of which had a different approach to purchasing. This was not only costly in terms of contract negotiations. It also sometimes resulted in a single organization having to develop different quality measures and adhere to different information requirements in the different regions.

Contracting for public health services

The PHC, which was responsible for purchasing public health services between 1993 and 1995, developed its own purchasing strategies. Soon after its establishment it undertook a major consultation exercise on the strategic direction for public health. It then developed a set of national goals, objectives and targets, which guided its purchasing decisions (Public Health Commission 1994).

For services provided by the Public Providers, the PHC negotiated agreements with the RHAs to manage these contracts. However the PHC negotiated directly with providers for national services, and also for some services provided by smaller, private organizations. It generally issued Requests for Proposals (RFPs – see section 2.5)

from providers. However, this appears to have been more a response to the need to comply with the Commerce Act than to any perceived need to introduce a competitive element into the contracting process. Even so, the process unsettled some incumbent providers. It also imposed high costs on smaller providers who did not have the capacity to undertake a lot of extra paperwork.

2.4 Setting prices

For most services there was little real “negotiation” over prices. The usual process was for the purchaser to set a price. Where providers had few competitors (as was the case for many of the services provided by Public Providers), providers could attempt to negotiate a higher price. However this often resulted in protracted and costly negotiations. The purchasers were constrained by their fixed annual budgets and there was often a gap between what was judged to be a fair price and the money that the RHAs had available. This caused considerable anguish for some providers, especially Public Providers who were required to manage the associated risk. Their financial deficits generally increased accordingly.

As separate purchasers, the RHAs were required (under the competition-promoting provisions of the Commerce Act) to set their own prices for the services that they purchased. They did, however, undertake some inter-regional comparative work to inform the price-setting process and sometimes looked to international price-setting regimes for benchmarking purposes.

Where there were many providers, some purchasers chose to vary the price according to the perceived quality of individual providers. In the case of rest homes, for example, one purchaser negotiated a price per patient day with each individual provider; another specified a narrow band within which the standard price that they were willing to pay per patient day might vary.

2.5 Contestable purchasing strategies

Although purchasers sometimes used the threat of contestable purchasing as a lever for keeping prices down, in practice, the vast majority of contracts were placed with

incumbent providers (see section 2.6 for more on this point). Situations where contracts were made contestable included:

- where there were many providers and some surplus capacity (e.g. rest home services)
- where the purchaser wished to buy additional volumes on a spot contract basis (e.g. elective surgery)
- where there was money for a new service (e.g. community-based mental health services)
- where an existing provider was not providing an adequate quality of service.

In cases where there was money for new services, the purchasers would first consider how the money should be spent by reviewing their strategic plans and the Crown's objectives. The usual approach to contestable contracting was then a two-step process. First, the purchaser would call for expressions of interest. The purchasers all developed lists of potential providers for this purpose, plus they maintained a wide network of personal and professional contacts. The purchaser would then refine its purchase requirements and issue a Request for Proposal (RFP), inviting any interested parties to submit more detailed proposals. These RFPs were then evaluated by the purchaser according to a defined set of criteria covering dimensions such as quality of service provision and availability of support services as well as price.

Although the evaluation criteria were made available to providers, this information did not initially include the amount of money available for the service. Therefore providers sometimes spent a lot of time and money submitting proposals that could not be funded. However this changed under the HFA (and also the PHC) who announced how much money they had available for each new service.

The RHAs had different views about the use of contestable purchasing strategies for services that had traditionally been supplied by the Public Providers. The Northern RHA felt that, as a general rule, for existing services, including elective procedures, it was preferable to defer opening up contracts to alternative providers until the Public Providers were better established. In the northern region therefore, any contestable purchasing of services

was largely confined to spot contracts for additional elective procedures for which the Minister had allocated extra money in an attempt to cut waiting lists.

In contrast, the Midland RHA chose to apply a contestable purchasing process to baseline volumes of some selected services and procedures in the first year. However the RHA did not consult with providers about which services or procedures would be contestable. This led to threats of legal action by some Public Providers under section 34 of the Health and Disability Services Act 1993, which required RHAs "...to consult its intentions relating to the purchase of services". This resulted in the promulgation of consultation documents by the RHA, which outlined the various options for purchasing for each service or procedure and called for submissions from interested parties. The purchasing manager reported that this consultation process, together with the development of longer-term purchasing plans, had added another six months to the purchasing process. These early experiences with contestable contracting encouraged the Midland RHA to review its contestable purchasing programmes and to consult with providers about the implications and the options before making services contestable.

The use of contestable purchasing for elective surgical procedures opened up opportunities for private providers (i.e. hospitals and specialist clinics) to enter the market. However, only a handful of private providers were successful in winning contracts. This may have been simply because private providers were often not competitive: either their price was too high, or they were unable to provide the necessary support services. However private providers argued that, if their prices were higher than in the public sector, this was primarily because they did not have the same historical information as the Public Providers about the risk profile of patients. Public Providers were certainly resistant to sharing this type of information with potential competitors. It was therefore necessary for private providers to build a risk premium into their price. Private providers also argued that the contracting process was biased against them because the RHAs were under political pressure to contract with Public Providers in order to maintain their financial viability. The separation of ministerial responsibility for purchasers and providers therefore did not succeed in completely isolating purchasing decisions from those relating to public provider performance.

Over time, problems in negotiating contracts directly with RHAs encouraged many private providers to sub-contract with Public Providers. Although the RHAs still had to sign off any such sub-contracts, this process was considerably less complex for private providers, in part because Public Providers did not have the resources to support lengthy contract negotiations.

2.6 Changing providers

As a general rule, purchasers tended to avoid changing providers wherever possible. Reasons for this included:

- interruption of continuity of service for consumers (e.g. rest homes)
- the cost of staff redundancies
- fear of possible legal consequences
- the possibility of media coverage that could be detrimental to the organization.

Circumstances under which purchasers did change providers varied, but was most commonly a response to a concern about some aspect of the quality of service rather than the price. For example, ACC placed a contract for emergency helicopter services with a different provider when the incumbent failed to match the terms and conditions offered by the new provider. However subsequently ACC encouraged the two providers to work together, with the original provider subcontracting with the new provider for some services.

In some cases, an inability to agree on the price of a particular service resulted in a Public Provider deciding to withdraw from a service. Public Providers were monitored by the Crown Company Monitoring Advisory Unit (CCMAU), a unit of the Treasury (New Zealand's Ministry of Finance). This agency operated with a more business-oriented perspective, and tended to focus on the financial performance of the Public Providers and encouraged them to exit a service if they were not paid a fair price, or if any part of a service was not specified in the contract. Public Providers were required to give 6 months' notice if they intended to cease providing all or part of a service. The RHA/HFA would then usually call for tenders from other providers. Types of service where this occurred included palliative care, disability support equipment and wheelchair

services, and sexual health services. If there was a satisfactory bid at a cheaper price, the service would be transferred to the successful bidder. If not, then the Public Provider was required to continue providing the service, but usually for a higher price.

Changing contracts did not always result in service improvements. In one notable example, an RHA chose to contract with a different provider for the provision of artificial limbs. This led to a deterioration in the quality of service, and loud objections from consumers who suffered considerable pain and inconvenience as a result.

Changing contracts also sometimes presented problems in terms of access to patient information. Having lost a contract, some providers were reluctant to hand over patient records, or even to provide the new provider with basic information about the average risk profile of patients.

2.7 Developing contracting skills and knowledge

The new environment required contracting players to develop a set of skills and proficiencies previously unnecessary in the coordination of health services. Both purchasers and providers found themselves on a sharp learning curve.

As newly established organizations, the purchasers had an opportunity to build up their capacity by recruiting people with the appropriate skills, knowledge, or qualifications. Many of these people had a legal background. However it also included people (including some health professionals) who had worked in particular services and who therefore had some knowledge of the structure, organization and possibly even the cost of services generally, and this often included the development of business skills. In later years, some providers also pursued this strategy for building up their capacity by employing people who had previously worked within a purchaser organization.

After the first couple of years, the RHAs began to provide training programmes for new staff covering topics such as negotiating skills and cultural safety. While most providers involved in contracting reported that, initially at least, they learned largely “on the job”, purchasers did sometimes provide various types of assistance to them on an ad hoc basis. This included:

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- financial assistance to cover items such as legal expenses
 - training in writing proposals (especially for new Māori and Pacific providers)
 - resource kits explaining various steps in the contracting process
 - assistance with basic business skills.

In addition, Te Puni Kōkiri (the Ministry of Māori Development)¹² developed a resource kit to help ensure that Māori were better equipped to try and contract with the RHAs.

Some RHA contracts also included funding for provider development and capacity building more generally, and this often included the development of business skills.

2.8 Costs of contracting

Costs of contracting are associated with four phases of the contracting process. These are:

- establishing contacts with appropriate parties and acquiring the necessary information
- designing and negotiating contracts
- monitoring, enforcing and adhering to contracts
- avoiding and resolving conflict.

In New Zealand, the legislative obligation of purchasers to consult with the community added an additional layer of costs to the process (see section 2.9).

Resources required to undertake these activities included staff time, specialised capital equipment (such as computerised information technology), accounting and legal fees, consultancy fees, stationery, telephone and travel costs. Although various attempts have been made to estimate the magnitude of the contracting costs, they have proved very difficult to quantify. However a number of general points can be made.

First, although contracting costs were initially high, they generally declined over time. In the early days of the operation of the 1993 Act, contracts routinely ran to 300 pages (see section 3.2). Such contracts were drafted by

¹² For further information refer to : <http://www.tpk.govt.nz/>

private legal firms and covered every possible eventuality. As the funding system was centralised, and in particular with the formation of the single HFA from the four RHAs, these processes became much more standardised and came to be administered by bureaucrats rather than by lawyers in private firms. This had the effect of significantly reducing transaction costs.

Second, interview-based evidence suggests that the contractual processes imposed large costs, both administrative and economic, on small providers including not-for-profit providers. The protracted nature of the contractual negotiations, the weighty legal content (e.g. multiple clauses dealing with complex intellectual property issues) and the frequency with which they had to be revisited eliminated some groups from participating in the process. In other cases, such as drug programmes for needle disposal schemes, purchasers had to “create” private providers in the marketplace where none existed before.

Third, costs were obviously higher when negotiations were prolonged because purchasers and providers could not agree on some aspect of the contract. Prolonged negotiation was less common where purchasers and providers had worked together for some time and established a good working relationship¹³.

Fourth, contracting costs increased when purchasers pursued a contestable purchasing strategy in preference to negotiating only with preferred providers. These costs arose from having to search for potential providers, circulate information, assess proposals, and negotiate new contracts. There were also sometimes extra legal costs associated with the tendering process. These additional costs may be justified if an alternative provider is more efficient or can provide a better quality of service.

Fifth, for some providers the compliance costs of contracting were initially high. This depended in part upon the adequacy of a provider’s information and communication technology. While many providers reported the need for additional investment in information technology, the ongoing costs of monitoring declined once good data collection systems were in place. In the absence of appropriate information technology, staff time had to be diverted to collect the information manually.

¹³ This would include where: i) some trust is established between the two parties, and each regards the other as honest, fair and as having integrity; ii) there is faith that the provider will deliver what they are contracted to and that the purchaser will pay them on time and be reasonable and understanding if any difficult problems arise; and iii) each develops an understanding of the other’s position and the limitations of what can realistically be achieved in the negotiations.

It is important to note that some of the data collected for monitoring contracts is also useful for management purposes. However, there are still additional transaction costs associated with submitting information to the purchaser, especially where this information is required in a particular format.

A final point to note is that, in New Zealand, the waves of restructuring added to the costs of contracting because the restructuring process caused skills, experience and established purchaser/provider relationships to be lost.

2.9 Legal problems and issues surrounding the contracting process

Competition concerns

There were a number of points where contractual mechanisms conflicted with competition policy. One of the intended benefits of contracting was that providers would often know better than purchasers what kinds of services the community was using and would be able to feed that information into the contractual negotiations, so that there would not be an information imbalance between the purchasers and providers. There were two ways in which this caused difficulties.

First, the Health and Disability Services Act (section 34) imposed obligations on purchasers to consult local communities before making decisions about which services to provide. Voluntary organizations, ethnic communities, and community and other groups were required to be canvassed in order to assess population needs. However, the very people who were consulted were sometimes later seeking the contract to provide such services. This was especially true of the local Māori communities. The Auditor-General's office noted the problem that consultations as to population needs sometimes appeared to compromise the integrity of tendering and other contracting processes. Public law requirements of consultation and private law requirements of fair commercial processes were sometimes at odds.

Second, the private law governing tendering in New Zealand gives the initial invitation to tender certain binding contractual force. If a tenderer submits an attractive

proposal outside the terms of the original invitation and that is accepted, the common law considers that there has been an unfairness to the other tenderers whose tenders conformed to the original specification. Rather than providing a process by which purchasers and providers can negotiate about the preferred outcomes, the common law of tendering considerably constrains what can be the proper subject of that negotiation. Again, the public goal of using contracting processes to help determine population needs was sometimes in conflict with ideas of fairness in commercial law, and this could be particularly problematic where the health needs were quite broadly identified, while at the same time innovative ways of delivering the services were being encouraged/sought. The use of RFPs (which omitted terms such as price) was presumably an attempt by purchasers to avoid the inadvertent creation of legally binding relationships.

Transaction costs

One solution to the problem of the high transaction costs associated with contracting (and especially where the service provider has to invest heavily in particular facilities that cannot be used for non-health services) is to negotiate for a longer-term contract. In one case, a provider sought a ten year contract to fund a new secure mental health facility, as the provider was concerned about the considerable capital outlay that would be required for the new facility, and the provider considered that it needed some security in the level of income that it would receive for this service, at least for a period of time. The 10 year contract was disallowed by the Commerce Commission as in breach of competition policy and the term of the contract was reduced to 5 years so as not to provide too great a barrier to entry into the market (Commerce Commission decision 275).

Restrictions imposed by the Commerce Act on cooperation between different purchasers or cooperation between different providers also limited the extent to which the costs of negotiation between the two parties could be reduced.

Breach of contract

The ultimate penalties for a breach of contract are non-renewal or cancellation of contract. The evidence is that these measures did not tend to be used. Even when providers appeared not to be conforming to contractual terms, the solution was usually to renegotiate those terms in the next financial cycle. There is evidence of some providers being continually funded even when they consistently failed to comply with standards. One example is a rest home that continued to receive funding by way of subsidy even though it did not segregate disabled young people from patients requiring geriatric care (*Bettina Rest Home v Attorney-General* 1999).

The interests of patients

Legally, patients are not parties to the contracts between purchasers and providers and have no enforceable rights under them. In one case involving the breakdown of contractual negotiations, the Judge was moved to remark that it is always the patients who lose out when relationships fall apart in this sector (*New Zealand Licensed Resthomes*, 1999). Under New Zealand law, merely benefiting from a contract does not give a patient the right or power to enforce contract promises. In order to give a third party contractual rights, a contract must evidence an intent to confer enforceable rights on that party.

One possible emerging legal avenue by which patients may enforce such non-contractual rights is the public law doctrine of legitimate expectations. It has the potential to apply in cases where a public agency (such as a purchaser) makes a (non-contractual) promise to an individual.

A recent English House of Lords decision (which is regarded as a highly persuasive authority in the New Zealand courts) has raised the prospect that patients may sometimes have a legitimate expectation to be treated at a particular facility if a public authority has made a representation to an individual that they will be cared for there and the quality of alternative accommodation is unknown (*R v North and East Devon Health Authority, ex parte Coughlan*, 2000). The House of Lords suggested that such a promise must be honoured if the consequences to the authority are financial only. The full extent of that doctrine has not yet been accepted by the New Zealand

courts. The orthodox legal view over the period that is the focus of this report (1990-2000) was that patients were not parties to the contracts, and representations made to patients did not create legally enforceable expectations.

Key points from chapter 2

- The legal environment was complex. Competition law concerns were often at odds with other objectives.
- Purchasers were required to base their purchasing decisions on a set of Crown objectives and to adhere to a set of Policy Guidelines that loosely described some elements of the contracting process.
- Most contracts were placed with incumbent providers: changing providers can be costly and may interrupt continuity of service.
- Some private providers argued that it was difficult for them to win contracts because (a) they did not have information about the risk profile of patients previously treated in the public sector, and (b) the government did not want to undermine the financial viability of Public Providers.
- There was little real negotiation on price.

Strengths of the contracting process:

- Both purchasers and providers were encouraged to focus on costs and volumes of services.
- Contracting led to greater clarity of resource use through the specification of services within contracts.
- Contracting opened up opportunities for new styles of service provision from providers that had not traditionally received public funds for health services.

Problems with contracting:

- The legal framework encouraged an adversarial approach in the early years.
- There was a lack of good information on costs and volumes.
- There were high transaction costs, especially in the early years.
- Both purchasers and providers require particular skills, especially in terms of legal expertise and contract negotiation experience. This increases administration costs, especially if this experience is obtained from external parties/consultants.
- Contracting costs were increased by the ongoing restructuring of purchaser and provider organizations.
- It may be difficult to find providers willing to provide some services. The requirement for Public Providers to provide a service if requested to do so by the Minister could therefore be important.
- The interests of patients were often under-represented in contractual processes.



CONTRACT CONTENT AND FORM

3.1 Content of contracts

The first set of Policy Guidelines to Regional Health Authorities (1992) suggested that contracts should specify:

- The nature and level of services to be provided
- The location where services are to be delivered
- The facilities that will be employed
- The access criteria for particular services
- The speed with which patients are to be given access to services (waiting times)
- Quality measures/standards
- The means of monitoring the contract, including access to premises and data
- The price to be paid, and methods for billing and payment
- The duration of contract
- The scope for variation of contract terms
- The procedure for settling disputes.

Although the details of contracts differed, especially in the early years, most followed these broad guidelines. Other clauses that were often included covered:

- Termination criteria
- Liabilities of each party
- Conditions for assignment of responsibilities, sub-contracting or joint ventures.

3.2 Form of contracts

One of the four RHAs set out all of the information within the central body of the contract. In the other three regions, the contracts contained two sections: the base contract plus a set of service schedules. The base contract contained terms and conditions that were common across providers, such as payment processes, dispute procedures, sub-contracting arrangements, and (sometimes) intellectual property. Details that related to the specific provider were covered in the schedules. They included a description of the purchase units, volumes, price, and quality and information requirements. Both sections of the RHA contracts were customised for each type of service.

HFA contracts also followed this two-section format. However the development of a National Purchasing Framework, which set out a set of standard terms and conditions that could be applied nationally for all providers, meant that only the details of volumes, prices and quality requirements needed to be negotiated with individual providers.

Contract language varied among the RHAs, with the Northern and Midland RHAs initially using formal, legalistic terminology while the Southern RHA used plain English. The contracts tended to be very detailed and lengthy.¹⁴ Even the base contract, which contained the terms and conditions, was sometimes over 70 pages long. However by the third year of contracting, the contracts had become shorter and less detailed, with plain English replacing legalistic language in all regions.

¹⁴ One interviewee referred to an early contract for \$300,000 that was 148 pages long.

3.3 Specification of services

In the absence of any contracting guidelines, the unit of service could be specified in a variety of different ways. For example, in the case of hospital services, the purchase unit could be defined simply in terms of general statements about access to facilities (e.g. 'hospital services') secured through a block contract, or in terms of cases (using diagnosis-related groups (DRGs) or some other measure of case mix), or even bed days, procedures or any mix of these (or any other) measures of volume.

All of the purchasers attempted to disaggregate services, by separately describing and contracting for parts of services (e.g. diagnostic services, treatment, clinical support services, hotel services, etc.). However the degree of disaggregation and the method of achieving it differed across regions and across services. Disaggregation of services has the potential to improve accountability of providers, provide clearer price signals to the market, and enable purchasers to make decisions based upon the relative cost-effectiveness of different components of service. By the same token, disaggregation may reduce provider flexibility and could result in discontinuity of care across services, or in gaps in services if some components of service are omitted unintentionally.

Public Providers

Initially, each of the RHAs took a rather different approach to the way in which services provided by the Public Providers were defined for contract purposes. While the general direction was to link output more closely with a price, the level of aggregation of services differed across the four regions. The Northern RHA broke services down into highly aggregated units called 'Components of Service'. These defined the type of service, the population covered, quality measures, details of access and patient coordination, and expected health outcomes. Contracts included crude indicators of expected utilisation rates based upon previous levels of throughput (such as bed days or number of discharges). Details of case mix were not specified in these early contracts and Components of Service did not have either a common description or a common price across providers.

In contrast, the Southern RHA used a case-based purchasing strategy in which providers were requested to indicate the price they wished to receive for each diagnosis-related group (DRG). The RHA in turn developed a benchmark price for each DRG, which formed the basis for contract negotiations. Thus in the southern region, an underlying principle of purchasing was the establishment of a common definition of service and a common price for all providers.

The RHAs soon began to compare purchasing practices and to pursue common methodologies. By 1995/1996, all of the RHAs had begun using the Australian system of DRGs (AN-DRGs) as a measure of output for medical and surgical services. Relative value weights (case weights) were established for each of the 667 AN-DRGs. These case weights then became the purchasing unit for most inpatient hospital services. The contracts specified both volumes and prices, and thus effectively established a fixed annual budget. Any additional volumes provided over and above the volume agreed in the contract were generally not reimbursed. The establishment of the HFA led to the development of a national “efficient” price for each case weight.

Case-weight purchasing provided Public Providers with few incentives to reduce the volume of services provided because if volumes reduced, their revenue would be reduced accordingly in the following year. However, it did provide a degree of flexibility in terms of case mix. For example, if cases treated became more complex, providers could reduce the number of less complicated procedures. Similarly, if acute admissions increased, they could offset this by reducing the number of elective procedures. Public providers were required to provide information to national health information collections and to report against contract requirements, and this information was used by purchasers to hold providers to account (see Chapter 5).

Primary health care services

As noted in Chapter 2.3, many primary care providers continued to supply consultations on a fee-for-service subsidy basis outside of the contract regime throughout the 1990s. However some group practices and community medical centres did provide these services under contract. As a general rule, payments to these providers were made

monthly according to the number of people registered with each practice. In negotiating these capitated contracts, purchasers and providers often disagreed about elements such as what constitutes “a service”, the definition of a “registered patient”, and the method for setting the level of the capitation payment.

While one RHA set out in some detail the range of services to be provided, most contracts were generally less prescriptive. No measures of volume were specified in the contracts. However, the RHAs required regular reports on utilisation rates, including the numbers of doctor and nurse encounters. They also sometimes called for additional information from providers on an ad hoc basis.

Other private providers

A number of difficulties arose as a result of subsidy arrangements for other private providers. As indicated earlier, while service levels and price were determined by contracting mechanisms, part of the contract price was often, in fact, funded as a subsidy to an individual patient. Long-term residential care is one example. Such patients had to have their health status individually assessed to determine the level of care they required. This had a number of consequences. Often a long-term care facility was funded in terms of numbers of beds at a particular level of care. As patients typically deteriorated and were reclassified as needing a greater level of care, they had to wait for such a bed to become available. To ensure continuity of care, residential care facilities had a choice of either carrying the cost of additional care themselves or compromising overall quality. It was difficult to anticipate these kinds of eventualities in the contracts. (See Chapter 4.2 for further discussion on this point.)

Public health services

The “unbundling” of funding for public health services from the area health board budgets (as described in Chapter 1.3) assisted the process of defining public health services for contract purposes. Even so, the difficulty of specifying public health services in any detail meant that most contracts were block contracts where price was based on (a) the historic cost of the service (b) the capacity of the provider and/or (c) the amount of funding available.

3.4 Quality measures

In the early years, measures of quality included in contracts varied across regions and across services. In some cases, purchasers simply worked with providers to develop and implement a quality improvement plan. In other cases, a set of minimum quality standards was specified within the contracts. These measures were wide ranging but generally fell into the broad categories of access, effectiveness, efficiency, acceptability and safety. They included such things as:

- ensuring consumer dignity, rights and privacy
- provision of culturally appropriate services
- provision of information
- employment of appropriately qualified staff
- accessibility (e.g. hours of opening, minimum waiting times)
- clinical quality measures (e.g. readmission rates, infection rates)
- written policy procedures (e.g. for restraining a patient, medication errors)
- physical environment (e.g. amount of space, toilet facilities, etc.).

Some providers expressed the view that the particular quality indicators that were included in their contracts did not provide any useful measure of the true quality of their service, especially in the early years. Even so, the inclusion of quality measures in the contracts clearly increased providers' awareness of quality issues and contributed towards the development of a culture of quality in service provision. It also encouraged purchasers to develop more robust quality indicators over time.

3.5 Response to Crown objectives

All purchasers clearly did take the set of Crown objectives into account in their purchasing activities, and did find these objectives useful in setting a direction for purchasing (see Chapter 2.3). However there was considerable variation across contracts and across the different objectives. As a

general rule, Crown objectives were reflected more clearly in the contracts with Public Providers than with other providers.

New services were purchased in all four of the initial health gain priority areas¹⁵, but most especially in mental health services (for which there was additional earmarked funding) and in health services for Māori. The objective of improving Māori health was also sometimes reflected in the general provisions of contracts. For example, quality standards often included a requirement to provide culturally appropriate services. However the meaning of this was not always clear and purchasers and providers sometimes had different interpretations of these clauses.

Most contracts also included reference to the terms of access to the service. Details of these differed across services but included elements such as minimum waiting times and maximum travel times. Although improving “affordability” was also included in the Crown’s access objectives, the potential for purchasers to influence any payments for services was limited because the level of subsidies and/or user charges for health and disability services is usually determined centrally.

Contracts were quite strong in terms of reference to the Crown’s legislative, ethical and safety requirements, many of the latter being defined in licensing regulations. However, as noted above, the specification of quality standards and measures of effectiveness of service varied considerably across purchasers and across different types of services.

3.6 Duration of contracts

The appropriate duration for a contract depends in large part upon the type of service and the structure of the market. Purchasers expressed a willingness to have longer contract terms in cases where services were not contestable or where a preferred provider was already providing a high quality of service at a reasonable price. This applied to services such as health protection services provided by Public Providers, and services provided by NGOs. In contrast, purchasers considered that the volume and price of medical and surgical services should be reviewed regularly.

In practice, the duration of contracts was largely dictated by the fact that purchasers had annual funding agreements

¹⁵ Until 1996/97, these were child health, Māori health, mental health and physical environment health.

with the Minister. The need to comply with competition law also restricted the extent to which purchasers and providers could agree to long-term contracts. These considerations meant that, initially at least, most contracts were for one year only. However by 1996, contracts of 2-3 years (and up to 5 years) were becoming increasingly common.

In the case of primary health services, the duration of contracts varied significantly depending on factors such as the type of service and the preference of either the purchaser or the provider. Where there were unresolved issues, temporary contracts for three or four months sometimes applied. These usually simply rolled over the existing arrangements until agreement about any new provisions could be reached. In contrast, there were some "evergreen" contracts, which applied until either party wished either to terminate the contract or to renegotiate its terms. In other cases, the term of the contracts was limited, usually to a period of one year but sometimes extendable to two or even three years. Purchasers were also subject to legal requirements under the Commerce Act and these requirements affected the length of contract that could be offered.

Table 1: Examples of contract content and form (1996)

	Type of contract	Volume measures	Quality measures	Duration of contract
Rest homes	Fee-for-service	Patient days	Clearly specified and monitored	1-2 years
Primary health care	Capitation	Patients registered No. of consultations	Poorly specified, monitored	Various: 3 months - 3 years, plus evergreen contract
Surgical services	Price and volume	Usually indicative only (DRGs, admissions, bed days, etc.)	Poorly specified, not monitored	1 year
Mental health	Block budget	Indicative only (admissions, patients seen, etc.) + input measures (number and mix of staff)	Poorly specified, not monitored	1 - 5 years

Key points from chapter 3

- Initially all terms and conditions were negotiated individually. Development of a standard set of terms and conditions under the National Purchasing Framework made things a lot simpler and less costly.
- Specification of services became more detailed over time. Clear specification of services is essential. Although this is a costly exercise initially in terms of time and expertise needed to develop these specifications and discuss them with providers, it was generally regarded as a good investment.
- Language changed from legalistic to plain English over time.
- Initially contracts were generally for 1 year, but the average duration of contracts gradually extended to 2–4 years.
- The ability of purchasers to negotiate long-term contracts was limited by:
 - (a) the Commerce Act
 - (b) the fact that purchasers had annual funding agreements with the Minister of Health.
- Crown objectives were reflected in both the process and content of contracts.
- The inclusion of quality measures in contracts contributed towards the development of a culture of quality in service provision.



PURCHASER/PROVIDER RELATIONSHIPS

4.1 Nature of relationships

When enquiring about the nature of purchaser/provider relationships, the most common response from both parties was “It depends”! This was usually followed by an explanation of the variables that had affected their particular relationships over time.

Overall, the nature of purchaser/provider relationships is probably best summed up by the interviewee who reported “There is always a natural tension”. This tension was especially apparent in the early years following the purchaser/provider split, when relationships were described by words such as “adversarial”, “formal” “acrimonious”, and “tense”. Some respondents referred to fluctuations in their relationship as both parties worked to establish their position. As would be expected, relationships tended to deteriorate whenever there were differences of opinion, or when funding was tight.

Some providers, especially those in larger organizations, also noted that their relationship with purchasers was complex in the sense that there were different levels of interaction. While face-to-face discussions between individuals were usually described as open, informal, cooperative and trustful, the relationship between the two organizations tended to be more formal and considerably less trustful.

Three other general observations can be made about the nature of the relationships between purchasers and providers. First, for all services there was an imbalance in the relationship. The purchasers, as monopsonists, enjoyed a position of considerable power. This was especially

threatening to those services where there was considerable competition between providers. Even in the cases of some Public Providers where there was little competition and therefore effectively a bilateral monopoly bargaining situation, the negotiating power was clearly unequal. One Public Provider described their relationship with the purchaser as “servant and master”. This imbalance was reflected in the level of trust between the two parties, with purchasers usually trusting providers more than providers trusted the purchaser.

Secondly, purchasers and providers perceived the nature of their relationship quite differently. Purchasers generally judged the relationship to be more informal, trusting, and cooperative than providers. Again this probably reflects the monopsony power of purchasers and the feeling of vulnerability on the part of providers.

Finally, providers made comments to the effect that the driving factor in providing a quality service was their ethical commitment to patients rather than their relationship with (or contractual obligations to) purchasers.

4.2 Sources of tension

Funding constraints

As more information became available about the costs of services, many in the sector concluded that there had been historic underfunding of Public Providers (Shiple 1994). They were therefore keen to use the contracting process to secure funding that was sufficient to cover their actual costs. However, as purchasers, the RHAs had fixed budgets, the quantum of which was also largely historically determined. There was therefore a gap between the cost of providing the services and the amount that RHAs were willing to pay. This resulted in tension when providers considered that either (a) the volume of service being demanded was too high, or (b) the price per unit of service that the RHA was willing to pay was too low.

Tensions sometimes increased, rather than decreased, when new money became available for new services. This was because potential providers would sometimes lobby the minister directly or advocate for increased funding through the media before negotiating with the relevant purchaser.

Lack of information

Reaching agreement on prices and volumes was especially problematic where the quality of cost data and other service information was poor. Lack of good information led to disputes and lengthened negotiations. It also sometimes meant that providers had little choice but to accept the offer made by the purchaser.

Poor communication

In some cases it appeared that poor communications systems were to blame for a poor relationship. Some providers complained that they received mixed messages from different purchaser personnel, or that they could never find the right person to speak to. On some occasions there was a mismatch between the types of people from the two organizations who were discussing contractual issues. Constant restructuring of the purchaser organizations exacerbated these problems.

Where contracts were made contestable through RFPs, some providers went to considerable effort to produce a robust proposal. Tension therefore occurred when these proposals could not even be considered because the RHAs had failed to indicate to providers how much funding was available.

Detailed specification and/or monitoring of services

The detailed specification of services in contracts tended to engender differences of opinion between the two parties and often made negotiations protracted and difficult. Providers were also unhappy with the high costs of data collection and of monitoring contracts, especially in cases where purchasers required the data to be supplied in a particular format. The absence of feedback, or of any indications that the purchaser had made any use of this information, further undermined relationships.

Contracting is also made difficult where changing circumstances cannot be anticipated nor incorporated into contracts easily. As noted in Chapter 3.3, problems arose in residential care facilities where the reclassification of a patient's needs required a higher level of care, which could

not be paid for if the provider was already providing the volume of care contracted for at that level. Case weights were used to overcome this problem in some contracts with Public Providers (see Chapter 3.3). More generally, however, contracts in health care could never be complete, with changes in health care needs and demands, referral patterns, technologies, and cost pressures underlining the importance of having flexibility in contracts and reinforcing the importance of good relationships in contracting in order to promote a flexible approach.

Legal environment

The legal status of contracts led to lengthy and detailed documents, and the requirement to comply with competition law discouraged collaboration and joint planning. Both of these rules increased the potential for the opinions and preferences of the two parties to differ. The fact that the Public Providers were operating as companies with directors liable for poor performance also created great tension and stress between the two parties.

4.3 Litigation

In a few cases, disputes between purchasers and providers were resolved through the courts. However none of these cases involved attempts by the purchasers to enforce the terms and conditions of agreements. (The Auditor-General's view was that the system operated more by way of self-monitoring of contractual compliance than monitoring by the purchasers of actual outcomes.) What litigation there was, tended to involve challenges by providers of the purchaser's contractual and consultation processes at the pre-contractual stage.¹⁶ Providers used litigation in an attempt to force the renegotiation or continuation of negotiations on aspects of the funding model. These challenges tended to be most acute at the point at which statutory fees schedules based on historical cost were replaced by contracts based on efficient pricing models. These kinds of claims were unsuccessful. This was largely because:

- (a) Despite the restructuring of the health sector and the contractual form, the Courts tended to regard the purchasers as public bodies distributing fixed

¹⁶ Two cases were *NZ Licensed Rest Homes v Midland RHA* High Court Hamilton 15 June 1999; Court of Appeal 128, 17 July 2000; *NZ Private Hospitals Association v Northern Regional Health Authority* High Court Auckland 440/94, 7 December 1994.

amounts of scarce public money: purchasers were not treated as unconstrained negotiating parties but as “perched uncomfortably between central government and ultimate consumers”.

- (b) Providers tended to have inflated expectations about how much could be subject to negotiation and expected to reach complete agreement with the purchaser. The reality was that the purchaser was a government agency acting as a monopsony during a period of cost reduction.
- (c) When the contractual relationships between purchasers and providers broke down, it was the patients who tended to suffer.

Other litigation¹⁷ involved purchasers and providers seeking access and disclosure of patient medical information for the purpose of negotiating and monitoring funding levels. The first case illustrates the tension between a private law contractual regime and a government’s legitimate interest in ensuring that public funds are properly spent. In the first case, Health Benefits Ltd investigated a general practitioner in relation to his claims for the general medical service subsidy. The Health Act 1956 (section 22G) had authorised them to inspect patient records for the purpose of such an audit in order to protect the public revenue. The practitioner questioned their ability to photocopy, inspect and retain patient files, by focusing on the issue of patient privacy. While some of the details of the practices were found to possibly give rise to a legal cause of action, the Health Act was taken to allow such an investigation. In the other case, it was the provider who sought access to a patients’ files for the purpose of negotiating with the Government about the appropriate level of subsidy.

Subsidy arrangements

Subsidy arrangements were also challenged. Again the public law nature of the arrangements tended to prevail over the private law form. In one case the Court of Appeal refused to adjust the service price for rest home care to account for an increase in Goods and Services Tax (*D-G Social Welfare v De Morgan* CA26/96). Effectively the case allowed a covert reduction in subsidy, which the rest home had to absorb. Subsidy arrangements tend to be regarded by judges as core government policy and properly subject to change. The cases also reveal that sometimes subsidies

¹⁷ *Hobson v Harding* (1995) 1 HRNZ 342; *Tozer v Attorney-General* High Court Auckland CP 609/97

continued to be paid in order to ensure continuity of care to individual patients, even though the service providers were in breach of other terms and conditions (*Bettina Rest Home v Attorney-General*, 1999). This is further evidenced by the fact that contractual methods of enforcement were practically unavailable to purchasers.

On the positive side, subsidy cases such as *Bettina* tend to illustrate that the extremely broad discretions to grant subsidies, which had formerly been exercised with little or no accountability, had been put on a more rational footing.¹⁸

4.4 Factors that alleviated tensions

The key factor that determined purchaser/provider relationships was the personality of the people involved. The establishment of personal links between individuals within contracting organizations was therefore key to the alleviation of tension. In the case of purchasers and multi-service provider organizations, this required responsibility for contracting for particular services being allocated to identifiable individuals. It also required face-to-face meetings, at least until a degree of rapport had been established between the two parties. In recognition of this, one RHA met on a face-to-face basis with all providers of care for older people. This included many small, independent providers, some of whom were located in fairly remote settlements.

While personalities were key, the overall approach to contracting taken by the purchasers also influenced purchaser/provider relationships. This is well illustrated by the approach taken by one RHA, which shared information with providers and was, according to one respondent, “head and shoulders above the rest”. It took a consultative and flexible approach, and worked with providers to set volumes, quality and prices of services. While providers still did not view their relationship with this RHA as a partnership, relationships were generally more trusting and less adversarial than with the other three RHAs. One RHA in particular took a very aggressive ‘take it or leave it’ approach to contracting. Relationships suffered accordingly.

The lack of good information very soon encouraged providers to put into place systems for improving the quality of their service and cost data. In the interim,

¹⁸ Under the former social welfare subsidy regime the government had met the difference between the patient's means and the cost of the service. There had been no maximum rate of subsidy.

relationships improved if purchasers and providers could agree on the source of data that was to be used, even if the quality of these data was poor.

Providers also noted the importance of purchasers being consistent and transparent in their purchasing strategies. Even where providers disagreed with a particular strategy, tensions were alleviated if the purchaser communicated the reasons for taking that approach and were consistent and fair in pursuing that strategy across all providers.

4.5 Changes in relationships over time

Closer relationships between purchasers and providers did develop over time, although not as quickly as might have been expected. This may be because the policy and legislative environment in New Zealand was not generally conducive to a more relational style of contracting, at least in the early years. In particular, the Commerce Act tended to discourage cooperation between contracting parties. Even so, relationships between the RHAs and providers had improved considerably by 1996.

The replacement of the RHAs by the HFA resulted in new staff in key negotiating positions as well as in new contracting processes. Purchaser/provider relationships therefore suffered something of a setback and high staff turnover tended to inhibit the development of ongoing personal relationships.

The shift in government policy away from a competitive contracting regime towards a more cooperative and planned approach to contracting, along with the move from four competing RHAs to a single purchaser, allowed the HFA to pursue a more relational style of contracting. In the case of larger providers, it shared information and problems, and worked with them to sort out any differences and to work together towards shared goals. Greater regional consistency through the standardisation of contract terms and conditions and the development of a national pricing framework also contributed to improved relationships between the HFA and Public Providers.

However, this was not always the case for many smaller, private providers and NGOs. For this group, a single national purchaser effectively meant the loss of any opportunity to discuss contractual arrangements with the purchaser on a

face-to-face basis. The greater standardisation of service frameworks also made it difficult to negotiate contracts on an individual basis. Relationships suffered accordingly.

4.6 The importance of good relationships

As relationships changed over time, the importance of good purchaser/provider relationships became increasingly apparent. As one interviewee noted: "If you have dysfunctional relationships, no matter how elegant the contract is, it won't work. It's about functional relationships between purchaser and provider, and between managers and clinical staff." The establishment of a trusting relationship between purchaser and provider reduces the need to rely on a contract to secure the desired outcome. A good relationship effectively means that the contract can be consigned to the bottom drawer.

Key points from chapter 4

- Good relationships are the key to successful contracting. However there is always a natural tension between contracting partners.
- There was an imbalance of power between the contracting partners, with the purchasers in the stronger position. Purchasers and providers therefore interpreted their relationships rather differently.
- Litigation may be pursued by providers when:
 - (a) funding arrangements are being changed by purchasers
 - (b) records are being used to investigate the appropriate behaviour of providers (including when the provider's practices for claiming funding are in question).
- Over time both purchasers and providers began to work more closely and relationships generally improved but this was sometimes disrupted by significant changes in personnel and organizational reorganization.

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- Face-to-face contact is especially important for smaller providers.
 - In a situation where there is historic underfunding of hospital services, additional funding could create tensions and problems, and would not necessarily result in increased services being delivered as providers sought to obtain higher prices for the services they already delivered.
 - Relationships could be improved where:
 - sources of information used in negotiations are agreed from the start, even if the quality of information is poor
 - information is shared by the purchaser with the providers (although there are some limits on what can be shared about specific providers with other providers)
 - purchasers have a consistent, fair, transparent and well-communicated purchasing strategy, with explanations for why that approach is being followed
 - standard terms and conditions are developed
 - the style of contracting is cooperative rather than competitive.



MONITORING AND ACCOUNTABILITY

5.1 Introduction

A key objective of the purchaser-provider split was greater transparency with respect to the volume and cost of service provision. Contracts encourage greater specification of services. If the performance of service providers is monitored, this in turn leads to increased accountability. However, monitoring of performance is only one way in which purchasers and providers were held to account in the sector.

Improved accountability was sought at a number of levels, with a hierarchy of performance monitoring mechanisms being put in place. In terms of accountability of purchasers to the Crown, an early approach was to develop Crown objectives that were translated into funding agreements with purchasers. Later the HFA developed a strategic business plan that responded to government objectives, and the strategic plan was reflected in a funding agreement between the Minister of Health and the HFA. This was then rolled down through the HFA operational plans and staff objectives. A second level of accountability then operated between purchasers and providers. It is this second level of accountability that is the main focus of this chapter. The issue of accountability from a consumer's perspective is also briefly discussed.

5.2 Approaches to monitoring

Under the Health and Disability Services Act (section 33), each purchaser was required to 'monitor the performance of purchase agreements or other arrangements by persons with whom it has entered into such agreements or arrangements'. Purchasers used two main approaches to monitor providers' performance: one to monitor volumes, the other to monitor the components and quality of care.

First, contracts included clauses that specified the data on service provision (usually numbers of services delivered) that providers were required to submit to purchasers. Three RHAs also included in their contracts with Public Providers sanctions if the required information was not provided on a regular basis. One of these was termination of contract if the provider did not provide the data, or the ability to claw back resources if a provider failed to report.

In spite of some difficulties with this type of monitoring (described in the next section), purchasers were sometimes able to monitor providers on a systematic and ongoing basis, especially with respect to under- and over-provision of services. Providers similarly commented on the attention paid by purchasers to discrepancies in volumes of service being delivered compared with contracted volumes. In other cases, the purchasers often simply watched and waited, and followed up only if there were particular indicators for concern or key markers in which the Ministry had a special interest. Some providers were of the view that, in later years particularly, the HFA might have been more assertive in their follow-up, preferring instead to support and educate providers in an effort to improve their performance.

The second broad approach to monitoring involved purchasers building into contracts a requirement to undertake audits, with providers' delivery of service being audited against a clear set of standards of care (which were usually process-related). In some cases (e.g. the Central RHA in mental health), all providers were to be audited on a random basis over a three year cycle. In other cases (e.g. the disability group in the HFA) the purchaser set aside resources to undertake random audits of certain numbers of providers (300 per annum). In addition, there were some one-off quality audits when a particular issue came up.

The approach to auditing varied across purchasers. Some worked with providers to identify the quality of care expected. The purchaser would then undertake an audit of service standards and, if necessary, then work with the provider to improve the quality of their service. Other audits were more punitive, with the potential for contract termination if quality standards could not be met. In some cases, there was consumer input into the audit standards and process.

Significant complaints made by consumers or others to the purchasers were also fed back by purchasers to providers as a part of performance monitoring. Audits on fee claims also took place, for example as part of Health Benefits Limited's (HBL) role in processing (primary care) claims, although the precedent for this type of audit predated the 1993 reforms. ACC also has case manager referrals to signal problems: if the volume of referrals stops or significantly reduces, they will investigate why, and may stop payments on a contract or not renew it.

Problems with monitoring

A number of problems relating to monitoring became apparent early on. First, the data needed by CCMAU and each of the RHAs were often either (a) different, (b) required in a different format or (c) required for different time periods. Similar problems arose in the disability support sector where providers could be monitored and/or audited by three agencies: the RHAs/HFA against contract, the Ministry of Health (for licensing purposes) and accreditation agencies. Providers complained about the quantity of information required and about the cost of collecting and reporting the information. They considered that the Ministry of Health and RHAs/HFA could usefully have worked together on their requirements and processes.

Second, studies showed that purchasers did not provide feedback on reports made by providers (Performance Monitoring and Review undated). Following up on monitoring and auditing continued to be a problem throughout the decade, with purchasers, including ACC, focusing far more attention on the actual contract than on monitoring and follow-up. A number of reasons were given for this, including that information systems were under-developed, but also that problems in monitoring were related to a lack of resources; a lack of skilled purchasers who understood

the services being monitored; a lack of technical skill to manipulate, analyse and interpret the data; and the fact that monitoring was considered to be a very labour-intensive task.

As a result of these issues, providers sought guidelines on the collection and use of information required in provider reports, and the Ministry of Health recommended that RHAs should agree with providers the best way of providing feedback to organizations on their reports. The Ministry also suggested that purchasers needed to negotiate and contract separately for any information additional to that directly related to the contract (Performance Monitoring and Review undated).

More recently, purchasers have noted the need to consider issues such as:

- the difficulties of measuring key dimensions of the contract (e.g. quality) (Performance Monitoring and Review undated)
- the extent of the information required, with recognition of the tension between the cost of providing data and compliance, the importance of the purchaser being clear on why it wants information, and linking all data requirements together. One approach is to avoid asking for information that can be obtained through payment systems; another is to recognise the importance of providers being involved and negotiating the performance indicators and the monitoring arrangements.

Effectiveness of monitoring

Providers have different opinions about the effectiveness of the performance monitoring processes. Some consider the auditing processes were quite weak, probably because they tended to focus largely on process issues rather than on service outcomes. The relevance of the processes that are being monitored is also sometimes rather questionable. Moreover, some providers considered that the quality indicators within the contracts often failed to capture the essence of service quality. Any monitoring of these indicators was therefore an unnecessary and ineffective additional

cost. Other providers were more positive, noting the potential contribution that performance monitoring can make towards continuous quality improvement.

Purchasers noted that improved data collection arising out of contracting allowed them to know their levels of commitment; and that there is 'more information than ever before; at least we know what the health system is doing'. However, while monitoring often took the form of ongoing quantitative data collection, purchasers also felt that 'you also need to get out there and see what's going on'. Thus, a purchaser may get more information informally than through a very formal contract monitoring arrangement, especially if they have developed a good relationship with the provider.

5.3 From monitoring to accountability

In early studies on contracting, a frequent comment was that improved accountability was an important benefit of the new system, with providers noting that they were clearer about their roles, and both parties citing improved information on the services actually delivered as a key outcome of the contracting process.

Resources were sometimes clawed back for lack of service delivery. However, it appears that purchasers generally felt they had only limited ability to hold providers to account through contracts. There were a number of reasons for this. First, delays in negotiating contracts meant that contracts were sometimes signed long after the services had been delivered. Second, payments to Public Providers were made monthly in advance, and this made it very difficult for purchasers to claw back the resources if the volume or quality of services did not meet the contract requirements. Furthermore, with resources in the sector so tight, purchasers felt that they needed to have very good grounds for clawing back resources. Third, as noted in Chapter 2.6, purchasers tended to avoid moving contracts to new providers because changing providers is a costly process, plus continuity of care is regarded as a fundamental component of quality for many services (especially long-term care).

In contrast to experiences under the RHAs/HFA, ACC has greater ability to hold providers to account. They will not pay for anything until the service has been delivered.

ACC will remove a budgetary provision for a provider if they are not using that particular budget. ACC is also able to use its fee-for-service transaction reporting system to provide it with regular information on performance and to hold providers to account for the delivery of contracted care. It also operates processes whereby new providers are initially contracted for one year only. Service delivery is then reviewed before a longer-term contract is offered. Arguably one reason for ACC's better position is that, because it purchases only services that are required for accident-related injuries, it has a choice of providers for most of these services. Even here, however, ACC notes that stopping payments or contracts is very difficult, given that it is a government-owned insurer, albeit working at arm's length from central government.

5.4 Role of contracts in holding providers to account

The contracts themselves were often not regarded as a sufficient mechanism to hold providers to account. Contracting in some cases became a bit of ritual. Others saw contracts as a change management tool rather than as an accountability mechanism, encouraging discussion of service development within the frame of contract discussions.

Contracts were often rolled over each year, with funding levels and services remaining largely unchanged (Te Puni Kōkiri 1997). It seems that once purchasers and providers had specified services and worked on pricing, contracts themselves became somewhat less relevant, although the process of renegotiation did allow service issues to be raised.

In terms of quality of care, there are a number of ways, in addition to contracts, in which providers can be held to account. These include the ability of consumers to complain to the Health and Disability Commissioner, as well as to professional regulatory bodies, which have legislative powers to oversee competencies of and care delivered by registered professionals (general practitioners, midwives, nurses, specialists and ancillary providers). These processes probably have more importance than contracts in holding various professional providers to account for the care they deliver. However, in some areas (such as rest homes,

community mental health service delivery), greater competition and the use of audit have clearly improved accountability in the sector.

5.5 Accountability from the consumer's perspective

From the consumer's perspective, the separation of purchasing from provision may blur the lines of accountability. Consumers may not be clear as to whether it is the purchaser or the provider who is responsible for aspects of services such as access to care, quality of service, or changes in the type or level of services provided. Consumers generally tended to assume that providers were responsible for any problems they encountered in the system, especially with respect to access to services. However in practice, access was sometimes constrained by decisions made by the purchaser with respect to types of levels of services they wished to purchase. This blurring of responsibilities suggests that, from the consumer's perspective, an integrated purchaser/provider model may offer greater accountability as only one agency is clearly responsible for decisions affecting service availability and quality.

Key points from chapter 5

- In order to improve accountability, performance monitoring mechanisms were put into place between the Crown and the purchasers, as well as between purchasers and providers.
- Difficulties in monitoring outputs or outcomes resulted in a tendency to monitor processes.
- Most monitoring took the form of ongoing quantitative data collection. However, where purchaser-provider relationships are good, a purchaser may get more information informally than through a very formal contract monitoring arrangement.
- Contract volumes were monitored quite closely. However purchasers were constrained in their ability to hold providers to account through contracts.

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- Providers' opinions about the effectiveness of monitoring for improving quality were divided. Some were of the opinion that quality measures within contracts did not capture the essence of quality; others considered that monitoring and audit made an important contribution to ongoing quality improvement.
 - Providers expressed concerns over the quantity of information required by purchasers and the cost of data collection.
 - Good information systems are essential to support the monitoring process.
 - Capacity to analyse information is important to the purchasing/contracting function.
 - From the consumers' perspective, having separate agencies responsible for purchasing and provision tends to blur the lines of accountability.
 - There are important accountability mechanisms outside contracts that help ensure quality of care. These include consumer complaints mechanisms/bodies and professional regulatory bodies.

SUMMARY AND CONCLUSIONS

In 1993, New Zealand implemented major changes to the way in which the health care system was organised. These reforms involved separating purchasing and provision functions and establishing new organizations, developing contracting arrangements between purchasers and providers, introducing a more competitive environment with providers competing for contracts from purchasers, and establishing a more commercial environment for Public Providers. These health reforms were extremely controversial, reflected politically in a number of restructurings during the 1990s. These changes saw the demise of the Public Health Commission, the amalgamation of four RHAs into one HFA, the removal of the focus on competition and the commercial orientation of Public Providers, and the eventual complete reorganization of the system in 2001.

Contracting for health services between purchasers and providers was a key component of the 1990s reforms. Moreover, in spite of the subsequent restructurings, contracting has remained a central part of the management of the health system in New Zealand. This remains true even with the latest set of reforms and the establishment of 21 District Health Boards (DHBs). Although the purchasing and provision of services delivered by the Public Providers has now been reintegrated to some degree under the DHBs, purchasing and provision of primary and community-based services remain separate. DHBs must therefore continue to contract with these providers. Thus it is clear that contracting has not been universally regarded as a bad thing.

A number of strengths in moving to a contracting environment have been noted in this report. These included forcing both purchasers and providers to focus on the costs and volumes of service they were delivering, and clarifying for the first time the services that were actually being provided in New Zealand. Service specification became more detailed over time, and, although this was sometimes costly, it was generally regarded as a good investment. Many providers felt that contracts encouraged them to focus on how they might improve quality of care, although the fear that a contract may be lost if quality of care did not improve, along with ethical issues, also played a role in improving quality of care. Contracting also opened up some opportunities for new styles of service provision from providers that had not traditionally received public funds for health services, especially encouraging the development of by-Māori, for-Māori service delivery.

On the other hand, there were problems in moving to a contracting framework. A very legalistic approach was taken in New Zealand initially and this encouraged an adversarial approach and resulted in high transaction costs. In the early days, a lack of good information on costs, volumes and quality made it difficult to compare providers' performance and to negotiate contracts. Transaction costs were particularly high in the early years, due to the legalistic approach taken, and the existence of four RHAs often contracting with the same providers but each with different contract requirements. Negotiations were often acrimonious, especially over prices. This, together with a lack of alternative service providers, highlights the importance of requiring Public Providers to deliver essential services in the event of any potential failure in supply.

The shift to a contracting environment was also hampered by the need for new expertise required by both purchasers and providers, especially legal expertise and contract negotiation expertise. In addition, competition law concerns were often at odds with other health sector objectives, making it difficult to negotiate longer-term contracts.

Over time, the content of contracts changed. Initially, all terms and conditions were negotiated individually. In the later period, the HFA developed a standard set of terms and conditions and this made contracting a lot simpler and far less costly. Language also changed from legalistic to plain English, and the length of contracts was gradually increased to between two and four years.

Good relationships were seen as the key to successful contracting. New Zealand providers felt that purchasers were in a much stronger position than providers, and both interpreted their roles differently. Purchasers judged the relationship to be more informal, trusting and cooperative than providers, probably reflecting the power providers felt that purchasers had over them and the vulnerability providers felt in a more competitive environment. However, relationships improved over time as purchasers and providers began to work more closely together. Small providers found face-to-face contact to be a particularly important part of good contracting.

The development of good purchaser-provider relationships was hampered by a number of factors. First, repeated reorganization of the sector's structure and constant changes in personnel often exacerbated the attempts by individuals to establish personal contacts within the relevant agencies. Second, as many in the sector felt there had been historic underfunding of hospital services, additional funding could create tensions and problems. This would not necessarily result in increased services being delivered as providers sought to obtain higher prices for the services they already delivered.

This study suggests a number of ways in which relationships might be improved. These include reaching early agreement on the sources of information to use in negotiations; sharing information where possible; purchasers having a clear purchasing strategy that is communicated to all involved in contracting; developing standard terms and conditions; and developing a style of contracting that is co-operative rather than competitive.

An important part of the contracting environment related to monitoring and accountability. A variety of approaches developed towards monitoring, and again commentators recognised the importance of having good relationships in managing monitoring and accountability. Concerns arose in terms of the quantity of information required by purchasers, and all have recognised how important it is to have good information systems to support monitoring. Effective monitoring relies, however, on having the capacity to analyse information, and sufficient skills and experience to do this were not always available in New Zealand.

In terms of accountability, New Zealand's experience shows that the political and market environments in which contracting takes place will affect the ability to successfully

use contracts for holding providers to account. The stronger the ability of purchasers to claw back resources and shift contracts, the stronger contracts are as an accountability mechanism. Hence, the overall approach to contracting, the degree of competition, the financial position of providers, and the commitment of politicians in a publicly-financed system will all affect the role of contracts in improving the accountability of providers.

In conclusion, as with any major reform, it took time for contracting in New Zealand to be bedded in place and for those involved to develop experience. New Zealand had some particular problems (such as ongoing restructurings) that exacerbated the development of a stable contracting environment. Competition for resources also made providers feel vulnerable and led to tensions in contracting relationships. In spite of this, contracting remains a key part of the New Zealand health sector. A particular challenge now is how to ensure the gains associated with contracting continue (e.g. enabling a range of providers to access resources) while continuing to reduce the associated transaction costs.

APPENDIX METHODS

Information in this report comes primarily from three separate sets of interviews with key contracting personnel. All three surveys covered both purchasers and providers. However the first two covered only those services purchased by the RHAs: they did not cover the Public Health Commission or the ACC.

Survey No. 1: This was a comprehensive survey undertaken in 1994/95 by Ministry of Health personnel (Performance Monitoring and Review undated). It covered both purchasers and (public and private) providers in all four regions of the country. Its purpose was to monitor the contracting process.

Survey No. 2: This second survey was undertaken in 1996 by Toni Ashton as part of her doctoral thesis (Ashton 1997). The survey covered a total of 53 key informants who were actively involved in contracting in the two northern RHA regions: 7 purchasers, 39 service managers, 5 umbrella groups and 2 unsuccessful private bidders. It focused on four services: surgical services, mental health services, primary health services and rest homes.

Survey No. 3: This last set of interviews was undertaken in 2001/2002 specifically for the purposes of this report. Key informants with experience in purchasing or provision in relation to public providers, primary health services, NGOs and public health services were identified by the researchers. Snowball techniques were used to identify additional key informants. In total, 11 purchasers and 9 providers were interviewed. Interviews were summarised, and summary scripts sent out to interviewees for checking. Scripts were then analysed using content analysis techniques.

A literature review of international and New Zealand material was also undertaken for this project.



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